Chestnut Health Systems
Client Rights

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 5 Definition of Client		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Statement of Client Rights		

CR 5 DEFINITION OF CLIENT

For purposes of these Client Rights Policies, “client” is intended to refer to both patients in the primary care setting and clients in the behavioral health programs.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section	Client Rights		
Policy Name and Number:	CR 10 Client Rights and Responsibilities		
Revision Date:	01/25/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CR 16 Use of Restraint and Seclusion		
Citation(s):	Missouri Department of Mental Health, Rights, Responsibilities, and Grievances, 9 CSR §10-7.020(2) Missouri Department of Mental Health, Rights, Responsibilities, and Grievances 9 CSR 10-7.060 Emergency Safety Interventions Mo. Rev. Stat. §630.110 / §630.115 / §630.125		
Related Documents:	Statement of Client Rights		

CR 10 CLIENT RIGHTS AND RESPONSIBILITIES

Chestnut Health Systems ("Chestnut") clients shall be informed of rights during assessment or upon admission to treatment. This initial orientation will be provided in a timely manner based on the client's presenting condition and type of services he or she will receive. The orientation will be presented in a manner understandable to the client and will be available in written form. Written acknowledgment of receipt of the orientation will be documented in the client's medical record.

Subsequently, clients receiving mental health services will be informed annually of their rights. For clients receiving health care via telemedicine, rights may be read to the client and the client must confirm verbally that he/she understands the information provided and that this information has been discussed with him/her by the provider prior to the delivery of services. Documentation of this process will be maintained in the medical record. Documentation of this process does not need to be completed at each transfer during the continuum of care. The statement of client rights shall be posted in areas accessible to clients at all times.

Clients shall be informed of their client responsibilities by the clinician responsible for their care and/or through program specific materials presented to clients involved with that specific program. The client responsibilities will be reviewed with clients at admission and whenever clinically necessary. The client and client's family will be allowed the opportunity to ask questions. Client responsibilities may include but are not limited to the expected behavior of clients in the program (for example, following program rules, showing respect, maintaining confidentiality of other clients and any restrictions on clothing worn), including the expectation of meeting financial commitments for payment of services.

Clients will be free from aversive conditioning of any kind, including, but not limited to:

- withholding food, water, or bathroom privileges
- painful stimuli,
- corporal punishment,
- Use of seclusion, restraint, time out, discipline or coercion or coercion for staff convenience.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 11 Confidentiality, Privacy and Security of Protected Health Information		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Health Information Technology for Economic and Clinical Health Act ("HITECH") Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 (the "Privacy Rule") Security Standards for the Protection of Electronic Health Information at 45 CFR Parts 160 and 164 (the "Security Rule") Federal Confidentiality of Alcohol and Drug Abuse Patient Records law and attendant regulations, 42 U.S.C. §290dd-2 and 42 C.F.R. Part 2 Illinois Mental Health and Developmental Disabilities Confidentiality Code Illinois Mental Health and Developmental Disabilities Confidentiality Act, 405 ILCS 5 and740 ILCS 110 Privacy Manual of Chestnut Health Systems, Inc. Missouri Department of Mental Health, Governing Authority and Program Administration, 9 CSR §10-7.090(7) and 9 CSR §10-5.220 Missouri Department of Mental Health, Confidentiality of Records, Mo. Rev. Stat. §630.140 Disclosure of Confidential HIV Information Section 191.656 and 191.657 of the Missouri Revised Statutes		
Related Documents:	Notice of Privacy Practices Notice of Privacy Practices and Client Rights		

CR 11 CONFIDENTIALITY, PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

Every patient has the right to the confidentiality, privacy, and security of his/her health information. Chestnut takes this responsibility seriously. All operations are conducted in a manner consistent with applicable federal and state confidentiality, privacy and security laws and regulations, including the following, as amended from time to time:

- The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and the implementing regulations thereunder, including but not limited to, the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 (the "Privacy Rule") and the Security Standards for the Protection of Electronic Health Information at 45 CFR Parts 160 and 164 (the "Security Rule"), and the requirements of the final modifications of the HIPAA Privacy Rule, Security Rule, et al., issued on January 25, 2013, and effective March 26, 2013;

- Federal Confidentiality of Alcohol and Drug Abuse Patient Records law and attendant regulations, 42 U.S.C. §290dd-2 and 42 C.F.R. Part 2, respectively;
- Illinois Mental Health and Developmental Disabilities Confidentiality Code and Illinois Mental Health and Developmental Disabilities Confidentiality Act, 405 ILCS 5 and740 ILCS 110, respectively;
- Section 630.140of the Department of Mental Health Section of the Missouri Revised Statutes,
- Illinois AIDS Confidentiality Act (410 ILCS 305) and.
- Disclosure of Confidential HIV Information Section 191.656 and of the Missouri Revised Statutes.

All patients (or legal guardian, as applicable) are provided a copy of Chestnut's Notice of Privacy Practices and a Client Rights document at the time of admission.

In addition to policies set forth in this Handbook, Chestnut maintains a separate manual of Privacy Policies to further ensure safeguarding of patients' health information. Staff are trained upon hire and annually on confidentiality and privacy policies contained in the Chestnut Handbook and Privacy Manual.

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Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 13 Access to Health Information		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CR 11 Confidentiality, Privacy and Security of Protected Health Information		
Citation(s):	Health Information Technology for Economic and Clinical Health Act ("HITECH") 21st Century CURES Act		

Related Documents:

CR 13 ACCESS TO HEALTH INFORMATION

Definitions

Access – the ability or means necessary to make EHI available for exchange, use or both.

Electronic access - an internet-based method that makes EHI available at the time the EHI is requested and where no manual effort is required to fulfill the request. 45 CFR § 171.302(d).

Electronic health information (EHI) - In the Final Rule, the ONC sought to align the definition of EHI with HIPAA's electronic protected health information (EPHI) that would be included in a designated record set. Thus, electronic health information (EHI) means EPHI as defined in 45 CFR § 160.103 to the extent that it would be included in a designated record set as defined in 45 CFR § 164.501, regardless of whether the group of records are used or maintained by or for a covered entity as defined in 45 CFR § 160.103. However, EHI shall not include:

- Psychotherapy notes as defined in 45 CFR § 164.501 (i.e., notes recorded in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record); or
- Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. 45 CFR § 171.102.

Until October 6, 2022, EHI is limited to the EHI identified by the data elements represented in the United States Core Data for Interoperability standard adopted in 45 CFR § 170.213. 45 CFR § 171.103. The limited data classes and data elements are:

1. Allergies and intolerances
2. Assessment and plan of treatment
3. Care team members
4. Clinical notes
5. Clinical Notes:
    5.1Consultation Note

5.2 Discharge Summary Note
5.3 History & Physical
5.4 Imaging Narrative
5.5 Laboratory Report Narrative
5.6 Pathology Report Narrative
5.7 Procedure Note
5.8 Progress Note – notes made by a nurse, physician, social worker, physical therapist, and other health care professionals that describe the patient's condition and the treatment given or planned

6 Goals
7 Health Concerns
8 Immunizations
9 Laboratory
10 Medications
11 Patient demographics
12 Problems
13 Procedures
14 Provenance
15 Smoking status
16 Unique device identifiers for patient's implantable devices
17 Vital signs

Exchange – the ability for EHI to be transmitted between and among different technologies, systems, platforms, or networks; and is inclusive of all forms of transmission such as birectional and network-based transmission.

Healthcare provider - The Final Rule generally speaks in terms of "actors," of which one type is a healthcare provider. Thus, this Policy uses the term healthcare providers vs. actors for clarity. As can be seen in the definition below, the ONC finalized the very broad definition of healthcare provider established under the HITECH Act under section 3000(3) of the PHSA, which is distinct and generally broader than the HIPAA definition.

The term "healthcare provider" includes a hospital, skilled nursing facility, nursing facility, home health entity or other long term care facility, healthcare clinic, community mental health center, renal dialysis facility, blood center, ambulatory surgical center, emergency medical services provider, Federally qualified health center, group practice, a pharmacist, a pharmacy, a laboratory, a physician, a practitioner, a provider operated by, or under contract with, the Indian Health Service or by an Indian tribe, tribal organization, or urban Indian organization, a rural health clinic, a covered entity under the 340B Drug Pricing Program, an ambulatory surgical center, and a therapist. See 45 CFR § 171.102; 42 U.S.C. § 300jj.

Information blocking by a healthcare provider - a practice likely to interfere with access, exchange or use of EHI,

(i) except as required by law or covered by an exception set forth in federal regulations, is likely to interfere with access, exchange, or use of EHI; and
(ii) the provider knows is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of EHI.

The information blocking regulation applies to a healthcare provider regardless of whether the HCIT solution(s) the provider uses is certified under the ONC Health IT Certification Program.

Interoperability - health IT that:
enables the secure exchange of EHI with, and use of EHI from, other health IT without special effort on the part of the user;

- allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and

- does not constitute information blocking. See 42 U.S.C. § 300jj.

Interoperability element - hardware, software, integrated technologies or related licenses, technical information, privileges, rights, intellectual property, upgrades, or services that: (1) may be necessary to access, exchange, or use EHI; and (2) is/are controlled by the covered component, which includes the ability to confer all rights and authorizations necessary to use the element to enable the access, exchange, or use of EHI. See 45 CFR § 171.102.

Requestor – a requestor can be a hospital, agency, patient, government entity, etc. The requestor is responsible for bi-directionally, communicating the provider. The provider is the data owner, responsible for bi-directionally communicating machine readable information from the electronic health record.

Use – the ability for EHI to be understood and acted upon once accessed or exchanged. "Acted upon" includes the ability to read and write and is also bidirectional.

45 CFR Part 171 –Information Blocking

The Information Blocking Rule prohibits certain actors, including health care providers, from engaging in practices that are likely to interfere with the access, exchange or use of electronic health information (EHI), unless the practice is required by law or a regulatory exception applies. Information blocking conducted by a health care provider occurs when a provider knows that such practice is unreasonable and is likely to interfere with access, exchange, or use of EHI.

Once a request to access, exchange, or use EHI is made, a health care provider must respond timely to the request. Delays or other unnecessary impediments could implicate the information blocking provisions. EHI may be requested via method including, but not limited to:

i. Patient portal
ii. Provider portal
iii. Application program interfaces (API)
iv. Email
v. Phone calls
vi. Verbal requests in person
vii. Patient access form

Information blocking practices can be a healthcare provider's acts or omissions—essentially anything that interferes with the access, exchange, or use of EHI. However, just because an action interferes with the access, exchange, or use of EHI does not mean the practice is automatically considered an info blocking violation—facts and circumstances unique to each action should be taken into account.

Information blocking practices may include but are not limited to:

1. Practices that restrict authorized access, exchange, or use under applicable state or federal law of such information for treatment and other permitted purposes under such applicable law;
2. Implementing health IT in nonstandard ways that are likely to substantially increase the complexity or burden of accessing, exchanging, or using EHI;
3. Limiting or restricting the interoperability of health IT, such as disabling or restricting the use of a capability that enables sharing EHI with users of other systems or restricting access to EHI by certain types of persons or purposes that are legally permissible, or refusing to register a software application that enables patient access to their EHI (assuming there is not a legitimate security reason that meets the conditions of the Security Exception);
4. Implementing health IT in ways that are likely to restrict the access, exchange, or use of EHI with respect to exporting complete information sets or in transitioning between health IT systems. This would include acts that make transitions between certified health information technologies more challenging (e.g., an EHR vendor charging excessive fees or using tactics to delay a practice's switch from their EHR to another vendor's EHR);

5. Acts that lead to fraud, waste, or abuse, or impede innovations and advancements in health information access, exchange, and use, including care delivery enabled by health IT;
6. Restrictions on access, exchange, and use, such as may be expressed in contracts, license terms, EHI sharing policies, organizational policies or procedures or other instruments or documents that set forth requirements related to EHI or health IT, such as Business Associate Agreements (BAAs); and
7. Rent-seeking (e.g., gaining larger profits by manipulating economic conditions) or other opportunistic pricing practices.

Healthcare providers may implicate the information blocking rule if they knowingly take actions that interfere with exchange, access, and use of EHI, even if no harm materializes. For nearly all EHI requests, health care providers must respond and release patient's medical records unless an appropriate exception can be identified and used.

The information rule does not override other state or federal laws applicable to the release of medical records.

- 42 CRF Part 2
- Illinois Mental Health Confidentiality Act
- Illinois AIDS Confidentiality Act

These laws impose specific preconditions that must be satisfied before information can be released. If the specific precondition being relied upon is patient consent and patient consent has not or cannot be obtained, then the healthcare provider should restrict access, exchange, or use of that information until the patient's consent is obtained.

The following are examples of practices that might implicate the prohibition against information blocking:

- Requiring a patient to sign a release of information before sharing the patient's EHI with unaffiliated providers for treatment purposes when the patient's consent is not required by state or federal law;
- Incorrectly claiming that HIPAA or other state and federal laws preclude a health care provider from exchanging EHI with unaffiliated providers;
- Disabling the use of HER capability that would enable staff to share EHI with users of other systems;
- Implementing a policy that restricts access to patient lab results for a certain amount of time. Even if patients are not aware there is a delay between when the results are available to the physician and when they are made available to the patient.
- Delaying a patient's access to their EHI for several days, even though the provider has the ability to provide same day access to the EHI (such as through a patient portal); and
- Using written agreements (such as a HIPAA Business Associate Agreement, HIPAA Data Use Agreement, or other data sharing agreement) or policies and procedures to forbid, limit or delay disclosures that would otherwise be permissible under state and federal law.

This list is by no means exhaustive. Other practices—acts or omissions—that a health care provider knows are unreasonable and likely to interfere with the access, exchange or use of EHI will implicate the Information Blocking Rule and may be unlawful, unless the practice is required by law or is covered by an exception.

There is no requirement under information blocking regulations to proactively make available any EHI to patients or others who have not requested the EHI. However, a delay in the release or availability of EHI in response to a request for legally permissible access, exchange, or use of EHI may be an interference under the information blocking regulations.

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Exceptions to Information Blocking

Eight reasonable and necessary activities have been identified as exceptions to the information blocking definition. The exceptions apply to certain activities that are likely to interfere with access, exchange, or use of EHI, but that would be reasonable and necessary if certain conditions are met.

If the healthcare provider's practice satisfies at least one exception, the actor will not be subject to enforcement actions under the information blocking provisions for civil monetary penalties (CMP) or appropriate disincentives. To satisfy an exception, each relevant practice by an actor at all relevant times must meet all the applicable conditions of the exception. Failure to meet the conditions of an exception does not automatically mean a practice that constitutes information blocking would not have guaranteed protection from CMPs or appropriate disincentives. The practice would instead be evaluated on a case-by-case basis to assess the specific facts and circumstances (*e.g.*, whether the practice would be considered to rise to the level of an interference, and whether the health care provider acted with the requisite intent) to determine whether information blocking has occurred.

There are **FIVE** exceptions in which a health care provider does not fulfill a request to access, exchange, or use EHI:

1. Preventing harm exception
2. Privacy exception
3. Security exception
4. Infeasibility exception
5. Health IT performance exception

There are **THREE** exceptions that describe practices that limit the content or manner of responding to a request to access, exchange, or use EHI:

1. Content and manner
2. Fees
3. Licensing

Information blocking regulations are directive and require healthcare providers to provide access, exchange, and use of EHI for nearly all requests. Exceptions are an important tool for healthcare providers to use in defense of a claim that their practice is information blocking.

There are many documentation requirements embedded within exception conditions. A major component of a healthcare provider's compliance with info blocking, and use of exceptions, is documentation. The specific facts and circumstances associated with a decision to use an exception will be important to include in documentation. Moreover, failing to meet the conditions of an exception does not automatically mean a practice is info blocking, only that there is not guaranteed protection from penalties or disincentives. Each act must then be evaluated on a case-by-case basis (e.g., level of impact, intent, or knowledge).

Healthcare providers must satisfy all applicable conditions of an exception at all relevant times to meet the exception as it relates to the access, exchange, and use of EHI. Each exception is limited to certain practices that clearly advance the aims of ONC's Final Rule and are tailored to align with the following criteria:

- Be reasonable and necessary: These reasonable and necessary practices include providing appropriate protections to prevent harm to patients and others; promoting the privacy and security of EHI; promoting competition and innovation in health IT and its use to provide health care services to consumers, and to develop an efficient means of health care delivery; and allowing system downtime to implement upgrades, repairs, and other changes to health IT.
- Address significant risk: The exceptions are intended to address what ONC considers a "significant risk" and that Actors would otherwise avoid engaging in out of concern that such activities could be interpreted as info blocking.

- Subject to strict conditions: Each exception is subject to strict conditions to ensure practices are limited to those that are reasonable and necessary.

EXCEPTION - PREVENTING HARM TO A PATIENT OR OTHER PERSON 45 CFR 171.201

This exception recognizes that the public interest in protecting patients and other persons against unreasonable risks of harm can justify practices that are likely to interfere with access, exchange, or use of EHI. It will not be information blocking for an Actor to engage in practices that are reasonable and necessary to prevent harm to a patient or another person, provided certain conditions are met.

A healthcare provider must hold a reasonable belief that the practice will substantially reduce the risk of physical harm to a patient or another natural person and the practice is no broader than necessary to substantially reduce the risk of harm. Practices include:
• Declining to share data that is corrupt, inaccurate, or erroneous.
• Declining to share data arising from misidentifying a patient or mismatching a patient's EHI.
• Refraining from a disclosure that would endanger life or physical safety of a patient or another person.

Healthcare provider's practice must meet the following conditions:

- Reasonable belief: The actor must hold a reasonable belief that the practice will substantially reduce a risk of harm to a patient or other natural person that would otherwise arise from the access, exchange, or use of EHI affected by the practice
- Practice breadth: The practice must be no broader than necessary to substantially reduce the risk of harm that the practice is implemented to reduce

Type of risk:

- Must be determined on an individualized basis in the exercise of professional judgment by a licensed health care professional who has a current or prior clinician-patient relationship with the patient whose EHI is affected by the determination; or
- Must arise from data that is known or reasonably suspected to be misidentified or mismatched, corrupt due to technical failure, or erroneous for another reason

Type of harm:
Must be one that could serve as grounds to deny access to an individual's protected health information under the HIPAA Privacy Rule (45 CFR 164.523(a)(3)).

- Practice must provide the patient right to request review of individualized determination of risk of harm consistent with the HIPAA Privacy Rule (45 CFR 164.523(a)(4)).
- Practice must be implemented based on either organizational policy or a determination specific to the facts and circumstances

Patients may opt to appeal a healthcare provider's use of the Harm Exception. Providers must implement their practice in a way that allows for the patient whose EHI is affected to exercise their rights under HIPAA or any federal, state, or tribal law to have the determination reviewed and potentially reversed.
The practice must be consistent with a written organizational policy that is
1. Based on relevant clinical, technical, other appropriate expertise;
2. Implemented in a consistent and non-discriminatory manner; and
3. Conforms each practice to the conditions in the harm exception

EXCEPTION - PROTECTING AN INDIVIDUAL'S PRIVACY 45 CFR 171.202

This exception recognizes that an Actor should not be required to use or disclose EHI in a way that is prohibited under state or federal privacy laws. It will not be information blocking if an Actor does not fulfill a request to access, exchange, or use EHI in order to protect an individual's privacy, provided certain conditions are met.

If a consent or authorization is required and the actor received a non-compliant consent the healthcare must use reasonable efforts within its control to provide the individual with a consent or authorization form that satisfies the required elements or provide other reasonable assistance to the individual to satisfy all required elements of the precondition. Individuals should not be improperly encouraged or induced to withhold the consent or authorization.

The Privacy Exception consists of four "sub-exceptions." The sub-exceptions ensure individual privacy rights are not diminished as a consequence of the info blocking provision and to ensure the info blocking provision does not require the use or disclosure of EHI in a way not permitted under the HIPAA Privacy Rule.

Whereas the HIPAA Privacy Rule permits, but does not require, covered entities to disclose ePHI in most circumstances, the info blocking rule requires the Actor to provide access, exchange, or use of EHI unless prohibited by law or covered by one of the exceptions.

Four sub-exceptions of privacy exclusion

1. Unsatisfied legal precondition to the release of EHI
    a. Physicians may withhold EHI if a state or federal privacy law imposes preconditions for providing access, exchange or use of EHI (e.g., a requirement to obtain a patient's consent before disclosing the EHI), if their practice:
        i. Is tailored to the applicable precondition;
        ii. Implemented in consistent and non-discriminatory manner; and
        iii. Either:
            (i) Conforms to healthcare provider's written organizational policies that address the organization's most restrictive preconditions; or
            (ii) Is documented by a physician on a case-by-case basis

2. Certified health IT developer not covered by HIPAA

3. Denial of individual's request for ePHI consistent with the HIPAA Privacy Rule
    a. HIPAA covered entity or business associate Actor may deny an individual's request for EHI under the HIPAA Privacy Rule's right of access if the Actor's practice complies with the Privacy Rule's "unreviewable grounds" for a denial of access.
        i. Unreviewable grounds under Privacy Rule:
            (i) Certain requests made by inmates of correctional institutions;
            (ii) Information created or obtained during research that includes treatment if certain conditions are met;
            (iii) Denials permitted by the federal Privacy Act; and
            (iv) Information obtained from non-health care providers pursuant to promises of confidentiality.

4. Respecting an individual's request not to share information
    a. An Actor may decline to provide access, exchange, or use of EHI if it meets the following requirements intended to align with an individual's HIPAA Privacy Rule right to request additional restriction:
        i. Individual requests that the Actor not provide such access, exchange, or use of the EHI without any improper encouragement or inducement of the request by the Actor.

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EXCEPTION - PROTECTING THE SECURITY OF EHI 45 CFR 171.203

The Security Exception allows providers to implement reasonable and necessary security practices and prohibits security practices that are disguised information blocking. The practices must be:

- Directly related to safeguarding the confidentiality, integrity, and availability of EHI
- Tailored to the specific security risk being addressed
- Implemented in a consistent and non-discriminatory manner

This exception is intended to cover all legitimate security practices by providers but does not prescribe a maximum level of security or dictate a one-size-fits-all approach.

A practice must meet both:

- General conditions; and
- Either the requirements for organizational policies or case-by-case determinations.

General conditions — A practice is not info blocking if it is:

1. Directly related to safeguarding the confidentiality, integrity, and availability of EHI;
2. Tailored to the specific security risk being addressed; and
3. Implemented in a consistent and non-discriminatory manner.

Actors and their security-related practices may satisfy proposed exception through:

1. Written organizational policies that are in writing, responsive to security risks identified and assessed, aligned with one or more applicable consensus-based standards or best practice guidance; and includes objective timeframes and other parameters for identifying, responding to, and addressing security incidents.; or
2. Determinations on a case-by-case basis under particular facts and circumstances. An individualized determination in each case the practice is necessary to mitigate the security risk to EHI and there are no reasonable and appropriate alternatives to the practice that address the security risk that are less likely to interfere with access, exchange, or use of EHI.

EXCEPTION - INFEASIBILITY OF THE REQUEST 45 CFR 171.204

The Infeasibility Exception applies when it would be infeasible for an Actor to respond to a request for access, exchange, or use of EHI. This exception recognizes that legitimate practical challenges may limit a healthcare provider's ability to comply with requests for access, exchange, or use of EHI. In some cases, the provider may not have or may be unable to obtain the requisite technological capabilities, legal rights, financial resources, or other means necessary to provide a particular form of access, exchange, or use. In other cases, the provider may be able to comply with the request but only by incurring cost or other burdens that are clearly unreasonable under the circumstances.

It will not be information blocking if a healthcare provider does not fulfill a request to access, exchange, or use EHI due to the infeasibility of the request, provided certain conditions are met. The practice must meet one of the following conditions as to why the request for access, exchange or use of EHI cannot be fulfilled:

- Uncontrollable events: a natural or human-made disaster, public health emergency, public safety incident, war, terrorist attack, civil insurrection, strike or other labor unrest, telecommunication or internet service disruption, or act of military, civil or regulatory authority.
- Segmentation: Unable to unambiguously segment the requested EHI from EHI that cannot be made available due to an individual's preference or because the EHI cannot be made available by law; or may be withheld in accordance with the preventing harm exception.
- Infeasible Under the Circumstances: The Actor demonstrates, prior to responding to the request, through a contemporaneous written record or other documentation its consistent and non-discriminatory consideration of certain factors that led to its determination that complying with the request would be infeasible under the circumstances

Document factors considered that make responding to a request infeasible under the circumstances.

- Review federal and state confidentiality laws and regulations to determine whether patient consent is required to disclose to HIE participants (care providers, social service agencies, payors, etc.) for the identified purposes (treatment, payment, etc.)
- Determine what information is shared via the HIE (entire record, primary care records, etc.)
- Ask the HIE its process for protecting "sensitive information" provided by federal and state confidentiality laws (is there a way to automatically opt-out certain information until the patient signs a specific consent form)
- Document in writing that the EHR system does not support data segmentation, including language from the infeasibility exception, if possible
- Determine whether the health center can respond to a patient request to access, exchange, and use of EHI in another manner
- Develop patient consent process to permit disclosure of sensitive information
- Request details of the vendor's timeframe for complying with the ONC's Interoperability Rule

The healthcare provider must, **within ten business days of receipt of the request**, provide to the requestor in writing the reason(s) why the request is infeasible. A provider may need to provide access to information that is not otherwise protected by federal or state privacy law (e.g., HIPAA Patient Right of Access). For example, print out an office note and hand redact protected information even if the Infeasibility Exception is claimed.

EXCEPTION - HEALTH IT MAINTENANCE OR IMPROVEMENT 45 CFR 171.205

This exception recognizes that for health IT to perform properly and efficiently, it must be maintained, and in some instances improved, which may require that health IT be taken offline temporarily. Healthcare providers should not be deterred from taking reasonable and necessary measures to make health IT temporarily unavailable or to degrade the health IT's performance for the benefit of the overall performance of health IT. The provider's practices must be related to the maintenance and improvement of health IT (e.g., temporary unavailability of data or degradation of the performance of health IT). Providers should also be allowed to protect the resiliency of their computer network if third-party applications negatively impact the performance of their systems. These practices must last no longer than necessary. It will not be information blocking for a provider to take reasonable and necessary measures to make health IT temporarily unavailable or to degrade the health IT's performance for the benefit of the overall performance of the health IT, provided certain conditions are met.

An Actor's practice to maintain or improve health IT performance is not info blocking when the practice meets one of four following conditions:

- Maintenance and improvement to health IT (e.g., an EHR upgrade).
- Consistent with existing service level agreements, where applicable.
- Practices that prevent harm and comply with Preventing Harm Exception.
- Security-related practices that comply with Security Exception.

Practices are to be implemented in a consistent and non-discriminatory manner.

If the unavailability is in response to a risk of harm or security risk, the provider must comply with the Preventing Harm Exception or Security Exception.

EXCEPTION - LIMITING THE CONTENT OR MANNER OF RESPONSE45 CFR 171.301

Content Condition

This exception provides clarity and flexibility to healthcare providers concerning the required content (i.e., scope of EHI) of a provider's response to a request to access, exchange, or use EHI and the manner in which the provider may fulfill the request. This exception applies to practices that involve the provider

responding to a request with limited information and in a manner other than what was requested by the requestor. Under this exception, a provider's practice of limiting the content of its response or the manner in which it fulfills a request to access, exchange, or use EHI will not be considered information blocking if the practice meets both a "content condition" and "manner condition."

Under the content condition, a provider may respond to a request to access, exchange, or use EHI by providing the data elements in the USCDI for 24 months following the final rule's publication date.

- Until October 6, 2022, the provider must respond with the subset of EHI identified by the USCDI data elements.
- After October 6, 2022, the provider must respond with all EHI in a designated record set (i.e., ePHI).

Under the manner condition, a provider must respond in the manner requested unless technically unable to fulfill the request, cannot reach agreeable terms with the requestor to fulfill the request respond, or agreeable license terms cannot be reached, in which case it must respond in an alternative manner.

- In the manner requested; or
- In an alternative manner.

If a provider does not fulfill a request in the manner requested because it is technically unable to fulfill the request or cannot reach agreeable terms with the requestor to fulfill the request, the actor must fulfill the request in an alternative manner without unnecessary delay in the following order of priority:

- Using technology certified to standard(s) adopted in part 170 that is specified by the requestor.
- Using content and transport standards specified by the requestor and published by the federal government or a standards developing organization accredited by the American National Standards Institute.
- Using an alternative machine-readable format, including the means to interpret the EHI, agreed upon with the requestor.

This is an important exception for physicians who are limited by their EHR vendor's ability to access, use, or exchange patient information. Chestnut will discuss the use of this exception with its EMS vendors.

EXCEPTION – FEES 45 CFR 171.302

This exception will most likely be applicable to EHR vendors rather than physicians or other providers.

Under the Fees Exception, Actors may recover certain costs reasonably incurred for the access, exchange, or use of EHI that HHS believes are unlikely to present information blocking concerns. The exception excludes certain fees, such as those based on electronic access to EHI by the individual. It will not be information blocking for a provider to charge fees, including fees that result in a reasonable profit margin, for accessing, exchanging, or using EHI, provided certain conditions are met.

ONC divided the Fee Exception into three conditions. To qualify for this exception, the Actor's practice must:

- meet the "basis of fees condition,"
- not include any of the fees addressed in the "excluded fees condition," and
- comply with the "Compliance with the Conditions of Certification condition" if the Actor is a health IT developer subject to ONC's Conditions of Certification.

A provider may charge fees for accessing, exchanging or using EHI if the fees are:

- Based on objective and verifiable criteria that are uniformly applied for all similarly situated classes of persons or entities and requests;
- Reasonably related to the actor's costs of providing the type of access, exchange, or use of EHI to, or at the request of, the person or entity to whom the fee is charged;
- Reasonably allocated among all similarly situated persons or entities to whom the technology or service is supplied, or for whom the technology is supported; and

- Based on costs not otherwise recovered for the same instance of service to a provider and third party.

EXCEPTION - LICENSING INTEROPERABILITY ELEMENTS 45 CFR 171.303

This exception will most likely be applicable to EHR vendors rather than physicians or other providers. The Licensing Exception seeks to balance an Actor's legitimate interest in protecting its intellectual property and earning a return on the investment with Cures' goal of interoperability and access, exchange and use of EHI.

According to the Licensing Exception, an Actor's practice to license interoperability elements for EHI to be accessed, exchanged, or used will not be considered information blocking if the practice meets certain timing requirements and licensing conditions. The Actor must begin license negotiations with the requestor within10 business days from receipt of the request and negotiate a license within 30 business days from receipt of the request. Royalties and terms of the license also generally must be reasonable and non-discriminatory, in accordance with specified licensing conditions. It will not be information blocking for an actor to license
interoperability elements for EHI to be accessed, exchanged, or used, provided certain conditions are met.

Info blocking may include interoperability element licensing practices or terms (e.g.,
royalties) with persons who require interoperability elements to develop or provide
interoperable technologies or services. Interoperability element means hardware, software, integrated technologies or related licenses, technical information, privileges, rights, intellectual property, upgrades, or services that:

- May be necessary to access, exchange, or use EHI; and
- Is controlled by the Actor, which includes the ability to confer all rights and authorizations necessary to use the element to enable the access, exchange, or use of EHI.

Negotiating a license: Upon receiving a request to license an interoperability element for the access, exchange, or use of EHI, the actor must begin license negotiations with the requestor within 10 business days and negotiate a license with the requestor within 30 business days.
License requirements include:

- Scope of rights
- Reasonable royalty
- Non-discriminatory terms
- Collateral terms
- Non-disclosure agreement

The actor must not engage in any practice that has any of the following purposes or effects:

- Impeding the efficient use of the interoperability elements to access, exchange, or use EHI for any permissible purpose.
- Impeding the efficient development, distribution, deployment, or use of an interoperable product or service for which there is actual or potential demand.
- Degrading the performance or interoperability of the licensee's products or services, unless necessary to improve the actor's technology and after affording the licensee a reasonable opportunity to update its technology to maintain interoperability.

PATIENT EDUCATION

ONC strongly encourages providers to educate patients and individuals about the risks of providing other entities or parties access to their EHI. Educating patients about the privacy and security practices of applications and parties to whom a patient chooses to receive their EHI is unlikely to interfere with access, exchange and use of EHI if the information meets the following criteria:

- Focuses on any current privacy and/or security risks posed by the technology or the third-party developer of the technology.
- Is factually accurate, unbiased, objective, and not unfair or deceptive.
- Provided in a non-discriminatory manner. For example, all third-party apps must be treated the same in terms of whether information is provided to individuals about the privacy and security practices employed.

A health care provider **may not** prevent an individual from deciding to provide their EHI to a technology developer or app despite any risks noted regarding the app itself or the third-party developer.

ONC recommends the following consumer education materials related to protecting EHI:

- ‘‘What You Can do to Protect Your Health Information’’ https://www.healthit.gov/topic/privacy-security/what-you-can-do-protect-your-health-information

- ‘‘Health IT: How to Keep Your Health Information Private and Secure: Fact Sheet’’ https://www.healthit.gov/sites/default/files/how_to_keep_your_health_information_private_and_secure.pdf

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 15 Mandated Reporting		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RM 15 – Patient Safety Events		
Citation(s):	Illinois Abused and Neglected Child Reporting Act (ANCRA) Department of Children and Family Services (DCFS) Manual for Mandated Reporters, Illinois Department of Children and Family Services Illinois Human Services Act, Rule 50 Office of Inspector General and 59 Illinois Administrative Code Part 50 Illinois Adult Protective Services Act (320 ILCS 20/) Illinois Division of Substance Use Prevention and Recovery (SUPR), Rule 2060 Illinois Concealed Carry Act and Firearm Owner's Identification ("FOID") laws Concealed Carry Act Missouri Concealed Carry Laws, Mo. Rev. Stat. §571.101 Missouri Department of Mental Health Reporting Requirements, Mo. Rev. Stat. §630.168, §630.167, 9 CSR §10-5.200 / §630.135 / §630.162, §630.655, §630.710		

CR 15 MANDATED REPORTING

Numerous incidents as noted in this policy are subject to mandated reporting to designated authorities. These include:

- Child abuse and neglect
- Elder abuse and neglect
- Client abuse, neglect or exploitation by staff
- Certain client deaths
- Serious occurrences in psychiatric residential treatment facilities
- Incidents and significant incidents in Division of Substance Use Prevention and Recovery funded programs
- Firearms Owners Identification Mental Health reporting

Some incidents may also qualify as patient safety events. Reference Risk Management Policy 15 to determine if a mandated reporting event also qualifies as a patient safety event. A Chestnut Incident Report should be completed that concisely states that a mandated report was made.

Following a mandated report against a Chestnut staff person, the supervisor of the staff person who is the subject of the report will immediately remove from the schedule and temporarily relieve the staff person of assigned duties. The staff person will remain unscheduled and relieved of duties until such time that the supervisor and/or Program Director has met with the Director of Human Resources or his/her designee and the Quality and Compliance Program Manager or his/her designee to determine an appropriate course of administrative action regarding the involved staff. Administrative actions may include but are not limited to

continuation in present position, reassignment, suspension or termination. When there is credible evidence supporting an allegation of abuse, Chestnut will remove the staff from all direct client contact.

Any mandated report made in error will immediately be reported to the Quality and Compliance Program Manager.

Applicable Rules in Illinois:

Illinois Child Abuse and Neglect
The Illinois Abused and Neglected Child Reporting Act (ANCRA) gives authority to the Department of Children and Family Services (DCFS) to investigate suspected child abuse and neglect. Under ANCRA, all Chestnut staff are mandated reporters and are thus required to report suspected child maltreatment immediately when they have "reasonable cause to believe" that a child known to them in their professional or official capacity may be an abused or neglected child; reference guidelines for defining “reasonable cause” in the DCFS Manual for Mandated Reporters. Reports are made following the organizational procedures for reporting child abuse and neglect.

Reports are made by calling the DCFS Hotline at 1-800-252-2873 and are followed by a written CANTS 5 report within 48 hours of calling the Hotline.

The Abused and Neglected Child Reporting Act places several requirements on Mandated Reporters:

1) Mandated Reporters are required to immediately report suspected child abuse or neglect by a parent or person responsible for the child’s welfare;

2) Privileged communication between professional and client is not grounds for failure to report. Willful failure to report suspected incidents of child abuse or neglect is a misdemeanor. Further, professionals may be subject to penalties by their regulatory boards;

3) State law protects the identity of all mandated reporters, and they are given immunity from legal liability as a result of reports they make in good faith, except that they may have to testify regarding an incident if the case becomes the subject of legal or judicial action; and

4) Reports must be confirmed in writing to the local investigation unit within 48 hours of the Hotline call. CANTS 5 forms may be obtained on-line.

Assessment of possible victims of child abuse or neglect are to be based on the following criteria:

The following are definitions of child abuse or neglect based on the most current edition of the *Manual for Mandated Reporters, Illinois Department of Children and Family Services*:

Physical Abuse as defined by ANCRA (Sec.3) occurs when a parent or a person responsible for the child's welfare:

5) "Inflicts, causes to be inflicted, or allows to be inflicted upon such child physical injury, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function". Such common injuries include bruises, human bites, bone fractures, and burns;

6) "creates a substantial risk of physical injury" likely to have the physical impacts listed above. Examples in DCFS allegation definitions include such incidents as choking or smothering a child, shaking or throwing a small child, and violently pushing or shoving a child into fixed objects. Other circumstances include incidents of domestic violence in which the child was threatened, violations

of orders for the perpetrator to remain apart from the child, and a history of past sexual abuse that may place other children at risk;

7) "acts of torture" which is defined by DCFS as "deliberately and/or systematically inflicting cruel or unusual treatment which results in physical or mental suffering";

8) "inflicts excessive corporal punishment" is included in ANCRA, but is not specifically further defined by DCFS. However, bruises inflicted on a child, especially a young child, are usually considered as meeting this definition;

9) “commits or allows to be committed the offense of female genital mutilation."; or

10) "causes to be sold, transferred, distributed, or given to such child under 18 years of age, a controlled substance" (i.e. illegal drugs) except when prescribed by a physician.

Sexual Abuse occurs when a person responsible for the child's welfare commits any of the following acts:

11) Sexually transmitted diseases are defined by DCFS as "diseases which were acquired originally as a result of sexual penetration or conduct with an individual who was afflicted";

12) Sexual penetration includes any contact between the sex organ of one person and the sex organ, mouth, or anus of another person. Typical acts include vaginal, oral, and anal sex;

13) Sexual exploitation is defined by DCFS as "sexual use of a child for sexual arousal, gratification, advantage, or profit". This includes such acts as explicit verbal enticements, child pornography, self-masturbation in the child's presence, and forcing a child to watch sex acts; or

14) Sexual molestation of a child, as defined by DCFS is "sexual conduct with a child when such contact, touching, or interaction is used for arousal or gratification of sexual needs or desires". Examples include fondling a child or having the child touch the perpetrator sexually. (DCFS Procedures 300.Appendix B).

For both physical and sexual abuse, parents and caretakers are charged with the responsibility to take reasonable steps to stop abuse. If they do not, they may be charged with abuse themselves. (ANCRA Sec. 3)

Neglect occurs when a person responsible for the child deprives or fails to provide the child with adequate food, clothing, shelter, or needed medical treatment. Neglect is also alleged when an adult provides inadequate supervision of a child. This can occur when children are left either unsupervised or in the care of someone unable to supervise due to his/her condition. ANCRA also includes the following when defining neglected child: “a child who is subjected to an environment which is injurious insofar as (i) the child’s environment creates a likelihood of harm to the child’s health, physical well-being, or welfare, and (ii) the likely harm to the child is the result of a blatant disregard of parent or caretaker responsibilities”. Children can suffer injuries that are the result of "blatant disregard" and are considered neglect. According to DCFS, “blatant disregard” means an incident where the real, significant, and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm.

Illinois Department of Children and Family Services (DCFS) mandated reports are documented on the DCFS CANTS 5 form - Written Confirmation of Suspected Child Abuse/Neglect Report: Mandated Reporters. Mandated reporters will be asked by DCFS to supply a written confirmation of their verbal report within 48 hours via the CANTS 5 form. A copy of the completed report will be forwarded to Medical Records

for inclusion in the client's medical record. No progress notes should be completed regarding any mandated report, including follow-up activity such as interviews.

Missouri Child Abuse and Neglect

The Missouri Department of Social Services Children's Division receives reports of suspected abuse, neglect, exploitation, and under age eighteen deaths. Reports are made to the Child Abuse and Neglect Hotline, and the information is referred to the appropriate Children's Division county office.

The Children's Division Child Abuse and Neglect Hotline (CA/NHU) is a toll-free telephone line which is answered seven days a week, 24 hours a day, 365 days a year. 1-800-392-3738

Mandated reporters include the following Chestnut positions, but are not limited to physician, nurse, hospital or clinic personnel that are engaged in the examination, care, treatment or research of persons, and any other health practitioner, psychologist, mental health professional, or social worker. Any person with reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately report to the division.

Client Abuse, Neglect, and/or Financial Exploitation by Staff

The Illinois Human Services Act, Rule 50, gives authority to the Illinois Department of Human Services, Office of the Inspector General. (OIG) to respond to reports of client abuse, neglect or financial exploitation. Any Chestnut employee who suspects, witnesses or is informed of an allegation involving mental abuse, physical abuse, sexual abuse, financial exploitation, or neglect by an employee against an individual ages 18-59 receiving mental health services is required to report to OIG. Reports are made following the organizational procedures for reporting client abuse, neglect or financial exploitation by staff.

All allegations of abuse/neglect, financial exploitation, and death (when abuse or neglect is suspected) shall be reported within 4 hours of initial discovery. Screening, delaying or withholding reports of incidents or allegations from OIG is not allowed. Chestnut required reporters will not delete, delay, withhold, limit or otherwise restrict any report information; although information may be added for clarification only purposes. Per Rule 50, intentional failure to report or intentional late reporting is a Class A misdemeanor offense. Retaliatory action will not be taken against an employee who reports in good faith as a required reporter.

Chestnut employees, temporary agency staff and volunteers will receive Rule 50 training at the time of hire and every 2 years thereafter. Contractual workers and subcontractors will receive abbreviated Rule 50 training. Training will be documented and included in the staff's training file.

The OIG hotline number is communicated to individuals and guardians at the time of admission and the number posted in plain sight at each Chestnut site where DHS mental health services are provided.

The Office of Inspector General and 59 Illinois Administrative Code Part 50 provides the following definitions:

> Access: Admission to a community agency or facility for the purpose of conducting imminent risk assessments, conducting investigations, monitoring compliance with a written response, or completing any other statutorily assigned duty, such as annual unannounced site visits, including but not limited to conducting interviews and obtaining and reviewing any documents or records that OIG believes to be pertinent to an investigation.
>
> Administrative Action: Measures taken by the community agency or the facility as a result of the findings or recommendations contained in the investigation that protects individuals from abuse, neglect, or financial exploitation and prevents recurrences and eliminates problems.

Allegation: Any assertion, complaint, suspicion or incident involving any of the following conduct by an employee, facility, or agency against an individual or individuals: mental abuse, physical abuse, sexual abuse, financial exploitation or neglect.

Bodily Harm: Any injury, damage or impairment to an individual's physical condition, or making physical contact of an insulting or provoking nature with an individual.

Deflection: Those situations in which an individual is presented for admission to a facility or agency and the facility or agency staff do not admit. This includes triage, redirection and denial of admission.

Egregious Neglect: A finding of neglect as determined by the Inspector General that represents a gross failure to adequately provide for, or a callous indifference to, the health, safety, or medical needs of an individual and results in an individual's death or other serious deterioration of an individual's physical condition or mental condition.

Employee: Any person who provides services at the facility of the community agency on or off site. The service relationship can be with the individual or the agency. Also "employee" includes any employee or contractual agent of the Department of Human Services or the community agency involved in providing or monitoring or administering mental health or developmental disability services. This includes but is not limited to: owners, operators, payroll personnel, contractors, subcontractors, and volunteers, Employee also includes someone who is no longer working for an agency or facility, but is the subject of an ongoing investigation for which OIG has jurisdiction.

Facility: A mental health or developmental disabilities center operated by the Department.

Final Report: A completed investigative report approved by the Inspector General that summarizes the evidence and that indicates whether the allegation of abuse, financial exploitation or neglect is substantiated, unsubstantiated, or unfounded based on the evidence gathered from the investigation, when the reconsideration and response period has expired.

Financial Exploitation: Taking unjust advantage of an individual's assets, property, or financial resources through deception, intimidation, or conversion for the employee's, facility's, or agency's own advantage or benefit.

Individual: Any person receiving mental health or developmental disabilities services or both from a facility or agency, while either on-site or off-site.

Mental Abuse: The use of demeaning, intimidating, or threatening words, signs, gestures, or other actions by an employee about an individual and in the presence of an individual or individuals that results in emotional distress or maladaptive behavior, or could have resulted in emotional distress or maladaptive behavior, for any individual present.

Neglect: An employee's, agency's, or facility's failure to provide or arrange for adequate medical care, personal care, or maintenance, and that as a consequence, causes an individual pain, injury, or emotional distress, results in an individual's maladaptive behavior or the deterioration of an individual's physical or mental condition, or places an individual's health or safety at substantial risk of possible injury, harm or death.

Non-accidental: Occurring with volition or consciousness; not occurring by chance.

Physical Abuse: An employee's non-accidental and inappropriate contact with an individual that causes bodily harm. "Physical abuse" includes actions that cause bodily harm as a result of an employee directing an individual to physically abuse another individual.

Recommendation: An admonition, separate from a finding, which requires action by the facility, agency, or Department to correct a systemic issue, problem or deficiency identified during an investigation.

Required Reporter: Any employee who suspects, witnesses, or is informed of an allegation of any one or more of the following: mental abuse, physical abuse, sexual abuse, financial exploitation or neglect.

Sexual Abuse: Any sexual contact or intimate physical contact between an employee and an individual, including an employee's coercion or encouragement of an individual to engage in sexual activity that results in sexual contact, intimate physical contact, sexual behavior or intimate physical behavior. Sexual abuse includes an employee's actions that result in the sending or showing of sexually explicit images to an individual(s) via computer, cellular telephone, electronic mail, portable electronic device, or other media with or without contact with the individual; or, an employee's posting of sexually explicit images of an individual online or elsewhere whether or not there is contact with the individual. Sexual abuse does not include allowing individuals to, of their own volition, view movies or images of a sexual nature, or read text containing sexual content unless the individual's guardian prohibits the viewing of such movies or images or reading of such material.

Sexual Contact: Inappropriate sexual contact between an employee and an individual involving an employee's genital area, anus, buttocks or breast(s) or an individual's genital area, anus, buttocks or breast(s), Sexual contact also includes sexual contact between individuals that is coerced or encouraged by an employee.

Sexually Explicit Images: Includes, but is not limited to, any material which depicts nudity, sexual conduct, or sadomasochistic abuse, or which contains explicit and detailed verbal description or narrative accounts of sexual excitement, sexual conduct, or sadomasochistic abuse. Sexually explicit images do not include those images contained in sex education materials used by employees to educate individuals.

Substantiated: There is a preponderance of the evidence found to support the allegation.

Unfounded: There is no credible evidence to support the allegation.

Unsubstantiated: There is credible evidence, but less than a preponderance of evidence to support the allegation.

The following procedures are followed in cases of suspected or alleged client abuse, neglect or financial exploitation by a staff person:

1. When any staff person suspects, witnesses or is informed of alleged client abuse, neglect, or financial exploitation, he/she will ensure the health and safety of the individual who is the subject of the allegation, other individuals and employees. When a medical emergency exists, 911 will be contacted.

2. The staff person will then immediately notify his/her supervisor or designee. If the supervisor is unavailable the staff person will immediately contact a member of the Quality Management department. The supervisor or QM staff is responsible for ensuring that a report is made to OIG within four (4) hours of initial discovery of the allegation.

   If the staff person is unable to contact one of the persons listed above, he/she will make the OIG report within four (4) hours of initial discovery of the allegation. Failure to report alleged abuse or neglect to OIG may result in disciplinary action, up to and including termination.

The staff person making the OIG report will notify a member of the Quality Management department and/or an appropriate program supervisor that OIG has been contacted.

The staff person who suspects, witness or is informed of alleged client abuse, neglect or financial exploitation will preserve any evidence and complete an incident report in accordance with Chestnut Policies and Procedures – RM 60 and RI 100. The report should confirm which Chestnut staff has made the phone call to OIG and other relevant information.

3. Minimally, the following information will be reported to the hotline concerning the allegation:
   - The client's name, date of birth, gender, disability and identification number or social security number;
   - Known information as to what, when, where, and how the incident occurred;
   - Identification of witnesses;
   - Known information about the accused, including name, contact information, and if the accused is presently working with or will be working with the deceased individual; and
   - The individual initiating the report, including name, contact information and relationship to the client.

4. Reported allegations that are in violation of Illinois law will be reported to the local law enforcement authority. For allegations of abuse, a police report must be made by either the client or the staff person. Staff will encourage the client or guardian to contact the authorities. If the client or guardian declines, staff will call the local police to report the allegation. Chestnut will notify OIG within one working day of the date and time the local law enforcement authority was notified and the name of the officer who took the report.

5. For allegations of physical injury, sexual abuse or any situation where the individual's health is in question, the staff person shall arrange for an immediate medical assessment by a Chestnut medical staff. If Chestnut medical staff cannot be accessed, the staff person should arrange for an immediate medical assessment via an emergency medical technician (EMT), paramedic or emergency room. It the client refuses medical assessment, staff should document the refusal, do visual and behavioral assessments to the best of one's ability, and document the results of the assessments. Findings of medical examinations will be fully documented. As applicable to the incident and when agreeable to the individual, victim services will be called.

6. In the event that the client is a minor, under the Illinois Abused and Neglected Child Reporting Act, 325 Illinois Administrative Code Part 5, Chestnut Health Systems staff are "mandated reporters" of suspected cases of child abuse or neglect and consequently the Department of Children and Family services will be immediately notified of the situation (refer to policy CR 15).

7. The allegation will be reported to OIG by the staff, supervisor, supervisor designee, or member of the QM department within the designated timeframes.

   Reports shall be made via the Hotline. Hotline number: 1.800.368.1463. Subsequent correspondence will be forwarded to the mailing address or fax number provided by OIG.

8. Upon receipt of the hotline report, OIG will make a decision to accept or decline the report. If the report is accepted, OIG will conduct an investigation. Chestnut is prohibited from conducting abuse and neglect investigations; however, Chestnut staff trained in OIG Rule 50.30f requirements are responsible to begin initial steps of the investigation, unless directed otherwise by OIG or a law enforcement authority.

9. Trained staff will assess for credible evidence and will ensure proper management of the incident as specified in Rule 50.30f.

Unless otherwise directed by OIG, trained staff will initiate the preliminary steps of the investigation using OIG approved methods to gather evidence and documents for whom there is no conflict of interest. Trained staff will reference and follow training guidelines regarding security of the scene, and preservation, collection, storage, custody and documentation of evidence. As applicable to the incident, this may include the need to:

- Secure the scene of the incident and preserve evidence;
- Identify, separate potential witnesses, and take statements;
- Identify and record the names of all persons at the scene at the time of the incident and, when relevant, those who entered the scene prior to it being secured;
- Secure all relevant documents and physical evidence; or
- Photograph the scene of the incident and the individual's injury.

Chestnut will comply with OIG's determination for further action to protect the safety of the individual, secure the scene of the alleged incident, preserve the evidence and maintain the integrity of the investigation.

10. OIG shall be granted access, for the purpose of investigating abuse, neglect or conducting other statutory duties, to any facility or program operated, funded, licensed or certified by the Department. Information concerning diagnosis and treatment for alcohol or drug abuse and/or concerning tests for human immunodeficiency virus (HIV) and diagnosis and treatment for acquired immune deficiency syndrome (AIDS) shall be disclosed to OIG in accordance with applicable state and federal regulations.

    Chestnut will not interfere with or obstruct an OIG interview or investigation. Chestnut will cooperate, protect the integrity of the OIG investigation and preserve evidence.

11. Following an OIG hotline report against a Chestnut staff person, the supervisor of the staff person who is the subject of the report will immediately remove from the schedule and temporarily relieve the staff person of assigned duties. The staff person will remain unscheduled and relieved of duties until such time that the supervisor and/or Program Director has met with the Director of Human Resources or his/her designee and the Quality and Compliance Program Manager or his/her designee to determine an appropriate course of administrative action regarding the involved staff. Administrative actions may include but are not limited to continuation in present position, reassignment, suspension or termination. When there is credible evidence supporting an allegation of abuse, Chestnut will remove the staff from all direct client contact.

12. After written notification from OIG that an allegation of abuse or neglect has been received, within 24 hours, Chestnut will notify the individual who is the subject of the allegation and/or the legal guardian, as applicable. If Chestnut is unable to reach the guardian by phone, a letter of notification will be sent within 24 hours.

13. Chestnut will ensure that at any point in that investigation that OIG is notified of any changes in the alleged individual's condition, the nature of the injury or allegation, the involvement of law enforcement authority, or the work status of the accused.

14. If, at any point, OIG determines and informs Chestnut that there is credible evidence of a possible criminal act, Chestnut shall notify the appropriate law enforcement authority immediately, but no later than 24 hours after such discovery, and shall notify OIG of that notification and any report/complaint number(s) within one (1) working day.

15. Upon completion and approval of its final investigative report, OIG forwards the report to Chestnut. Chestnut will respond accordingly to the report within the required timeframes.

Final reports will remain confidential and be released only in accordance with applicable state and federal statutes. The identity of any person as the complainant shall remain confidential unless authorized by the complainant.

Additionally, Chestnut will inform the individual and the guardian of the finding contained within the final report, specifically whether the allegation was substantiated, unsubstantiated or unfounded.

16. If OIG determines that an allegation of abuse, neglect and/or exploitation is substantiated, a Regional or Clinical Director shall work with Executive Management and Human Resources to determine the appropriate course of administrative action regarding the involved staff person. Such action may include disciplinary action up to and including termination.

17. Chestnut will maintain a local investigative case file containing copies of all investigatory materials. This includes all evidence, such as photographs, written statements and records. The file shall also include documentation of all corrective actions taken as a result of the case.

Client Death

The Illinois Human Services Act, Rule 50, gives authority to the Illinois Department of Human Services, Office of the Inspector General (OIG) to respond to certain client deaths. Any Chestnut employee who becomes aware of a client death which occurs under the circumstances stated in Rule 50 is required to report to OIG. Reports are made following the organizational procedures for reporting client death.
The following procedures are followed in cases of client death when the death meets one of these criteria:

1. Any death occurring within 14 calendar days after discharge or transfer from a residential program or facility;

2. Any death occurring within 24 hours after deflection from a residential program or facility**;**

3. Any death of an individual occurring on the premises of a Chestnut-licensed or Chestnut-certified facility even though not alleged to be a result of abuse or neglect.

Adult Client Abuse, Neglect, and/or Financial Exploitation by Non-Staff

The Illinois Adult Protective Services Act (320 ILCS 20/) gives authority to the Illinois Department of Aging to respond to reports of alleged abuse, neglect and financial exploitation of an adult with disabilities aged 18-59 who reside in a domestic living situation or of an adult aged 60 or older.

This Act provides that if a “mandated reporter” has reason to believe that an “eligible adult”, who because of a disability or other condition or impairment is unable to seek assistance for himself/herself, has been subjected to abuse, neglect, or financial exploitation, the mandated reporter must, **within 24 hours** after developing such belief, report this suspicion to the Adult Protective Services (APS) Hotline, 866.800.1409, 800.544.5304 (TTY)

Under this Act, an “eligible adult” is defined as either (1) an adult with disabilities ages 18 through 59 who resides in a domestic living situation and whose disability impairs his/her ability to seek or obtain protection from abuse, neglect, or exploitation, or (2) a person 60 years of age or older who resides in a domestic living situation and is, or is alleged to be, abused, neglected, or financially exploited by another individual or who neglects himself/herself.

These reporting obligations apply only to “mandated reporters” under the Act.

A mandated reporter is defined to include any of the occupations required to be licensed under the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Marriage and Family

Therapy Licensing Act, the Medical Practice Act of 1987, the Nurse Practice Act, the Physician Assistant Practice Act of 1987, and the Professional Counselor and Clinical Professional Counselor Licensing and Practice Act.

Any Chestnut staff member licensed as any of the above would qualify as a mandated reporter under the Act if he/she has reason to believe that an adult with disabilities between 18-59 years of age who resides in a domestic living situation or an adult aged 60 or older has been subjected to abuse, neglect or financial exploitation.

Staff not meeting the legal definition of “mandated reporter” may utilize the APS Hotline for reporting purposes and must obtain a disclosure authorization for the Illinois Department on Aging to make a report. A mandated reporter as described above is not required to obtain a disclosure to make a report.

Without patient authorization or a court order, a report of this type of abuse may only be done by making an anonymous report. Anonymous reports are reports that do not disclose that a patient is a recipient of substance abuse or mental health treatment services. Staff should not disclose their identities or the program from which they are calling, In addition, calls should not be made from a location that would give away the caller identification due to caller ID mechanisms.

Programs that are part of larger facilities offering many types of services may be able to make reports as long as they do not state that the patient is part of the substance abuse treatment program.

Serious Occurrence in Psychiatric Residential Treatment Facilities

Federal law requires Illinois to have a protection and advocacy system for individuals with disabilities. Equip for Equality is the Illinois designated organization. Federal Psychiatric Residential Treatment Facilities (PRTF) regulations require that serious occurrences including resident death, serious injury, suicide attempts, and use of restraint for youth admitted to a chemical dependency residential program must be reported to the State designated Protection and Advocacy system. An employee working in a Chestnut PRTF who discovers a serious occurrence is required to ensure a report of the occurrence to Equip For Equality. Reports are made following procedures in the Substance Use Disorder Youth Services Manual for reporting a serious occurrence in a PRTF.

Incident and Significant Incident in Division of Substance Use Prevention and Recovery Programs

The Illinois Division of Substance Use Prevention and Recovery (SUPR) Rule 2060, requires the reporting of any incident or significant incident to SUPR. An incident is any action by staff or patients that led to, or is likely to lead to, an adverse effect on patient services because of a deviation from established patient care procedures. A significant incident is any occurrence at the facility which requires the services of the coroner and/or which renders the facility inoperable. Reports are made following the organizational procedures for reporting incidents and significant incidents in SUPR programs.

Perceived significant Incidents shall be verbally reported to the Program Director immediately. The Program Director shall report to the applicable Vice President of Integrated Care who will report to Chestnut's Corporate Compliance Officer, General Counsel and CEO. The incident will be reviewed by these parties and if determined to be a SUPR significant event, a designated executive leader will report the incident to the Department of Human Services Division of Licensing and Monitoring within 24 hours after its occurrence. A written report shall be submitted to the Division of Licensing and Monitoring within ten (10) calendar days.

Firearm Owners Identification Mental Health Reporting
Inpatient Mental Health Admissions and Persons Adjudicated as Mentally Disabled

Pursuant to the Illinois Concealed Carry Act and Firearm Owner's Identification ("FOID") laws, Chestnut has several important reporting obligations to the Illinois Department of Human Services ("DHS") that may arise during the course of patient care.

Method of Reporting - Inpatient Mental Health Admissions/Discharges and Persons Adjudicated as Mentally Disabled - All required reports regarding inpatient or residential mental health admissions and discharges and persons adjudicated as mentally disabled shall be administratively reported to the DHS FOID Mental Health Reporting System website by staff designated by Chestnut as system users. All reports will be made in accordance with required reporting guidelines and timeframes. If an obligated Chestnut site does not have an admission or discharge in a given week (7-day period), designated staff will use the "Nothing to Report" function on the website.

Inpatient Mental Health Admissions/Discharges
Chestnut facilities and programs that provide mental health treatment are required to report all admissions for inpatient or residential mental health treatment to DHS within 7 days of the admission. Specifically, this reporting obligation applies to sites funded by DHS, Division of Mental Health that provide 24 hour "supervised transitional residential programs". More specifically, the following Chestnut sites fall within this reporting obligation:

- Oakmont (Pontoon Beach)
- HUD I – Mainstay (Granite City) – excludes HUD II
- HUD III – Fairview Heights (Fairview Heights) – includes only supervised beds
- Crisis Stabilization Unit (Granite City) – includes only crisis admissions, excludes Veteran and/or Detox admissions
- Crisis Stabilization Unit (Bloomington) – includes only crisis admissions, excludes Detox admissions

These same sites are also required to report discharges to DHS within seven (7) days.

The reporting of inpatient mental health admissions/discharges does not apply to any inpatient substance use disorder programs.

Persons Adjudicated as Mentally Disabled
All inpatient and outpatient Chestnut facilities and programs that provide mental health treatment are also required to report to DHS any persons who Chestnut becomes aware have been determined by a court, board, commission or other lawful authority to be mentally disabled within seven (7) days.

Firearm Owners Identification Mental Health Reporting
Persons Posing a Clear and Present Danger OR Developmentally Disabled Persons

The Concealed Carry Act also establishes mandatory reporting obligations for physicians, clinical psychologists and qualified examiners at Chestnut.

Specifically, any physician, clinical psychologist or qualified examiner at Chestnut is required to report to DHS within 24 hours any person whom the physician, clinical psychologist or qualified examiner determines: (1) poses a clear and present danger to himself/herself or others; or (2) is developmentally disabled.

"Qualified examiners" include:

- a licensed clinical social worker
- a registered nurse with a master's degree in psychiatric nursing and at least 3 years of clinical training in evaluating and treating mental illness
- a licensed clinical professional counselor with a master's or doctoral degree in counseling, psychology, or a similar field and at least three years of mental health counseling experience
- a licensed marriage and family therapist with a master's or doctoral degree and at least three years of experience that includes providing mental health services

Should a self-report to the FOID Mental Health Reporting System be necessary, all mandated reporters are encouraged to register at the State's website, https://foid.dhs.illinois.gov/foidpublic/foid/.

A person "poses a clear and present danger" if he/she:

1) Communicates a threat of serious physical violence against a reasonably identifiable victim or poses a clear and imminent risk of serious physical injury to himself or another person, as determined by a physician, clinical psychologist, or qualified examiner; or

2) Demonstrates threatening physical or verbal behavior, such as violent, suicidal, or assaultive threats, actions, or other behavior, as determined by a physician, clinical psychologist, qualified examiner, school administrator, or law enforcement official.

A person is "developmentally disabled" if he/she has a disability which:

1) Is attributable to any other condition which results in impairment similar to that caused by an intellectual disability;

2) Requires services similar to those required by intellectually disabled persons; and

3) Originates before the age of 18 years, is expected to continue indefinitely, and constitutes a substantial handicap.

In the event that a clinician who is not a mandated reporter believes a client poses a clear and present danger or is developmentally disabled, the clinician should consult with his/her supervisor or QM staff to determine what actions may be appropriate.

Method of Reporting - Persons Posing a Clear and Present Danger OR Developmentally Disabled Persons - Pursuant to the Illinois Mental Health and Developmental Disabilities Confidentiality Act, all physicians, clinical psychologists, or qualified examiners who are mandated reporters shall provide notice directly to DHS or to their employer who shall then report to the Department, within 24 hours after determining that a person poses a clear and present danger to himself, herself, or others, or is determined to be developmentally disabled.

Accordingly, when a mandated reporter determines that a person poses a clear and present danger or is developmentally disabled, he/she will immediately notify their supervisor or designee. The supervisor (or if the supervisor is unavailable, the mandated reporter) will immediately a member of the Quality Management department. Once informed, the QM staff becomes responsible for reporting to DHS with the designated timeframe. The mandated reporter is responsible to provide the required reporting elements to QM staff via an internal method set forth by QM.

Reports shall be made via the DHS FOID Mental Health Reporting System website which provides immediate access for reporting. https://foid.dhs.illinois.gov/foidpublic/foid/.

If a mandated reporter is unable to reach a QM staff, he/she is then responsible to ensure that the report is made to DHS within 24 hours of the determination. An incident report is to be completed confirming the self-report and any other relevant information.
Mandated reporters are expected to follow Chestnut's procedure for reporting as described in this policy; however, nothing in this policy shall be construed such that a mandated reporter cannot also provide direct notice to DHS.

Pursuant to the federal confidentiality regulations at 42 CFR Part 2, when making a mandated report to DHS, any diagnosis of alcohol or substance abuse should not be included in the report.

Duty to Warn

A staff person who is treating an individual who makes a specific threat of violence may disclose confidential communications made to the staff by the individual to a third party in order to protect others or the individual from harm. To make such a disclosure, the staff must, in good faith, determine that the disclosure of the communication is necessary to protect the individual or another person against a clear, imminent risk of serious physical or mental injury or disease or death. The threat must constitute a specific act of violence against a specific person. The danger to the person must be imminent. Danger is imminent if, in the staff's determination, the client is capable of the violence and has a specific plan to carry it out.

The warning may only be communicated to persons reasonably able to prevent or lessen the threat made by the individual. This could include the person against whom the threat was made, the police, or family members or friends of the client or person against whom the threat was made. The warning may contain the following information:

- The name of the individual who made the threat;
- The individual's address, phone number, and other contact information, if known; and;
- The nature of the threat.

Any warnings given must be documented in the medical record.

A member of the QM department should be consulted regarding each duty to warn situation. If a member of the QM department is not available, staff should consult their supervisor. If a supervisor is not available, staff should use professional judgment and follow criteria as established in this policy.

Applicable Laws in Missouri:

Reporting Abuse, Neglect, and Misuse of Funds/Property in the Mental Health Settings (Mo. Rev. Stat. §630.135, §630.162, §630.167, §630.168, §630.655, and §630.710)

The Missouri Department of Mental Health provides the following definitions:

Misuse of funds/property: The misappropriation or conversion for any purpose of a client's funds or property by an employee or employees with or without the consent of the client or the purchase of property or services from a client in which the purchase price substantially varies from the market value.

Neglect: Failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any client when that failure presents either imminent danger to the health, safety, or welfare of a client or a substantial probability that death or serious physical injury would result. This would include, but is not limited to, failure to provide adequate supervision during an event in which one client causes serious injury to another client.

Physical abuse:

1. An employee purposefully beating, striking, wounding, or injuring any client;
2. In any manner whatsoever, an employee mistreating or maltreating a client in a brutal or inhumane manner; or
3. An employee handling a client with any more force than is reasonable for a client's proper control, treatment, or management.

Sexual abuse: Any touching, directly or through clothing, of a client by an employee for sexual purpose or in a sexual manner. This includes, but is not limited to:
1. Kissing;
2. Touching of the genitals, buttocks, or breasts;
3. Causing a client to touch the employee for sexual purposes;
4. Promoting or observing for sexual purpose any activity or performance involving clients including any play, motion picture, photography, dance, or other visual or written representation;
5. Failing to intervene or attempting to stop inappropriate sexual activity or performance between clients; and/or
6. Encouraging inappropriate sexual activity or performance between clients.

Verbal abuse: An employee making a threat of physical violence to a client, when such threats are made directly to a client or about a client in the presence of a client.

All Chestnut's employees must immediately file a written complaint if an employee has reasonable cause to believe that a client has been subjected to any of the outlined abuses while under the care of Chestnut. Such written complaints shall be made to the Director of Quality and Compliance or his/her designee. Chestnut will investigate all complaints and comply with its reporting obligations outlined in 9 CSR §10-5.200 and all other applicable Missouri laws. In cases of sexual abuse, Chestnut must promptly notify local law enforcement authority and will fully cooperate with any subsequent investigation.

Missouri Child Abuse and Neglect (Mo. Rev. Stat. § 210.115)

The Missouri Department of Social Services Children's Division receives reports of suspected abuse, neglect, exploitation, and under age eighteen deaths. Reports are made to the Child Abuse and Neglect Hotline, and the information is referred to the appropriate Children's Division county office.

The Children's Division Child Abuse and Neglect Hotline (CA/NHU) is a toll-free telephone line which is answered seven days a week, 24 hours a day, 365 days a year. 1-800-392-3738.

Mandated reporters include the following Chestnut positions, but are not limited to physician, nurse, hospital or clinic personnel that are engaged in the examination, care, treatment or research of persons, and any other health practitioner, psychologist, mental health professional, or social worker. Any person with reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately report to the division.

Missouri Elder Abuse (Mo. Rev. Stat. §192.2405 to 192.2470)

Missouri requires that mandated reporters, such as physicians, nurses, first responders, hospital and clinic personnel, who have the responsibility for the care of an eligible adult and who become aware of circumstances that may reasonably be expected to be the result of, or result in, abuse or neglect of an eligible adult to make such a report to the Missouri Department of Health and Human Services.

“Abuse”, the infliction of physical, sexual, or emotional injury or harm including financial exploitation by any person, firm, or corporation and bullying;

“Eligible adult”, a person sixty years of age or older who is unable to protect his or her own interests or adequately perform or obtain services which are necessary to meet his or her essential human needs or an adult with a disability, as defined in section 192.2005, between the ages of eighteen and fifty-nine who is unable to protect his or her own interests or adequately perform or obtain services which are necessary to meet his or her essential human needs;

“Likelihood of serious physical harm”, one or more of the following:
(a) A substantial risk that physical harm to an eligible adult will occur because of his or her failure or inability to provide for his or her essential human needs as evidenced by acts or behavior which has caused such harm or which gives another person probable cause to believe that the eligible adult will sustain such harm;
(b) A substantial risk that physical harm will be inflicted by an eligible adult upon himself or herself, as evidenced by recent credible threats, acts, or behavior which has caused such harm or which places another person in reasonable fear that the eligible adult will sustain such harm;
(c) A substantial risk that physical harm will be inflicted by another upon an eligible adult as evidenced by recent acts or behavior which has caused such harm or which gives another person probable cause to believe the eligible adult will sustain such harm;
(d) A substantial risk that further physical harm will occur to an eligible adult who has suffered physical injury, neglect, sexual or emotional abuse, or other maltreatment or wasting of his or her financial resources by another person.

“Neglect”, the failure to provide services to an eligible adult by any person, firm or corporation with a legal or contractual duty to do so, when such failure presents either an imminent danger to the health, safety, or welfare of the client or a substantial probability that death or serious physical harm would result;

These reports of elder abuse can be made at 1-800-392-0210 or online via this link: https://apps4.mo.gov/APS_Portal/ .

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 16 Use of Restraint and Seclusion		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CR 15 – Mandated Reporting		
Citation(s):	Requirements for States and Long Term Care Facilities (42 CFR 483 Subpart G) Conditions of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services For Individuals Under Age 21 Missouri Emergency Safety Interventions, Missouri Department of Mental Health, 9 CSR §10-7.060, Mo. Rev. Stat. §630.175		

CR 16 USE OF RESTRAINT AND SECLUSION

With the exception of its Psychiatric Residential Treatment Facility (PRTF) for adolescent substance use disorder residential treatment, Chestnut prohibits the use of restraint. Chestnut in all of its programs prohibits the use of seclusion.
This policy governs the use of the use of restraint within its adolescent substance use disorder residential treatment program Clients receiving this service, and when appropriate their guardian(s), shall be notified regarding at or prior to admission regarding Chestnut's use of use of restraint and seclusion. Only appropriately trained staff may participate in use of restraint.

DEFINITIONS

A. Crisis Prevention Institute (CPI) Nonviolent Crisis Intervention®: Nonviolent crisis intervention training designed to teach best practices for managing difficult situations and disruptive behaviors

B. Drug Restraint: Any drug that is administered to manage a client's behavior in a way that has the temporary effect of restricting the client's freedom of movement. Chestnut does not use drugs as a restraint

C. Emergency Safety Situation: Unanticipated client behavior that place the client or others at serious threat of violence or injury if personal restraint is not utilized.

D. Mechanical Restraint: Any device attached or adjacent to the client's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body. Chestnut does not use mechanical restraints.

E. Personal Restraint: The application of physical force without the use of any device, for the purposes of restraining the free movement of a client's body. The term personal restraint does not include briefly holding, without undue force, a client in order to calm or comfort him or her, or holding a client's hand

to safely escort a client from one area to another. Chestnut does use personal restraint in certain circumstances (discussed further below) to protect the safety of the client and other clients and staff.

F. Seclusion: The involuntary confinement of a client alone in a room or an area from which the client is physically prevented from leaving. Chestnut does not use seclusion.

G. Time Out: The restriction of a client for a period of time to a designated area from which the client is not physically prevented from leaving, for the purpose of providing the client an opportunity to regain self-control.

Chestnut will only utilize personal restraint in emergency safety situations.

Staff trained in CPI specialized techniques may physically hold a client to prevent them from doing harm to themselves or others. Emergency safety interventions will be performed in a manner that are safe, proportionate, and appropriate to the severity of the behavior, also taking into consideration the client's chronological and developmental age; size; gender; physical, medical, psychiatric condition, and personal history (including any history of physical or sexual abuse).

Chestnut does not use mechanical or drug restraints and will only use personal restraint to ensure the safety of the client or others during an emergency safety situation and only until the emergency safety situation has ceased and the client's safety and the safety of others can be ensured. Chestnut believes that every client has the right to be free from restraint or seclusion, in any form, used as a means of coercion, discipline, convenience or retaliation and will never utilize restraint for any reason other than safety.

Chestnut does not use seclusion. In the event a client’s behavior escalates to a level that cannot be managed by time out or personal restraint, 911 will be contacted in order to have emergency personnel transport the client from the facility to a secure environment such as a medical psychiatric unit.

In the event that a client should be personally restrained, the parent and/or guardian shall be informed as soon as possible, with attempts starting at the time that the restraint is initiated and within one hour of the conclusion of the emergency intervention. In addition, the state Medicaid Agency and the State-designated Protection and Advocacy system (Equip for Equality) shall be informed by our staff in writing as per CR 15 Mandated Reporting. All notification attempts and contacts will be documented in the client’s medical record.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 20 Client Grievances		
Revision Date:	08/25/2021		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Missouri Department of Mental Health, Rights, Responsibilities, and Grievances, 9 CSR §10-7.020(7)		

CR 20 CLIENT GRIEVANCES

Any client with a grievance against Chestnut policy, procedures, or staff may register their complaint either verbally or in writing with any Chestnut staff person. If the grievance is with a staff member then it is appropriate for the client to communicate their concern to the appropriate Program Director. If the concern is with the Program Director then the client may communicate their concern to the appropriate Executive Leadership Council (ELC) member. If the issue is with the ELC member then the client may communicate their concern to the Chief Executive Officer (CEO). If the issue directly involves the CEO or if the client believes an expressed quality or safety concern has not been satisfactorily resolved via the organizational Chain of Command, the client may submit his/her grievance to the Executive Committee of the Board of Directors. While encouraged to follow this grievance procedure, the client has the right at any point to contact advocacy, licensing, funding, or accreditation entities. Chestnut will cooperate with any such entities in any review or investigations.

All complaints expressed to Chestnut's staff will be reviewed as soon as possible. The staff shall provide reasonable assistance to the client wishing to file a grievance. Chestnut's review of grievances shall be consistent with principles of due process.

Emergency complaints will be dealt with immediately through consultation among the appropriate clinical and administrative staff. Recommendations for dealing with client grievances will be offered by the staff and the outcome communicated to the person filing the complaint.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 30 Services for People with Disabilities		
Revision Date:	06/27/2018		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CR 30 SERVICES FOR PEOPLE WITH DISABILITIES

Clients with disabilities shall have an equal opportunity for services. Each individual with a disclosed disability will be assessed and accommodations will be determined in conjunction with that individual. Reasonable accommodations that could be offered include but are not limited to TDD, accessible rooms, tapes/recorders, sign language interpreters, and other specialized services in an effort to provide services that are comparable to those provided to all clients.

For every client, the appropriate level of care is recommended based on the client's needs. In the event that a Chestnut program is not deemed appropriate to meet the needs of the client with a disability, Chestnut will facilitate a referral to an alternative service provider. The client's individual medical record will note accommodations provided for those clients with a known disability.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 35 Service and Therapy Animals		
Revision Date:	06/22/2022		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	SI 250 – Service Animals and Pets		
Citation(s):			

CR 35 SERVICE AND THERAPY ANIMALS

In accordance with the Americans with Disabilities Act ("ADA") and other relevant State and Federal laws and regulations, Chestnut respects clients' rights with respect to service and therapy animals and will accommodate them to the extent required by law. See SI 250 for additional information.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 40 Advanced Directives		
Revision Date:	08/25/2021		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Missouri Life Support Declaration Act, Mo. Rev. Stat. §459.015		

CR 40 ADVANCED DIRECTIVES

Due to the nature of treatment at Chestnut, it is unlikely that a client's health needs would require that decisions about advanced directives, or future medical care as it relates to life supports or resuscitation would be made during the course of treatment. Chestnut will comply with Advanced Directives within the scope of its licensure. During the intake procedure, clients are presented with a statement of applicable state laws on advanced directives and do not resuscitate orders.

An acknowledgement is placed in the client’s medical record regarding receipt of the statement, along with any advanced directives provided by the individual. Staff involved in the individual’s treatment will be aware of these documents via a notification in the electronic health record. Advanced directives will be provided to emergency medical personnel. In order to ensure continuity of care for shared behavioral health and primary care patients, copies of advanced directives received in either program will be shared with the other consistent with Medical Records procedures.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 50 Consent to Treatment		
Revision Date:	08/25/2021		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	IL Mental Health Code Missouri Department of Mental Health, 9 CSR §10-7.020(2); Minors' Ability to Contract, Mo. Rev. Stat. §431.056 Missouri Consent to Surgical or Medical Treatment, Mo. Rev. Stat. §431.061		
Related Documents:	Consent to Treatment Consent for Psychotropic Medication		

CR 50 CONSENT TO TREATMENT

Consent Generally

A consent will be obtained when a Chestnut Family Health Center provider performs a procedure.

Clients have the right to refuse treatment. Whenever a client refuses care, test(s), procedure(s) or any prescribed treatment, the refusal will be documented in the medical record.

Treatment at Chestnut is voluntary. All clients receiving treatment from Chestnut will acknowledge their authorization for such treatment through a signed written Consent to Treatment document. When appropriate, the family or guardian will also be asked to consent to the treatment. A copy of the signed Consent to Treatment document will be maintained in the medical record.

Illinois Minor Consent

Chestnut routinely encourages adolescent clients to permit their parents or guardians to sign the consent to demonstrate their concurrence with the treatment process.

Substance Use services - Adolescent clients, age 12 or older, may sign a consent to treat without parental or guardian approval.

Illinois mental health services – Adolescent clients, age 12 or older, may sign a consent to treatment on his or her own. However, if the minor is under age 17, only eight (8) sessions, each lasting a maximum of 90 minutes, may be provided before parental consent is obtained. Chestnut cannot inform the minor's parent, guardian or person in loco partentis unless it is believed that such disclosure is necessary. A minor 16 years of age or older may consent to voluntary inpatient admission but a parent must be immediately informed upon admission.

A consent for psychotropic medication should be obtained when a Chestnut prescriber orders such medication for an adolescent.

Missouri Minor Consent

Missouri mental health and substance use services – In Missouri, minors, persons under the age of 18, cannot generally consent to medical, mental health or substance use services without a parent or legal guardian's consent except in the following circumstances: (i) the minor is lawfully married; (ii) the minor is a parent or legal custodian of a child, and in that circumstance the minor can consent for himself/herself, his/her child and any child in his/her legal custody or (iii) the minor is 16 or 17 years of age and he/she is homeless, self-supporting and the minor's parent has expressly or impliedly consented to the minor living independent of the parents' or guardians' control.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 60 Client Communication		
Revision Date:	08/25/2021		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Missouri Department of Mental Health, Rights, Responsibilities, and Grievances, 9 CSR §10-7.020(3)(B); Mo. Rev. Stat. §630.110.1(1), (3).		

CR 60 CLIENT COMMUNICATION

Clients involved in residential treatment have the right to appropriate communication with family members and friends. In addition, Missouri clients have the following communication rights which cannot be restricted in any way: to communicate by sealed mail or otherwise with the Missouri Department of Mental Health, and, if applicable, his or her legal counsel and any court of jurisdiction

Adult residential clients have access to a pay phone and can send and receive US mail. For youth residential clients, an approved callers list will be established and only individuals on that list will be allowed to make phone contact. Youth clients may obtain additional phone privileges depending upon their status in treatment.

Restriction of communication will be based on therapeutic needs of the client and fully explained to the client at the time of restriction and documented in the medical record.

Staff shall maintain confidentiality of clients when assisting clients with receiving or making phone calls.

Personal communication devices, such as cell phones, laptops, and tablets are prohibited or restricted in residential treatment programs.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 65 Client Images and Recordings		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CR 65 CLIENT IMAGES AND RECORDINGS

No staff member shall create a visual image or an audio or video recording without the client's express written permission. Any such image or recording may only be made on a Chestnut owned device and for business-related purposes. The image or recording may be used only for the purpose for which permission was sought and obtained.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Client Rights		
Policy Name and Number:	CR 70 Visitation and Visiting Hours		
Revision Date:	08/25/2021		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Missouri Department of Mental Health, 9 CSR §10-7.020(3)(B)(4)		
Related Documents:	Visitor's Policy and Procedures Statement		

CR 70 VISITATION AND VISITING HOURS

Residential clients have the right to visitors during their treatment experience. Clinical decisions to restrict visitors are fully explained to the client and/or family members. In no event, shall visitation be prohibited for Missouri clients for visits by the client's attorney, physician, or clergy in private at reasonable times.

A copy of the visitor's policy and procedures statement is provided to all clients upon admission to a residential program.

Each residential program will post visiting hours for its programs. Requests for special visiting arrangements can be made through the client's primary staff.

Chestnut Health Systems
Clinical Privileges

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 100 Clinical Privileges Policy Statement		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Health Resources Services Administration (HRSA) Health Center Program Compliance Manual Health Resources Services Administration (HRSA) Site Visit Protocols PIN 2001-16 – Credentialing & Privileging of Health Center Practitioners PIN 2002-22 – Clarification of Bureau of Primary Health Care Credentialing & Privileging Policy Outlined in Policy Information Notice 2001-16 TJC Ambulatory Care Standards Human Resources Chapter TJC Behavioral Health Care Standards Human Resources Chapter FTCA Deeming Application Evaluation Self Checklist Program Assistance Letter for FTCA coverage		

CP 100 CLINICAL PRIVILEGES POLICY STATEMENT

This policy applies to all clinical staff, employed, or contracted, volunteers and provider organizations such as locum tenens, group practices, and/or training programs. The purpose of credentialing and privileging is to ensure verification of the credentials of health center clinical staff and to define their privileges to increase the safety of patients and provide the highest quality health care to our patients.

Credentialing and privileging will be performed on all licensed, certified, or other clinical staff, if applicable, before assuming patient care activities.

Completed and verified credentialing and privileging packets will be reviewed by parties listed in the accountability and responsibility sections below and make recommendations and/or decisions to approve, modify, deny, or remove privileges the applicant (at hire) or staff member (renewal) for credentialing and privileging. The health center determines whether to use an appeals process in conjunction with such determinations; and whether to implement corrective action plans in conjunction with the denial, modification, or removal of privileges.

The health center maintains files or records for all credentialed and privileged clinical staff (employees, individual contractors, volunteers) in a secure locked environment. The files contain at a minimum documentation of licensure, credentialing verification, and applicable privileges, consistent with all operating procedures.

If the health center contracts for formal written referral agreements with provider organizations (locum tenens, group practices, training programs, etc) that provide services within its scope of project the health center must ensure that such providers are licensed, certified, or registered as verified through a credentialing process, in accordance with applicable Federal, state, and local laws; and competent and fit

to perform the contracted or referred services, as assessed through a privileging process. The health center makes determinations whether to disallow individual providers or organizations from providing health services on the health center's behalf. These determinations must be consistent with health center contracts/cooperative agreement language with individual providers or organizations clearly addressing health center role and responsibilities in credentialing and privileging.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 110 Board Delegated Authority to Privileging Committee		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 110 BOARD DELEGATED AUTHORITY TO PRIVILEGING COMMITTEE

The Board of Directors delegates to the Clinical Privileging Committee the authority to evaluate and recommend to the Board the assignment of clinical privileges to Licensed Independent Practitioners, Clinical Managers, Medical Managers, and applicable leadership, as well as the responsibility for carrying out identified credentialing and privileging responsibilities.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 120 Responsibilities of Clinical Privileging Committee and Chairperson		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Privileging Source Document		

CP 120 RESPONSIBILITIES OF CLINICAL PRIVILEGING COMMITTEE AND CHAIRPERSON

The Clinical Privileging Committee is responsible for the performance of the following functions:

a. Ensure that all persons recommended for clinical privileges are qualified and competent.

b. Delineate clinical privileges and the basis for authorization.

c. Recommend to the Board of Directors the awarding of clinical privileges.

d. Recommend to the Board of Directors the renewal of clinical privileges.

e. Temporarily deny, suspend, curtail, or revoke clinical privileges on an immediate basis whenever objective information merits such action.

f. Specify the objective information on which clinical privilege decisions are made.

g. Hold regularly scheduled meetings no less than 4 times per year.

h. Convene meetings when requests for initial/new clinical privileges or renewal of clinical privileges have been made or when a credentialing, privileging or peer issue arises.

i. Review and approve minutes from Clinical Privileging Committee meetings.

j. Periodic review and approval of matrixes and source documents that inform clinical privileging processes.

k. Provide at least annual review of privileging, credentialing and peer review policies and procedures and make subsequent recommendations to the Board of Directors.

The Clinical Privileging Committee Chairperson ("Chairperson") is responsible for the performance of the following functions:

a. Create and maintain minutes from Clinical Privileging Committee meetings.

b. Maintain matrix of eligible service area designations to which specific staff titles and/or positions may make application. Update necessary forms.

c. Coordinate credentialing and privileging activities with Human Resources and Legal department.

d. Coordinate activities to gain necessary information for privileging evaluation with Human Resources department.

e. Advise Clinical Privileging Committee of ongoing regulatory, accreditation, and payor credentialing and privileging requirements. Maintain associated source document.

f. Coordinate temporary privileging with Chief Clinical Officer.

g. Convene Clinical Privileging Committee for privileging recommendations and performance of other functions for which it is responsible.

h. Facilitate privileging recommendations to the Chief Clinical Officer for presentation to the Board of Directors.

i. Facilitate privileging decision appeals.

j. Ensure confidentiality of peer review minutes, reports, and discussion.

k. In his/her planned absence, designate an alternate member of the Privileging Committee to assume the responsibilities of the Chairperson.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 120.10 Clinical Privileging Committee		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 120.10 CLINICAL PRIVILEGING COMMITTEE

The Board of Directors defines the membership of the Clinical Privileging Committee may consist of the following:

- (Chairperson) Quality and Compliance Program Manager
- Vice President(s) of Integrated Care
- Chief Operating Officer/General Counsel
- Chestnut Family Health Center Medical Director(s)
- Lead Advanced Nurse Practitioner(s)
- Director of Human Resources
- Chief Clinical Officer
- Director of Chestnut Family Health Center
- Integrated Wellness Clinical Director
- CFHC Nursing Leads (Coordinator and Manager
- Medical Director(s) or their designee)
- Dental Manager or designee

The majority vote of those present at any Clinical Privileging Committee meeting at which a quorum is achieved is required to constitute an act of the Committee. To constitute a quorum, a simple majority of the Clinical Privileging Committee members must be present.

No committee member shall be present during the evaluation of his/her own background, credentials and competence related to actions regarding clinical privileges.

No committee member shall participate in the evaluation of the background, credentials and competence related to actions regarding clinical privileges of his/her direct supervisor.

Any committee member who is not present at the previous meeting must abstain from motioning or approving the previous meeting's minutes.

At any Committee meeting at which an applicant is being considered for clinical privileges, the clinical manager/director of the program in which the applicant is from shall make himself or herself available, by teleconference or otherwise. In addition, and if requested by the Committee Chairperson, such clinical manager/director is expected to provide information and feedback regarding such applicant in advance of

a Committee meeting. If a physician applicant is being considered for privileging, a Medical Director must be present or provide advisement to the committee Chairperson or designee so that this feedback is included in the discussion and consideration of the applicant. If an Advanced Nurse Practitioner or Physician's Assistant is being considered for privileging, a Medical Director or Lead APRN must be present or provide advisement to the committee Chairperson or designee so that this feedback is included in the discussion and consideration of the applicant.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 130 Definitions		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 130 DEFINITIONS

Licensed Independent Practitioner (LIP): An individual permitted by law to provide care and services without the direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. Chestnut Health Systems defines LIPS as:

- Physicians
- Dentists
- Dental Hygienist
- Nurse Practitioners
- Physician Assistants

Other Licensed or Certified Health Care Practitioner (OLCP): An individual who is licensed, registered, or certified but is not permitted by law to provide patient care services without direction or supervision. Chestnut credentials and privileges the following other practitioners:

- Nurses
- Licensed Behavioral Health Professionals
- Certified Medical Assistants (CMA, CNA, CMOA)

Other Clinical Staff (OCS): Staff that are not required by the state to be certified or licensed that provide clinical care. Chestnut credentials and privileges the following other clinical staff:

- Medical Assistants

Primary Source Verification (PSV) is verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner.

Secondary Source Verification (SSV) uses methods to verify credentials when PSV is not required. Privileging is required of each practitioner specific to the services being provided. The health center verifies its clinical staff possess the requisite skills and expertise to manage and treat patients and to perform the medical procedures that are required to provide the authorized services. It is the responsibility of the health center to assure clinical staff have met standards of practice and training that enable them to manage and treat patients and/or perform procedures and practices with a level of proficiency which minimizes the risk of causing harm. Verification procedures are appropriate to the specialty of each practitioner, the breadth of clinical services offered by the health center and the circumstances of the center's accessibility to

ancillary and tertiary medical practitioners. For other licensed or certified health care practitioners and other clinical staff privileging is completed during the orientation process via a supervisory evaluation based on the practitioner's job description and supervisory performance evaluations for privileging renewal.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CR 140 Privileging Categories		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Privileging Authorization Form		

CP 140 PRIVILEGING CATEGORIES

Privileging is awarded in three categories: type, site(s) and service area(s). At the time of a privileging decision, all categories are addressed and documented on the Privileging Authorization form.

Privileges will be of the following type:

- Temporary
- New
- Renewal
- Supplemental

Any privileging may be conditional, which may result from pending verification or receipt of documentation.

Privileges will be granted specific to each care delivery site.

Privileges will be granted by professional service area.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 150 Delineation of Service Areas and Clinical Privileges		
Revision Date:	010/04/2021		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CP 150.80		
Citation(s):			

CP 150 DELINEATION OF SERVICE AREAS AND CLINICAL PRIVILEGES

Privileges are awarded at the service level within each delineated service area. Privileges specific to distinct populations are awarded based on provider qualifications. As appropriate to the service level, further delineation to the procedure level will be determined by the Clinical Privileging Committee at the recommendation of the Medical Director(s).

The Privileging Committee will approve a matrix of eligible service area designations to which specific staff titles and/or positions may make application. The matrix will be maintained by the Chairperson.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 150.20 Description and Delineation of Medical Management Area		
Revision Date:	10/04/2021		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 150.20 DESCRIPTION AND DELINEATION OF MEDICAL MANEGEMENT AREA

Medical Management (MM): Privileges are awarded to the Medical Director(s) or Dental Director(s) who are responsible for identifying the scope of medical services and developing and supervising medical and dental procedures and protocols. Medical Management privileges are:

MM 1 Develop and approve all medical protocols utilized by Chestnut treatment programs. Clinical protocols shall meet The Joint Commission, state, and federal licensing and/or certification requirements.

MM 2 Supervise assigned personnel and contractors for the delivery of provider services.

MM 3 Coordinate Medical and Dental Services with Clinical Services through the involvement of the physicians, psychiatrists, dentists, nurse practitioners and nurses within in the clinical services programs.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 150.30 Description and Delineation of Behavioral Health Services Area		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	77 Ill. Adm. Code 2060 (“Rule 2060”) 59 Ill. Adm. Code 132 (“Rule 132”)		
Related Documents:	Data 2000 Waiver		

CP 150.30 DESCRIPTION AND DELINEATION OF BEHAVIORAL HEALTH SERVICES AREA

For all currently privileged individuals (i.e., those individuals privileged prior to the revision date of this policy), the following privileges will remain in effect until their privileges are renewed, at which point the privileges set forth in CP 150.45 will apply:

Behavioral Health (MS): Service privileges are awarded to those physicians, advanced practice registered nurses and clinicians who are approved and appropriately licensed or registered to perform behavioral health. Behavioral Health privileges are:

MS 1 Provide comprehensive physical health assessments on selected clients including: health history, physical examination, and evaluation of lab and diagnostic test results.

MS 2 Provide psychiatric assessments and medication evaluations on clients including, medical history, review of systems, psychiatric history, physical examination, lab testing, medical decision making & plan/recommendations, and interviews as appropriate.

MS 3 Prescribe and supervise the use of psychotropic medications. Assess the need to, prescribe, monitor, and supervise the administration and use of psychotropic medications with patients.

MS 4 Provide consultation to staff, other providers, and clients for management and treatment of health care needs.

MS 5 Administration of health care treatments and/or medications to clients for their Behavioral healthcare needs to manage short-term and chronic illnesses.

MS 6 Approval of assessment, diagnosis and treatment plan for adult and/or youth addiction use disorder clients, per 77 Ill. Adm. Code 2060 (“Rule 2060”).

MS 7 Approval of assessment, diagnosis and treatment plan for adult and/or youth mental health clients, per 59 Ill. Adm. Code 132 (“Rule 132”).

MS 8 Conduct certification of need for services on Psychiatric Residential Treatment Facility admissions as part of the independent team. This privilege is granted only to physicians specifically contracted for this service.

MS 9 Collaborate with other providers for the purpose of coordination of care.

MS 10 Authority to act as collaborator for nurse practitioners. This privilege is granted only to physicians.

MS 11 Administration of health care treatments and/or medications to patients for their health care needs to manage substance use disorders utilizing Medication Assisted Treatment (Buprenorphine). This privilege requires DATA 2000 waiver.

MS 12 Administration of health care treatments and/or medications to patients for their health care needs to manage substance use disorders utilizing Medication Assisted Treatment (Non-Buprenorphine). This privilege does not require DATA 2000 waiver.

MS 13 Authority to act as a proctor/preceptor for students training in the area of behavioral health services.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 150.40 Description and Delineation of Primary Care Services Area		
Revision Date:	6/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	77 Ill. Adm. Code 2060 (“Rule 2060”) 59 Ill. Adm. Code 132 (“Rule 132”)		
Related Documents:			

CP 150.40 DESCRIPTION AND DELINEATION OF PRIMARY CARE SERVICES AREA

For all currently privileged individuals (i.e., those individuals privileged prior to the revision date of this policy), the following privileges will remain in effect until their privileges are renewed, at which point the privileges set forth in CP 150.45 will apply:

Primary Care Services (HC): Primary Care privileges are awarded to nurses, medical assistants, medical office assistants, physicians, physician assistants, advanced practice registered nurses, and licensed behavioral health clinicians who are approved and appropriately licensed, registered or certified to perform primary care services.

HC 1 Provide comprehensive health assessments on patients including: health history, physical examination, and evaluation of lab and diagnostic test results.

HC 2 Administration of health care treatments and/or medications to patients for their health care needs to manage short-term and chronic illnesses.

HC 3 Provide health education to patients of the health center.

HC 4 Coordinate care for health center patients with other health care providers, social service agencies and community resources.

HC 5 Under the direction of a Licensed Independent Practitioner, administer health care treatments and/or medications to patients for their health care needs to manage short-term and chronic illnesses. (Other Licensed or Certified Health Care Practitioners only.)

HC 6 Approval of assessment, diagnosis and treatment plan for adult and/or youth addiction clients, per 77 Ill. Adm. Code 2060 (“Rule 2060”).

HC 7 Approval of assessment, diagnosis, and treatment plan for adult and/or youth mental health clients, per 59 Ill. Adm. Code 132 (“Rule 132”).

HC 8 Supervise assigned health center personnel.

HC 9 Discontinued.

HC 10 Discontinued.

HC 11 Provide consultation to staff, other providers, and clients for management and treatment of health care needs.

HC 12 Collaborate with other providers for the purpose of coordination of care.

HC 13 Authority to act as collaborator for -nurse practitioners. This privilege is granted only to physicians.

HC 14 Perform duties for conditions that fall within the typical scope of a Medical Assistant (MA) including but not limited to: collect and document patient information, perform vitals, administer and evaluate point of care tests with structured guidance, perform phlebotomy activities, prepare and assist with medical examinations, perform health screenings.

HC 15 Perform duties for conditions that fall within the typical scope of a Medical Assistant or Laboratory Technician including perform phlebotomy activities, collect blood (venipuncture and capillary sampling) and non-blood specimens for the purpose of in house or submission to external lab.

HC 16 Administration of health care treatments and/or medications to patients for their health care needs to manage addiction disorders utilizing Medication Assisted Treatment (Buprenorphine). This privilege requires DATA 2000 waiver.

HC 17 Administration of health care treatments and/or medications to patients for their health care needs to manage addiction disorders utilizing Medication Assisted Treatment (Non-Buprenorphine). This privilege does not require DATA 2000 waiver.

HC 18 Authority to act as a proctor/preceptor for students training in the area of primary care services.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 150.45 Description and Delineation of Medical Services Area		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	77 Ill. Adm. Code 2060 (“Rule 2060”) 59 Ill. Adm. Code 132 (“Rule 132”)		
Related Documents:			

CP 150.45 DESCRIPTION AND DELINEATION OF MEDICAL SERVICES AREA

After the effective date of this policy, and beginning with all new privileging applicants and all currently privileged individuals whose renewal date arises thereafter, the following privileges will be available:

Medical Services (MS): Medical Services privileges are awarded to nurses, medical assistants, medical office assistants, physicians, physician assistants, advanced practice registered nurses, and licensed behavioral health clinicians who are approved and appropriately licensed, registered, or certified to perform primary care or behavioral health services.

MS 1 Provide comprehensive health assessments on patients including: health history, physical examination, and evaluation of lab and diagnostic test results.

MS 2 Provide psychiatric assessments and/or medication evaluations on clients including, medical history, review of systems, psychiatric history, physical examination, lab testing, medical decision making & plan/recommendations, and interviews as appropriate.

MS 3 Administration of health care treatments, consultations and/or medications to patients for their health care needs to manage short term and chronic illnesses.

MS 4 Provide health education to patients of the health center.

MS 5 Coordinate care for health center patients with other health care providers, social service agencies and community resources.

MS 6 Under the direction of a Licensed Independent Practitioner, administer health care treatments and/or medications to patients for their health care needs to manage short-term and chronic illnesses. (Other Licensed or Certified Health Care Practitioners only.)

MS 7 Prescribe and supervise the use of psychotropic medications. Assess the need to, prescribe, monitor, and supervise the administration and use of psychotropic medications with patients.

MS 8 Approval of assessment, diagnosis and treatment plan for adult and/or youth addiction clients, per 77 Ill. Adm. Code 2060 (“Rule 2060”).

MS 9 Approval of assessment, diagnosis, and treatment plan for adult and/or youth mental health clients, per 59 Ill. Adm. Code 132 (“Rule 132”).

MS 10 Supervise assigned health center personnel.

MS 11 Provide consultation to staff, other providers, and clients for management and treatment of health care needs.

MS 12 Collaborate with other providers for the purpose of coordination of care.

MS 13 Authority to act as collaborator for -nurse practitioners. This privilege is granted only to physicians.

MS 14 Perform duties for conditions that fall within the typical scope of a Medical Assistant (MA) including but not limited to: collect and document patient information, perform vitals, administer and evaluate point of care tests with structured guidance, perform phlebotomy activities, prepare and assist with medical examinations, perform health screenings.

MS 15 Perform duties for conditions that fall within the typical scope of a Medical Assistant or Laboratory Technician including perform phlebotomy activities, collect blood (venipuncture and capillary sampling) and non-blood specimens for the purpose of in house or submission to external lab.

MS 16 Administration of health care treatments and/or medications to patients for their health care needs to manage addiction disorders utilizing Medication Assisted Treatment (Buprenorphine).

MS 17 Administration of health care treatments and/or medications to patients for their health care needs to manage addiction disorders utilizing Medication Assisted Treatment (Non-Buprenorphine).

MS 18 Authority to act as a proctor/preceptor for students training in the area of primary care services.

MS 19 Authority to act as a proctor/preceptor for students training in the area of behavioral health services.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 150.50 Description and Delineation of Dental Services Area		
Revision Date:	03/04/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 150.50 DESCRIPTION AND DELINEATION OF DENTAL SERVICES AREA

DS 1 Perform duties for conditions that fall within the typical scope of a Dental Assistant (DA) including but not limited to: collect and document patient information, perform vitals, administer and evaluate point of care tests with structured guidance, perform radiographs, prepare and assist with dental examinations and treatment, perform health screenings and provide dental health education to patients.

DS 2 Perform duties for conditions that fall within the typical scope of a Dental Hygienist (RDH) including but not limited to: collect and document patient information, perform vitals, administer and evaluate point of care tests with structured guidance, perform and interpret radiographs, provide preventive dental services, perform health screenings and provide dental health education to patients.

DS 3 Perform duties for conditions that fall within the typical scope of a Public Health Dental Hygienist (PHDH) including but not limited to: collect and document patient information, perform vitals, administer and evaluate point of care tests with structured guidance, perform and interpret radiographs, provide oral exams, provide preventive dental services, perform health screenings and provide dental health education to patients.

DS 4 Perform duties for conditions that fall within the typical scope of a Dentist (DMD or DDS) including but not limited to: collect and document patient information, perform vitals, administer and evaluate point of care tests, perform and interpret radiographs, provide diagnostic and oral exams, provide preventive dental services, perform dental treatment, perform health screenings and provide dental health education to patients.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 150.60 Description and Delineation of Obstetrical Services Area		
Revision Date:	10/04/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 150.60 DESCRIPTION AND DELINEATION OF OBSTETRICAL SERVICES AREA

OB 1 Gynecology - Evaluate, diagnose, consult, perform history and physical exam, and treatment of female patients presenting with illness, injuries, and disorders of the gynecologic or genitourinary system, and treatment of illness and injuries of the mammary glands.

OB 2 Obstetrics - Perform history and physical exam, treat and provide follow-up care to female patients presenting in any condition or stage of pregnancy, including injuries and disorders of reproductive system.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 150.70 Description and Delineation of Pediatric Services		
Revision Date:	10/04/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 150.70 DESCRIPTION AND DELINEATION OF PEDIATRIC SERVICES AREA

PD1 Provide comprehensive health assessments on selected pediatric patients including health history, physical examination, and evaluation of lab test results.

PD2 Administration of health care treatments and/or medications to patients for their health care needs to manage short-term and chronic illnesses.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 150.80 Description and Delineation of Other Specialty Services Area		
Revision Date:	10/04/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 150.80 DESCRIPTION AND DELINEATION OF OTHER SPECIALTY SERVICES AREA

Specialty: Occasionally individuals may possess expertise that is not covered in the routinely performed activities or services within the agency. In such instances, the Clinical Privileging Committee may create additional privileges to accommodate the situation.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 160 Positions Requiring Privileging		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Health Resources and Services Administration (“HRSA”)		

CP 160 POSITIONS REQUIRING PRIVILEGING

Staff members, employed or contracted, occupying the following job positions regardless of the Chestnut program he/she works for or within, shall be appropriately privileged and credentialed:

- Medical Director
- Physician
- Dentist
- Dental Director
- Dental Hygienist
- Mid-Level Practitioner {(i.e., Advance Practice Registered Nurse (APRN) or Physician Assistant (PA). Mid-Level Practitioners seeking privileges must have a collaboration agreement(s) with a Chestnut privileged physician.}

Additionally, the following staff members, employed or contracted, considered by Health Resources and Services Administration (HRSA) as “Other Licensed or Certified Health Care Practitioners” occupying the following job positions within Chestnut Family Health Center shall be appropriately privileged:

- Nurse (RN or LPN)
- Care Coordinator
- Licensed Behavioral Health Professionals
- Laboratory Technician
- Medical Assistant (CMA, CNA, CMOA)

The following staff members, employed or contracted, considered by Health Resources and Services Administration (HRSA) as “Other Clinical Staff” occupying the following job positions within Chestnut Family Health Center shall be appropriately privileged:

- Medical Assistants

Clinically privileged staff members, employed or contracted, are accountable to the Vice President(s) of Integrated Care, Chief Clinical Officer, Lead APRN and/or Medical Director(s), who in turn are responsible to the Board of Directors, for the quality of patient/client care.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 170 Credentialing		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	TJC Ambulatory Care Standards Human Resources Chapter TJC Behavioral Health Care Standards Human Resources Chapter		
Related Documents:	Credentialing/Privileging Source Document		

CP 170 CREDENTIALING

Credentialing is the process of assessing and confirming the qualifications of licensed, certified, or clinical management staff. For employed or contracted staff whose positions require privileging, credentialing activities will be coordinated and completed by the Human Resources, Managed Care, and Legal Departments. Credentials are reviewed and verified at the time of initial and renewal of privileging. Credentials such as licensure, registration or certification with expiration dates are monitored and verified accordingly. Primary source verification will be completed as required.

A detailed credentialing/privileging source document which outlines methods and sources of verification/query by privileging type will be utilized to inform credentialing activities and privileging evaluations. The source document confirms that activities and information gained is consistent with regulatory, accreditation and organizational requirements, including those related to primary source verification. The Privileging Committee Chairperson is responsible for verifying requirements on an on-going basis and maintaining the document. The Clinical Privileging Committee is responsible to review and approve the document as needed, but no less than annually.

The following credentialing documents and associated activities will be performed consistent with the credentialing/privileging source document and will be commensurate with the position, type, site and services for which privileges are sought:

Initial and recurring review of credentials for all clinical staff (LIPs, OLPs, other clinical staff, if applicable) ensure the verification of at minimum the following, as applicable:

1. Primary source verification of current licensure, registration, or certification. Primary verification of state licensure will be performed via the Internet through the appropriate board (i.e. Board of Nursing or Board of Medicine).

2. Education and training for initial credentialing only using:

   Primary verification for LIPs of the highest degree attained. This may be performed via the Internet through the National Student Clearinghouse or the registrar's office of the appropriate

university. Residency and Board Certification will be verified through the American Medical Association and through the American Nurses Credentialing Center for APRN's.

Primary or other sources (i.e. copy of diploma) for OLPs and any other clinical staff, as applicable.

If the applicant is not Board or Nationally Certified, competency to practice may be evaluated by a review of the past 2 years CME's or CEU's.

3. The National Practitioner Data Bank (NPDB) will be queried for the health center for all clinical staff (LIPs, OLCPs, and OCS), certain key staff, and others as required.

4. Clinical staff member's identity for initial credentialing only using a government-issued picture identification.

5. Drug Enforcement Administration (DEA) registration

6. Current documentation of basic life support training.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 180 Evaluation Process for Privileging		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	TJC Ambulatory Care Standards Human Resources Chapter TJC Behavioral Health Care Standards Human Resources Chapter		

CP 180 EVALUATION PROCESS FOR PRIVILEGING

Initial and recurring review of privileging for all clinical staff (LIPs, OLPs, other clinical staff, if applicable) ensure the verification of at minimum the following, as applicable

- Fitness for Duty: An appropriate response in the CAQH Medical Condition attestation question or similar attestation documents.
- For initial privileging only verification of current clinical competence via training, education, and, as available, reference reviews. References will be verified by phone contact or via email, with the author of the reference letter.
- For renewal of privileges, verification of current clinical competence via peer review or other comparable methods such as supervisory performance reviews.
- Verification of immunizations and communicable disease status per health center protocol.

Staff privileges may be modified, denied, or removed based on assessments of clinical competence and/or fitness for duty. In instances in which current competence is not established at hire or maintained and identified though the reappointment process, adverse incidents, and/or other clinical or patient safety/risk occurrences the Board of Directors may modify, deny, or remove a provider's privileges. The privileging date is the approval decision date made by The Committee Chairperson or the Clinical Privileging Committee and is documented in writing.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 190 Credentialing and Privileging Related to Contracted Health Center Service		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Privileging section of HRSA compliance manual		

CP 190 CREDENTIALING AND PRIVILEGING RELATED TO CONTRACTED HEALTH CENTER SERVICES

Contracts for required services for Chestnut Family Health Center will include credentialing requirements and participation in privileging of licensed or certified health care practitioners.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 200 Temporary Privileges		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 200 TEMPORARY PRIVILEGES

Staff requiring privileges cannot render services until temporary privileges are minimally granted. This does not prevent staff from participating in orientation and training activities.

The Chief Clinical Officer or the Medical Director, may award temporary privileges for a period not to exceed twelve (12) weeks. Temporary privileges for a time period in excess of twelve weeks must be reviewed and approved by the Clinical Privileging Committee. In no case should temporary privileges extend beyond sixteen (16) weeks.

Credentialing and privileging activities for temporary privileges will be performed consistent with the credentialing/privileging source document and will be commensurate with the position, type, site and services for which privileges are sought. The Chairperson will consult with the Lead APRN or Medical Director as needed, including when the application for privileges deviates from the source document.

Human Resources, Managed Care, and Legal Departments will gather and prepare credentialing and privileging documentation for temporary privileges. Upon receipt of all necessary documents, the CCO or Medical Director will review and determine authorization of temporary privileges. Upon a determination regarding temporary privileges, the completed copy of the Authorization for Clinical Privileges form will be retained in the privileging file with supporting documents. Applicants and their supervisor will be notified regarding the status of temporary privileges.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 210 New Privileges		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CP 180 Evaluation Process for Privileging		
Citation(s):			

CP 210 NEW PRIVILEGES

A comprehensive privileging application packet must be completed by each applicant.

The specific privileges of services for each applicant will be listed and reviewed, with an initial recommendation for temporary privileges from the Chief Clinical Officer or Medical Director and a final recommendation to the Board of Directors from the Clinical Privileging Committee.

For licensed independent practitioners, the CCO and applicable privileging committee member will provide an evaluation that reviews the background, credentials and competency of the person seeking privileges.

For other licensed or certified health care practitioners, the Chief Clinical Officer and the appropriate Chestnut Family Health Center leader will conduct an evaluation process that reviews the background, credentials and competency of the person seeking privileges and make a final determination for privileging. Other leadership may be consulted as needed, including when the application for privileges deviates from the source document.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 220 Renewal of Privileges		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CP 180 Evaluation Process For Privileging		
Citation(s):			

CP 220 RENEWAL OF PRIVILEGES

Licensed Independent Practitioners (LIP) - At least every two years, with privileging being valid until October 31, of the second year, unless withdrawn earlier, each privileged LIP, employed or contracted, will be reviewed by the Clinical Privileging Committee and Medical Director for the purpose of evaluating the individual's background, credentials and competency, to determine a recommendation for retention of privileges.

For LIPs, Human Resources and Managed Care staff and/or Legal Department will provide credentialing, other supporting documentation and a Clinical Privileges Recommendation form for renewal of privileges.

Consistent with CP 180, the CCO and/or applicable VPIC will ensure the completion of competency evaluation materials for an applicant prior to the privileging committee meeting at which the renewal applicant will be considered for privileging. When all required renewal materials are compiled and deemed satisfactory by the CCO and/or applicable VPIC, the CCO and/or applicable VPIC will coordinate with the Privileging Chairperson for the applicant to be presented at an upcoming committee meeting. At the committee meeting, the onus will be on the CCO and/or applicable VPIC to present the applicant to the Privileging Committee with a recommendation regarding the applicant's renewal of privileges.
Other Licensed or Certified Health Care Practitioners (OLCP) - At least every two years, unless withdrawn earlier, each privileged OLCP, employed or contracted, will be reviewed by the Chief Clinical Officer and Chestnut Family Health Center leadership for the purpose of evaluating the individual's background, credentials and competency to determine retention of privileges.

For all privileged staff - Credentialing and privileging activities for renewal of privileges will be performed consistent with the credentialing/privileging source document and will be commensurate with the position, type, site and services for privileges sought to be retained.

Human Resources and Managed Care staff and/or Legal Department will provide credentialing and application documentation for renewal of privileges. To ensure consistency and simplify processes, individuals whose renewal of privileges fall beyond the biannual rotation as of October 31, may be privileged earlier than 24 months.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 230 Changes To Privileges Previously Granted		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 230 CHANGES TO PRIVILEGES PREVIOUSLY GRANTED

With supervisory approval, clinically privileged staff may require or request that privileges in addition to those currently given be added or that privileges be removed. The staff may ask for revised privileges by written request. Upon receipt of the request, the CCO or Medical Director will review the staff's existing privileging file to determine whether the existing application contains enough current information to require only a supplemental application or whether a new application is needed and will consult with the appropriate program manager regarding the request. The CCO or Medical Director will have the authority to request any additional or updated information that is part of the normal privileging process for which they deem necessary in order to make a determination for temporary privileging for the revised privileges consistent with the temporary privileges policy. Recommendation for revised privileges for LIPs by the Clinical Privileging Committee to the Board of Directors will be made consistent with the new clinical privileges policy. Recommendations for revised privileges for OLCPs by the CCO and Chestnut leadership will be made consistent with the new clinical privileges policy.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 240 Process for Privileging – Licensed Independent Practitioners		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 240 PROCESS FOR PRIVILEGING – LICENSED INDEPENDENT PRACTITIONERS

Upon appointment as a Chestnut staff or contract position requiring privileges, the applicant must submit a completed privileging application

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As necessary, the applicant will work with the Human Resources staff, designated Legal Department staff and their supervisor to complete the application for clinical privileges and provide required supporting documentation. Upon completion of the application process, the applicant's materials will be reviewed by the CCO or Medical Director.

The Clinical Privileging Committee shall review all materials for new and renewal of privileges for LIPs and recommend to the Board of Directors the granting of privileges, provided that the application considered by the Committee are complete and satisfactory. The Chairperson of the Board of Directors has access to applicant packets and Privileging Committee meeting minutes, thus giving the Chairperson the opportunity to review materials and seek additional information if needed. A memo from the Clinical Privileging Chairperson will outline Committee recommendations and will be included in the Board packet. The Clinical Privileging Committee Chairperson or designee in their absence will attend Board of Directors meetings to answer Board inquiries regarding recommendations. Board of Director meeting minutes will reflect privileging actions of the Board. Fully executed privileging authorization forms and application materials will be retained in the privileging file. Applicants will be notified regarding assignment of privileges.

Following initial granting of clinical privileges, privileged LIPs are required to submit to the Clinical Privileging Committee an application for renewal of privileges at least every two (2) years. Renewal/review of clinical privileges will occur at least once every two (2) years. Exceptions to this may occur upon Committee recommendation and Board approval.

The Medical Director (or designee) is responsible for conducting or arranging for peer reviews of all LIPs contracted or employed by Chestnut. Ongoing peer reviews will be conducted.

Documentation of the peer review will be completed and will remain in the possession of the Medical Director or designee. A memo summarizing the aggregated results will be signed by the Medical Director or designee and submitted to each applicant's supervisor, and the Legal Department for inclusion with the completed renewal packet for review by the Committee in determining renewal of privileges.

The Legal Department will maintain privileging information in the staff member's or contractors privileging file and ensure the privileging occurs within the designated timeframes. Human Resources and Managed Care staff will monitor licenses and all dated aspects of the approved staff and ensure that the personnel and privileging files contain the updated information. The Legal Department staff will complete periodic and ad hoc reviews of privileged staff files. Any deficits in paperwork shall be communicated to the particular staff and his/her supervisor. Any deficits in paperwork that concern licensure or certification will additionally be communicated to the Privileging Committee Chairperson, Human Resources, and the Chief Clinical Officer.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 241 Process for Privileging – Other Licensed or Certified Practitioners		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 241 PROCESS FOR PRIVILEGING – OTHER LICENSED OR CERTIFIED PRACTITIONERS

Upon appointment to a Chestnut staff or contract position requiring privileges, the applicant must submit a completed privileging application.

As necessary, the applicant will work with the Human Resources staff, designated Legal Department staff and their supervisor to complete the application for clinical privileges and provide required supporting documentation. Upon completion of the application process, the applicant's materials will be reviewed by the Chief Clinical Officer (CCO) or designee.

The CCO and the designated Health Center leadership shall review all materials for new and renewal of privileges for OLCPs and OCS's and approve the granting of privileges, provided that applications considered are complete and satisfactory. The signed Clinical Privileges Recommendation form, application, and credentialing, competency and background materials for each applicant will be the basis for the review. Both the CCO and appropriate Health Center leadership shall sign the Clinical Privileges Recommendation form for OLCPs and OCSs. The fully executed form and application materials will be maintained in the privileging file, in accordance with the records retention policy. Applicants will be notified regarding assignment of privileges.

Following initial granting of clinical privileges, privileged OLCPs are required to apply for renewal of privileges at least every two (2) years. Renewal/review of clinical privileges will occur at least once every two (2) years. Exceptions to this may occur upon Committee recommendation and board approval.

The Legal Department will maintain privileging information in the privileging file and ensure the privileging occurs within the designated timeframes. Human Resources and Managed Care staff will monitor applicable expiration dates and ensure that the personnel and privileging files contain the updated information. The Legal Department staff will complete periodic and ad hoc reviews of privileged files. Any deficits in paperwork shall be communicated to the staff and their supervisor. Any deficits in paperwork that concern licensure or certification will additionally be communicated to the Privileging Committee Chairperson, the Chief Clinical Officer, and Vice President of Integrated Care

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 250 Appeal of Privileging Decisions		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 250 APPEAL OF PRIVILEGING DECISIONS

Any LIP that is denied or discontinued clinical privileges may appeal this determination. To initiate the appeal process the LIP must submit a written appeal request to the Committee Chairperson. The written appeal must be submitted within 30 calendar days. The Committee Chairperson together with the Privileging Committee reviews the appeal request and decides to uphold or reverse its previous decision. The appeal decision made is final.

Decisions of the Clinical Privileging Committee and/or the Chief Clinical Officer or Medical Director on awarding of clinical privileges may be appealed to the Board of Directors ONLY under the following circumstances:

In cases where the decision to deny, place conditions, revoke or suspend clinical privileges is contested by the individual to whom the decision applies, a written appeal citing an objective and quantifiable basis for disagreement with the decision must be filed with the Clinical Privileging Committee within ten working days of the receipt of the decision. The Chairperson will forward the written appeal and a written comment by the Clinical Privileging Committee to the Executive Committee of the Board of Directors within 20 days of receipt of the appeal. The Executive Committee will have 60 days after receipt of the appeal and comments from the Clinical Privileging Committee to review and consider the appeal. The Executive Committee of the Board shall consult with the Clinical Privileging Committee prior to submitting its findings and recommendations to the Board of Directors. The Board of Directors shall have 30 days in which to consider the findings and recommendations of the Executive Committee of the Board and the Clinical Privileging Committee after which time the Board of Directors will inform the individual making the appeal of its decision.

The action taken by the Clinical Privileging Committee with respect to denial, revocation, or suspension of clinical privileges shall remain in effect until a final decision is made by the Board of Directors.

Neither the Clinical Privileging Committee nor the Board of Directors shall discriminate on the basis of race, color, religion, creed, sex, gender identity, gender expression, national origin, age, sexual identity, marital status, ability or disability, military or veteran status or other factors prohibited by law in the authorization of clinical privileges.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 255 Automatic Termination of Privileges		
Revision Date:	06/29/2016		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CP 255 AUTOMATIC TERMINATION OF PRIVILEGES

Upon expiration or termination of any privileged employee or contracted individual's relationship with Chestnut, such individual's privileges will concurrently and immediately be terminated.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 260 Ethical Pledge		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	Personnel Policy Code of Conduct and Ethics		
Citation(s):			

CP 260 ETHICAL PLEDGE

At the time of application and renewal of clinical privileges, each individual is required to provide documentation of their intention to comply with the Code of Conduct and Ethics found in the Chestnut Personnel Policies, as well as the Code of Ethics for their particular professional specialty, i.e., Medicine, Psychiatry, Obstetrics, Dental, Pediatrics, Nursing, Social Work, Counseling, etc.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 280 Peer Review		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	735 ILCS 5/8-2101		

CP 280 PEER REVIEW

I. PURPOSE

A. To provide a mechanism that enables the Supervisor, Medical Director, Chief Clinical Officer, a Peer Review Advisory Committee, Clinical Privileging Committee, and the Board of Directors to assess the performance and competence of individual staff members, employed or contracted. This may include conducting evaluations and using the results of such assessments and evaluations to improve competence, practice, and patient care.

B. To ensure that the program staff is provided a fair and equitable procedure to address complaints and identify issues relating to patient care and treatment.

C. To assist program staff in practice and performance improvement to obtain optimal patient outcomes and required documentation according to funders.

II. GOALS

A. To monitor the performance of privileged medical staff.

B. To monitor trends in performance by analyzing aggregate data and case findings, utilizing comparative data when available.

C. To identify any existing opportunities for practice and performance improvement of practitioners, provide feedback, and develop plans for improvement/correction to improve the quality of care provided by practitioners and/or needed funder documentation.

D. To assure that the processes for practice evaluations are clearly defined, objective, equitable, timely and appropriate.

III. DEFINITIONS

Focused Practitioner Evaluation (FPE): Process used to assess current competency of Practitioners. This process may also be used to investigate concerns arising from ongoing Practitioner performance.

Individual Additional Review (IAR): Heightened review resulting from a trigger including but not limited to the following: an issue identified in OPE; the occurrence of a sentinel event; unusual adverse individual case or pattern of care; significant trends or events; event that has potential for or actually results in untoward patient outcome; practice outside of the standard of care; or behavioral concerns including disruptive or unprofessional conduct.

Licensed or Certified Health Care Practitioner: An individual required to be licensed, registered, or certified in in the practitioner's State of practice. Licensed or certified health care practitioners can be divided into two (2) categories:

1. Licensed independent practitioners (LIPS): physician, nurse practitioner, and nurse midwife or any other individual permitted by law and Chestnut Family Health Center to provide medical care and services without direction or supervision, within the scope of the individual's license.

2. Other Licensed or Certified Health Care Practitioners: An individual working in Chestnut Family Health Center who is licensed, registered, or certified but is not permitted by law to provide patient care services without direction or supervision.

Ongoing Practitioner Evaluation (OPE): A mechanism whereby the staff, Peer Review Committee, and Quality Management personnel can identify Practitioner practice trends that affect quality of care and patient safety on an ongoing basis. The ongoing process continually evaluates individual Practitioners for performance and competency-related issues using multiple sources of information.

Opportunity for Improvement (OI): An objectively verifiable divergence from the standard of care by a Practitioner to a degree less than that of negligence, such that it may require counseling or communication with the Practitioner to ensure compliance with the correct standard of care.

Peer: A Practitioner who has similar expertise and/or certification in the practice area of the reviewed Practitioner.

Peer Advisory Review Committee: The Board of Directors delegates to the Peer Review Advisory Committee the authority and responsibility to provide oversight of the peer review process that includes the IAR and the FPE processes. It is the intent of this Policy that all deliberations discussed, reviewed, or conducted by or within the peer review process set forth herein are protected by 735 ILCS 5/8-2101. No member of the Peer Advisory Review Committee shall be present during the review of his/her own performance or competence.

Standard of Care: A diagnostic and treatment process that a Practitioner should follow for a certain type of patient, medication, illness, or clinical circumstance.

IV. PEER REVIEW PROCESS

A. Ongoing Practitioner Evaluation (OPE)

1. OPE is a continuous process that does not focus on one event or situation. The Medical Director shall establish reporting requirements. The report shall include ongoing practice evaluation for each Practitioner.

2. The Medical Director will determine the structure of the peer review process. The Quality Management Department will facilitate the review with direction from the Medical Director.

3. The data used in the OPE may include the following:

    a. A random sampling of medical records will be reviewed for each Practitioner. Subjective and objective assessments of Practitioner's evaluation, management and practice patterns will be included.

    b. Aggregate data on rate-based indicators for individual Practitioners, using comparative data when available;

    c. Data collected and assessed through the quality improvement process which may include, but are not limited to:

        i. Review of procedure(s) performed and their outcomes;

        ii. Patterns of pharmaceutical usage;

        iii. Length of stay patterns;

        iv. Morbidity and Mortality data;

        v. Practitioner's use of consultants;

        vi. Specific Chestnut process audits or clinical guidelines audits; and

        vii. Compliance with laws, regulations, or other rules and policies.

    d. Data collected regarding billing and coding patterns.

4. OPE data will be evaluated by the Medical Director, or designee, on a quarterly basis. When statistically significant data or the review process suggests that a Practitioner's performance deviates from his/her colleagues and/or the standard of care to a substantive degree as determined by the Medical Director, the matter will be identified as "Opportunity for Improvement" assessment and will be documented and discussed with the practitioner privately. Three or more OI in a two year period may be the cause for an Individual Additional Review (IAR). If in the opinion of the Medical Director, matters are more serious, then they should be escalated to the Peer Advisory Review Committee for a Focused Practitioner Evaluation (FPE).

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Privileges		
Policy Name and Number:	CP 290 Peer Advisory Review		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	735 ILCS 5/8-2101-2102		

CP 290 PEER ADVISORY REVIEW

The Board of Directors delegates to the Clinical Privileging Committee the authority and responsibility to convene a Peer Advisory Review Committee when a peer issue arises. To ensure that the privileged staff are provided a fair and equitable procedure to address complaints and identify issues relating to patient care and treatment. It is the intent of this Policy that all deliberations discussed, reviewed, or conducted by or within the peer advisory process set forth herein are protected by 735 ILCS 5/8-2101. No member of the Peer Advisory Review Committee shall be present during the review of his/her own performance or competence.

A. Individual Additional Review (IAR)

1. Individual Additional Review will be conducted when any of the following occurs:

    a. Occurrence reports via OPE that identify a pattern of practice or behavior that is outside of acceptable standards.

    b. However, if an event or occurrence that raises serious concerns regarding patient safety or well-being or dangerous or disruptive behavior among the staff or facility, then the Peer Advisory Review Committee may immediately escalate the situation to a Focused Practitioner Evaluation (FPE), as set forth below.

2. IAR Process

    a. If concerns regarding performance or behavior of a Practitioner, such as those identified above, are raised during an OPE, those concerns will be forwarded directly to a Peer Advisory Review Committee.

    b. The Practitioner involved in the event shall be invited to a meeting of the Peer Advisory Review Committee where the case will be presented.

    c. Adequate notice shall be provided to the Practitioner at least two (2) weeks prior to the case review.

d. The Practitioner has the right to review the chart prior to the meeting and be advised of the specific concerns being addressed. Access to each will be provided to the Practitioner at the time of notice of the meeting is provided to them.

e. The Practitioner has the right to attend the meeting in person or address the concerns via written correspondence. Practitioner's legal counsel will not be permitted.

f. After IAR, within forty (40) days, the Peer Advisory Review Committee will submit an assessment to the Board, or its designee, and to the Practitioner as to whether care was appropriate or there was an Opportunity for Improvement. The Committee will also recommend whether the Opportunity for Improvement warrants discipline or corrective action. The Committee's recommendation will be considered by the Board, or its designee, when issuing a final determination.

g. If the Practitioner disagrees with the Peer Advisory Review Committee's assessment and recommendations, they may appeal the decision by filing written notice with the Peer Advisory Review Committee within thirty (30) days following the issuance of the Peer Advisory Review Committee's decision. Appeal may be taken as described using the process set forth below.

3. Board Final Determination.

a. If not first appealed, the Board, or its designee, will issue a final determination in writing to the Practitioner within thirty (30) days following receipt of the Peer Advisory Review Committee's recommendation. The Board, or its designee, may follow the Peer Advisory Review Committee's recommendation or, based upon the evidence presented at the IAR, issue its own findings, conclusions and discipline or corrective action, if applicable.

b. The Board's final determination may require the Practitioner to undergo additional training or counseling, engage in practice under a preceptor, or impose discipline up to and including suspension or termination.

B. Focused Practitioner Evaluation (FPE)

1. The Peer Advisory Review Committee shall review the files on all Practitioners who have accumulated three (3) or more "Opportunity for Improvement" assessments within a 2-year period.

2. After receiving a report or the accumulation of the three (3) Opportunity for Improvement assessments, the Peer Advisory Review Committee will evaluate the information submitted and determine that either no action is indicated or that action is indicated. If action is indicated, the Committee will institute an FPE.

3. The Peer Advisory Review Committee may immediately institute an FPE in the event of the following:

a. Sentinel event or near miss with potential for major or permanent injury that occurred because of the Practitioner's practice and/or performance;

b. An unusual adverse individual case or pattern of care including substantiated staff concerns related to the Practitioner's skill and performance;

c. Behavior concerns related to disruptive or unprofessional behavior including sexual harassment, mistreatment of staff or facility, and inappropriate conduct with patients;

d. Significant trends or events identified based on review of aggregate data or individual case review; or

e. Any other event, occurrence, situation, or outcome that the Peer Review Committee, in its discretion, believes raises serious concerns regarding the Practitioner's competence, patient or staff safety, or potential legal exposure.

4. Once the Committee has decided to implement an FPE, a "Focused Review Committee" shall be formed consisting of three (3) members selected by the Peer Advisory Review Committee. At least one (1) of the three (3) Practitioners must have similar training, specialization, and/or experience as the Practitioner, and, if necessary, one (1) or more external reviewers may participate in the FPE. No member of the Focused Review Committee will be a direct report of the Practitioner under review.

5. The Peer Advisory Review Committee shall notify the Practitioner that an FPE will be conducted. The Practitioner shall have the ability to participate in the review process. The Focused Review Committee performing the focused review shall determine the CP of Practitioner participation, i.e. written, through personal meetings, or any other form appropriate to the circumstances. If the Practitioner is disruptive or in any way interferes with the process, she or he will be excluded from the Focused Review Committee's review.

6. The FPE shall be completed within thirty (30) days of the appointment of the Focused Review Committee. That time may be extended for good cause by the Peer Advisory Review Committee upon the request of the Focused Review Committee. If an extension is necessary, the Peer Advisory Review Committee will notify the Practitioner in writing.

7. FPE requires the cooperation of the Practitioner. If the Focused Review Committee finds the Practitioner uncooperative, it may report back to the Peer Advisory Review Committee and request termination of the FPE. In these circumstances, the Peer Advisory Review Committee shall notify the Practitioner and determine whether the incident may lead to corrective action.

8. Upon concluding the FPE, the Focused Review Committee shall make a written report to the Peer Advisory Review Committee and to the Practitioner with recommendations that may include, but not be limited to, a recommendation for no further monitoring, a recommendation for continued monitoring, periodic meetings with an appointed preceptor, that the Peer Advisory Review Committee proceed with a formal disciplinary process, or that the Practitioner be suspended or discharged. The Practitioner may, within ten (10) days of receiving a copy of the report, provide his or her input to the Peer Advisory Review Committee for its consideration.

9. The Peer Advisory Review Committee will consider the information received from the Focused Review Committee and Practitioner. Within thirty (30) days following receipt of the letter of the Focused Review Committee's recommendations or the Practitioner's input, the Peer Advisory Review Committee will issue its assessment to the Board of Directors, or its designee.The Peer Advisory Review Committee may adopt the Focused Review Committee's recommendations, revise, and incorporate the recommendations, or issue its own findings, conclusions, and recommendations based upon the information provided to the Focused Review Committee and any additional information submitted by the Practitioner. The Peer Advisory Review Committee, in its discretion, may allow the Practitioner to submit

additional evidence during its review. However, the Committee's deliberations will not be open to Practitioner or third parties.

10. If the Practitioner disagrees with the Peer Advisory Review Committee's decision, they may appeal the decision by filing written notice with the Peer Advisory Review Committee within thirty (30) days following the issuance of the Peer Advisory Review Committee's decision, utilizing the Appeal Process, below. If not appealed, the decision will become final after thirty (30) days.

11. Board Final Determination.

    a. If not first appealed, the Board, or its designee, will issue a final determination in writing to the Practitioner within thirty (30) days following receipt of the Peer Advisory Review Committee's decision. The Board, or its designee, may follow the Peer Advisory Review Committee's recommendation or, based upon the evidence presented during the FPE, issue its own findings, conclusions and discipline or corrective action, if applicable.

    b. The Board's final determination may require the Practitioner to undergo additional training or counseling, engage in practice under a preceptor, or impose discipline up to and including suspension or termination.

D. Appeal

1. If a Practitioner wishes to appeal any decision of the Peer Advisory Review Committee, they may submit a written request to appeal the decision within thirty (30) days following the issuance of the Committee's decision. The Peer Advisory Review Committee will then schedule a formal hearing and provide the Practitioner with written notice of the hearing within thirty (30) days following the Practitioner's request. The Appeal will be heard by a panel convened by the Board of Directors.

2. Formal hearing processes will be utilized for the appeal of the Peer Review Advisory Committee's decision. This will include:

    a. The right to legal counsel;

    b. The ability to engage in written discovery;

    c. The ability to submit written evidence;

    d. The ability to submit testimony – both lay and expert;

    e. The ability to cross-examine witnesses; and

    f. The ability to submit written briefs, within ten (10) days following the conclusion of the hearing.

3. The Board panel will consider all evidence and information submitted at the hearing and issue its decision within forty-five (45) days following the submission of written briefs, or, if none, following the conclusion of the hearing.

4. The Board panel's decision will be forwarded to the Board for the Board, or its designee's, final determination.

E. Board Determination

1. The Board, or its designee, will issue a final determination in writing to the Practitioner within sixty (60) days following its receipt of the letter of the Peer Advisory Review Committee's recommendation or the Board panel's decision. The Board, or its designee, may follow the recommendations or, based upon the evidence presented at the hearing or appeal, issue its own findings, conclusions and discipline or corrective action, if applicable.

2. The Board's final determination may require the Practitioner to undergo additional training or counseling, engage in practice under a preceptor, or impose discipline up to and including suspension or termination.

3. The Board's final determination is not subject to appeal.

4. If applicable, the outcome of the determination will be reported to the appropriate authorities. When an outcome of any element of the competency evaluation suggests that an individual's privileges should be modified or removed, the Clinical Privileging Committee shall review the evaluation information. As appropriate, the Committee will make recommendations for mitigation actions, including as determined appropriate, recommendations to the Board of Directors for modified or removed privileges. Reportable clinical privileges actions will be submitted to the National Practitioner Databank. (NPDB)

F. General Principles Regarding Peer Review

1. When the case involves specialty specific practice, the review of cases will be conducted by Practitioners who have appropriate expertise in the specialty and subject matter involved. Practitioners who have direct involvement in the case under review may not participate as reviewers.

2. Detailed documentation of all communications and discussions related to the proceedings with the involved Practitioner(s) must be filed with the case summary.

3. Nothing herein will be construed to limit or prohibit the Peer Advisory Review Committee from taking immediate action to summarily suspend a Practitioner where it is an emergency; where the health and safety of patients are at issue; or where the facility, staff, and other Practitioners may be at risk due to Practitioner's conduct or behavior. In the event of a summary suspension, Practitioner will be granted the appeal rights, set forth above.

4. Peer review will be conducted in conjunction with PP 380, Impaired Professionals/Staff, to ensure that Practitioners receive appropriate treatment and rehabilitation without impacting patient or other staff's safety.

G. Confidentiality

1. Reports of case reviews, records, documents, and Committee minutes are maintained as confidential and are subject to protection under 735 ILCS 5/8-2101 and -2102.

2. Confidential minutes, reports and discussions held in executive session meetings are kept on file in a designated and secured place and are not stored with other healthcare records or other documents that are not covered by the State peer review laws. Copies are not distributed unless authorized by the Chairperson of the respective Committee. The minutes will be available for review by a Committee member, officer, Board Member, or designated

administrative representative. Cases should not be discussed outside of the peer review process.

3. Except for required reports and action items, the confidential business, documents, and confidential discussions of the Committee meetings may not be communicated in any way to individuals not serving on the Committee without prior authorization from the Chairperson of the Privileging Committee or the General Counsel.

Chestnut Health Systems
Clinical Services

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 01 Treatment Philosophy		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):			
Citation(s):			

CS 01 TREATMENT PHILOSOPHY

Chestnut Health System ("Chestnut") is committed to a series of strategic initiatives throughout its many programs and service lines, including prevention, its substance use and mental health treatment programs, primary care and oral health services, that are designed to create a comprehensive delivery system that integrates behavioral healthcare, primary healthcare, oral healthcare and wellness.

Chestnut's treatment philosophy is based on the premise that substance use and mental health issues, often correlate with physical health issues, are treatable health problems and that recovery is possible for everyone.

Chestnut integrates trauma informed practices into its daily operations. Trauma informed care respects the feelings and experiences of individuals served and offers safety and hope. The goal of these practices is to create/promote the following:

- A safe, calm and secure environment with supportive care
- A system-wide understanding of trauma prevalence
- Diversity, equity & inclusive cultural competence
- Consumer voice, choice and self-advocacy
- Recovery, consumer-driven trauma specific services
- Healing, hopeful, honest and trusting relationships

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 02 Integrated Care Vision		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):			
Citation(s):			

CS 02 INTEGRATED CARE VISION

Chestnut's vision for integrated care is, "Multidisciplinary team members working together with a patient centered health home framework to provide patient care, utilizing a comprehensive approach that fully integrates Chestnut's scope of services."

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 05 Program Manuals		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☒Clinical	
Policy Cross Reference(s):	CSB 655 Program Specific Procedures CSB 660 Policy and Procedure Library		

Citation(s): Health Resources Service Administration (HRSA) Health Center Compliance Manual Chapter 19 Board Authority / Section 330(k)(3)(H) of the PHS Act; 42 CFR 51c.303(i), 42 CFR 56.303(i), 42 CFR 51c.304(d), and 42 CFR 56.304(d); and 45 CFR 75.507(b)(2)

CS 05 PROGRAM MANUALS

The Chestnut Corporate Policy Handbook acts as an overall guide to govern the implementation of policy. Individual program and/or business units describe how these overall policies are implemented through procedures/processes in programs.

Programs will develop and maintain manuals to provide program specific procedures and/or protocols. Program directors are responsible for the content of program manuals, unless otherwise designated by the Chief Executive Officer, Chief Clinical Officer or applicable Vice President of Integrated Care. Program directors are responsible for reviewing and/or updating program manuals no less than every two years. For 330 funded programs, the Board of Directors will approve identified policy changes as required by regulatory requirements.

Staff is expected to be familiar with and to comply with procedures contained in their respective program manuals.

Chestnut will maintain a library of program manuals. Program directors will submit program manuals to the Quality and Compliance Program Manager.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 10 Initial Contact		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only Add Observer	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☒Clinical	
Policy Cross Reference(s):	CS 05 Program Manuals CS 20 Initial Screening And/Or Triage		
Citation(s):			

CS 10 INITIAL CONTACT

The goal of initial contact is to determine and respond to immediate needs and determination of the need for Chestnut services. Chestnut makes a distinction between:

- screening interviews that are crisis assessments or brief initial contacts,
- screenings that are intended to determine a person's appropriateness for Chestnut services,
- comprehensive assessments that are intended to diagnose, place, and provide the foundation for treatment planning, and
- triage interviews that are intended to determine a person's level of need for additional or immediate assessment by medical professionals.

Clients may initiate contact through electronic means, patient portal, telephone, or video contact, walk-in or through referral from another provider, community agency, referral entity, or collateral. Each clinical program is expected to maintain procedures within its program manual that offer reasonable methods for clients to initiate contact and access services.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 20 Initial Screening and/or Triage		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☒Clinical	
Policy Cross Reference(s):	CS 05 Program Manuals		
Citation(s):	Joint Commission Behavioral Healthcare CTS.02.01.01 through CTS.02.01.17 Missouri Department of Mental Health, Service Delivery Process and Documentation, 9 CSR 10-7.030(A).		

CS 20 INITIAL SCREENING AND/OR TRIAGE

Each program is expected to maintain procedures for initial screenings and triage that meet routine, urgent, or emergency care of the population served. Programs will describe these protocols in their program manuals. Initial screenings shall be sufficiently comprehensive to protect the safety of the individual and/or others.

- Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. Qualified staff must address emergency needs immediately.
- An urgent need is one that, if not addressed immediately, could result in the individual becoming a danger to self or others, or could cause a health risk. Qualified staff shall address urgent service needs within one (1) business day of the time the request was made.
- Columbia Suicide Severity Rating Scale- (CRSS) –to be completed according to specific program manuals.

Routine service needs are indicated when a person requests services or follow-up, but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. Routine service needs shall be addressed within ten (10) days.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 25 Waiting Lists		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CS 05 Program Manuals		
Citation(s):	Joint Commission Behavioral Healthcare CTS.01.02.01		

CS 25 WAITING LISTS

Due to the high demand for services, some Chestnut programs maintain waiting lists. It is the responsibility of each program with a waiting list to document associated protocols in its program manual. The program director or designee will provide ongoing oversight and management of the waiting list.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 26 Special Arrangement for Referral Source		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):			
Citation(s):			

CS 26 SPECIAL ARRANGEMENT OR REFERRAL SOURCE

Chestnut has special arrangements with specific agencies from which referrals are accepted based solely on the referral source's assessment of the client's needs and amenability for treatment. This does not eliminate the need for Chestnut staff to conduct a screening or evaluation of the referred client, to rule out any emergency or urgent needs.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 30 Assessment		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CS 05 Program Manuals		
Citation(s):	Joint Commission Behavioral Healthcare CTS.02.02.01 through CTS.02.02.09 and CTS 02.03.01 through CTS.02.03.09 Missouri Department of Mental Health, Service Delivery Process and Documentation, 9 CSR §10-7.030		

CS 30 ASSESSMENT

Assessment is viewed as a continuous process beginning at admission. It is the responsibility of each program to maintain assessment and treatment placement processes that are sufficient to address the needs of clients served. Assessment will be sensitive to the health literacy, language spoken and cultural considerations of the individual.

The scope of the assessment shall be commensurate with the nature and intensity of the services offered. If additional needs are identified, recommendations may be made for further assessment and/or treatment.

The assessment will be sufficient to determine service needs and for the development of an individualized treatment plan, if is medically necessary. Assessment will be ongoing to determine the need for continued treatment. The ongoing assessment information will be documented in the treatment plan, progress notes or assessment update documents. Assessments utilized shall be documented in the program's manual.

For non-330 funded behavioral health clients, Chestnut utilizes the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) which integrates assessment and treatment planning into a single process. The comprehensive IM+CANS is a lifespan tool that provides a standardized, modular framework for assessing the global needs and strengths of individuals. The IM+CANS is inclusive of the following:

- A complete set of core and modular CANS items, addressing domains such as Risk Behaviors, Trauma Exposure/Adverse Childhood Experiences, Behavioral/Emotional Needs, Life Functioning, Substance Use, Developmental Disabilities, and Cultural and Diversity factors:
- A fully integrated mental health and substance use assessment and treatment plan;
- An integrated physical Health Risk Assessment (HRA); and
- A population-specific addendum for youth involved with the child welfare system.

The least restrictive, most clinically appropriate level of care shall be recommended to meet the needs of the client. Any concerns related to level of care recommendations shall be resolved in cooperation with the client, the assigned staff, and the treatment team.

Treatment placement for substance use disorder clients in state licensed substance use treatment programs shall be based on the American Society of Addiction Medicine (ASAM) *Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.*

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 50 Assessment for Suicide Risk		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):			
Citation(s):	NPSG		

CS 50 ASSESSMENT FOR SUICIDE RISK

Screening/assessment shall be viewed as a continuous process and conducted at frequencies determined by program processes and more frequently as determined by individual need. Programs will address screening and assessment for suicide risk in its program manual.

At admission and as part of ongoing assessment, Chestnut provides suicidality screening and/or assessment for each individual, utilizing the PHQ-2, PHQ-9, and/or Columbia Suicide Severity Rating Scales (C-SSRS).

The following factors are used to determine an individual's level of suicidal risk:

- Ideation
- Intent
- Past suicidal behavior
- Recentness of past suicidal behavior
- Protective Factors (internal and external)
- Availability (i.e., gun in house)

Suicidal risk is stratified as follows:

- High suicide risk – suicidal ideation with intent or intent with plan in past month, or suicidal behavior within past 3 months
- Moderate suicide risk – suicidal ideation with method, without plan, intent or behavior in past month, or suicidal behavior more than 3 months ago, or multiple risk factors and few protective factors
- Low suicide risk – wish to die or suicidal ideation without method, intent, plan or behavior, or modifiable risk factors and strong protective factors, or no reported history of suicidal ideation or behavior

Interventions and safety planning will be commensurate with currently assessed risk level. Safety plans will be developed using the Brown-Stanley template. As appropriate, counseling on access to lethal means (CALM) will be part of the intervention and/or safety planning.

Each residential program will determine admission criteria related to suicide risk and will maintain processes for interventions related to risks. All are documented in program manuals.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 60 Assessment of Trauma, Abuse, Neglect and Exploitation		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CR 15 Mandated Reporting		
Citation(s):			

CS 60 ASSESSMENT OF TRAUMA, ABUSE, NEGLECT AND EXPLOITATION

Programs will assess trauma, abuse, neglect and exploitation. Staff will be educated about the effects of these experiences. An individual's experience of trauma, abuse, neglect or exploitation will be considered in the planning and delivery of care, treatment, and services. As appropriate, individuals will be referred for specialized services.

All cases of alleged or suspected abuse, neglect, or exploitation are reported to appropriate authorities in accordance with Chestnut policy, law, and regulations. Staff will refer to the Chestnut Policy Handbook, Client Rights, CR 15 Mandated Reporting section for specific reporting information.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 80 Assessment of Physical Health		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CS 05 Program Manuals		
Citation(s):	Joint Commission Behavioral Healthcare CTS.02.01.07 (Physical Health Assessment) Joint Commission Behavioral Healthcare CTS.02.01.09 (Screening for Pain) Joint Commission Behavioral Healthcare CTS.02.01.11 (Screening for Nutrition)		

CS 80 ASSESSMENT OF PHYSICAL HEALTH

Chestnut recognizes that individuals who are receiving behavioral healthcare, treatment, or services often do not receive the care needed regarding their physical health. Primary healthcare can address prevention, wellness, early diagnosis of disease and treatment of acute and chronic illnesses. In concert with these basic acknowledgements, the physical health of each individual seeking services at Chestnut shall be considered at the time of admission and throughout treatment. Behavioral healthcare clients shall be screened to determine the need for a physical examination or medical referral. This screening shall take place during the assessment process. The process will include screening for physical pain and nutritional status. Timeframes for completion of the screening and any subsequent medical consultations, reviews, exams and referrals will be based on the accrediting, funding and licensure standards for each program and will be delineated in each program manual. Chestnut staff are encouraged to refer individuals to Chestnut's Family Health Center for their primary & psychiatric care needs.

When a course in health improvement is suggested to the client, staff will assist the client in utilizing available program and community resources. Any appointment with service providers, the onset, resolution, or improvement of health problems, or health treatments are recorded in a progress note.

For individuals with eating disorders, an assessment will be made of the individual's beliefs, perceptions, attitudes, and behavior regarding food. Family observations will be considered as available and appropriate.

If at any time the client's health problem renders the client incapable of participating in the assigned program, an appropriate referral is made.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 90 Admission/Non-Admission/Discharge Criteria		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CS 100 Readmission Criteria CS 05 Program Manuals		
Citation(s):			

CS 90 ADMISSION/NON-ADMISSION/DISCHARGE CRITERIA

Each behavioral healthcare clinical program is required to have written admission and discharge criteria and processes documented in the program's manual. The admission/non-admission/discharge criteria shall not discriminate against any individual on the basis of sex, race, color, religion, national origin, age, sexual orientation, gender identity or expression, marital status, disability, military status or other status protected by law. All criteria will be in compliance with all applicable license regulations and laws.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 100 Readmission Criteria		
Revision Date:	06/24/2015		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CS 90 Admission/Non-Admission/Discharge Criteria		
Citation(s):			

CS 100 READMISSION CRITERIA

Readmission is defined as admission of a client seeking additional services for the same or a new presenting concern following a discharge from a previous treatment episode. In all instances, the program's admission criteria must be met.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 105 Telehealth Services		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CR 10 Client Rights and Responsibilities		
Citation(s):	45 C.F.R. § 160, 164		

CS 105 TELEHEALTH SERVICES

The advancements and continued development of medical and communications technology have a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of healthcare, particularly in the area of telemedicine. Telemedicine is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider. A provider should not render medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from patients. Such requirements shall at all times be in compliance with applicable state and federal laws. Chestnut will utilize telehealth/telemedicine and other forms of technology in accordance with federal confidentiality regulations.

The utilization of telehealth services offers an alternative to face-to-face services in the provision of identified medical and clinical services. Telehealth services may only be offered as approved by Chestnut leadership and only with similarly approved technology solutions and platforms. Chestnut strives to maintain its commitment to a trauma informed environment and approach in the utilization of services provided via telehealth.

Prior to or at the beginning of the first telehealth service, staff should discuss and document telehealth risks and benefits with the patient, parent and/or guardian. Confidentiality during telehealth and its limits should also be discussed with the patient. While staff may only implement confidentiality controls from their origin of the session, they should discuss expectations of the client/guardian.

Services provided via telehealth must be documented following Chestnut's policies and procedures. Additionally, staff will document in the progress note the type of platform used during the telehealth service delivery.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 110 Internal Treatment Program Transfers and Referrals		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CS 90 Admission/Non-Admission/Discharge Criteria		
Citation(s):			

CS 110 INTERNAL TREATMENT PROGRAM TRANSFERS AND REFERRALS

Client needs and requests are continually assessed and coordinated through Chestnut referral. Based upon case reviews and consultation, transfers or referrals to another Chestnut treatment program may be recommended. Clients who are referred to another program must meet the admission criteria for that program. For continuity of care, relevant information between behavioral health and primary care services shall be shared. Documentation of the need and justification for referral, transfer or discharge is completed at the time of referral, transfer, or discharge.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 120 Individualized Treatment Plans		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CS 05 Program Manuals		
Citation(s):	Joint Commission Behavioral Healthcare CTS.03.01.01 through 03.01.05 Missouri Department of Mental Health, Service Delivery Process and Documentation, 9 CSR §10-7.030		

CS 120 INDIVIDUALIZED TREATMENT PLANS

Treatment plans for primary healthcare clients will be based on the patient's acute needs and chronic diseases. Program specific clinical guidelines are included in program manuals.

For non-330 funded behavioral health clients, Chestnut utilizes the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) which integrates assessment and treatment planning into a single process.

All clients participating in clinical services shall have an individualized treatment plan developed in consultation with the client and/or their family/natural support system, when appropriate and with proper consent. The initial treatment plan (ITP) may be developed based on the client's presenting concerns and the initial assessment. For Addiction Services, following the ITP, a master treatment plan (MTP) is developed. It is reviewed and updated by staff with client participation.

The goals and objectives are to be written in measurable changes in the client's behavior or knowledge, with interventions that are designed to meet the therapeutic needs and preferences of the client. The client and their family/natural support system are encouraged to actively participate in the development of their treatment plan. When conflicts arise between clients and their guardian regarding treatment participation, the case is reviewed and the decision that is in the best interest of the client is discussed with the client and their family/natural support system. Treatment plan reviews will be clinical in nature, documenting the individual's continuing need for services. The treatment plan will continue to reflect the client's needs, perceptions, preferences, and strengths. The client's perception of their progress on treatment goals and objectives shall be documented in the medical record.

Treatment plan reviews are conducted in accordance with each program's guidelines and all licensure requirements.

Outcomes will be assessed via data from the IM+CANS.

Results are used to inform treatment goals and objectives and to evaluate outcomes of care, treatment or services provided.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 130 Medication Management		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):			
Citation(s):			

CS 130 MEDICATION MANAGEMENT

Medication management protocols for behavioral healthcare clinical programs will be maintained in the Patient Care Manual for Behavioral Healthcare Settings. The manual will provide a framework for an effective and safe medication management system for these programs. The manual is reviewed and approved by the Medical Director. The review and approval process will be monitored by the Quality and Compliance Program Manager.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 135 Dietary		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):			
Citation(s):			

CS 135 DIETARY

Residential treatment programs provide food and nutritional products to residents, in accordance with applicable state, county and city health regulations. Meals and snacks are served at times that are normal and appropriate for the age of the residents applicable to Chestnut's food and dietary program. Some meals are provided through a contractual arrangement with a local restaurant or caterer. Some food is provided directly by Chestnut and when possible nutritional choices are considered. Staff are assigned responsibility for preparing, storing, distributing, and administering food and nutritional products. Substitutions to the menu by the caterer are permissible. Food is prepared and stored in following proper conditions of sanitation, temperature, light, moisture, ventilation, and security. Identified staff in Illinois are certified in food service sanitation by the Illinois Department of Public Health.

Dining areas are supervised during mealtimes. Staff assist individuals who require help eating. Special diets and altered diet schedules as determined by medical staff, are accommodated. The food behaviors of persons with eating disorders and other identified individuals will be monitored. The cultural, religious, and ethnic food preferences of individuals are honored, when possible, unless contraindicated.

Chestnut contracts the services of a consulting dietician. The consulting dietitian provides consultation and training in meal planning, management of modified diets, food service sanitation, safety, and education for facility staff and clients as needed. The dietician reviews and approves program menus.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 140 Tobacco Use		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	PP 1627 Tobacco Free Workplace		
Citation(s):	The Smoke-Free Illinois Act Missouri Clean Indoor Air Act, Mo. Rev. Stat. §191.767		

CS 140 NICOTINE USAGE

Chestnut recognizes nicotine and tobacco use and dependency as a chemical addiction and a serious health hazard. The Smoke-Free Illinois Act prohibits smoking in virtually all public places and workplaces. Per the Act, no person shall smoke in or within 15 feet of any entrance to a public place or place of employment.

Similarly, the Missouri Indoor Clean Air Act prohibits smoking in public places (which include healthcare facilities), except in designated smoking areas.

Cigarette smoking, cigar smoking, tobacco chewing, and use of vape products are not permitted in any Chestnut treatment building or in any common area of a Chestnut housing program. Smoking cigarettes, chewing tobacco, and the use of vape products are only permitted in designated outside smoking areas. Adolescent clients are not permitted to use any tobacco or vape products and staff are not permitted to provide such products to adolescents. Adults participating in residential substance use treatment programs are either limited or prohibited in the amount of time that they are allowed to smoke, chew tobacco, or use vape products throughout the day.

Chestnut staff shall offer clients assistance in tobacco cessation or discontinuation of the use of tobacco or nicotine products. The methods of assistance shall be consistent with the nature of the treatment setting.

Clients, staff and visitors are expected to comply with Chestnut's Tobacco Free Workplace Policy guidelines set forth in Personnel Policy 1627.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 160 Discharge Planning		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CS 05 Program Manuals CS 165 Termination of Chestnut And Client Relationship		
Citation(s):	Missouri Department of Mental Health, Service Delivery Process and Documentation, 9 CSR §10-7.030		

CS 160 DISCHARGE PLANNING

Chestnut Family Health Center is the medical home for its patients. Discharge occurs only when the patient separates from the medical home, leaves the geographic service area, or becomes deceased.

Discharge planning for non-330 funded behavioral healthcare clients shall begin upon admission to a treatment service. Discharge plans shall be documented in the client's record and include client and family/support system participation (when appropriate). In Missouri, a written discharge plan shall contain the following: documented treatment episode(s) and the outcome of each episode, including but not limited to, the following: date of admission and discharge; identified needs at intake; referral source as applicable; services provided and the extent to which established goals and objectives were achieved; reason(s) for or type of discharge; diagnosis or diagnostic impression at last contact; recommendations for continued services and supports; information on medication(s) prescribed or administered, as applicable; and signature of staff completing the plan. The discharge plan may also contain other information as necessary.

Procedures for discharge will be documented in program manuals.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 170 External Referrals		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	Reference Policy re: Disclosure Authorization		
Citation(s):	Joint Commission Behavioral Healthcare CTS.03.01.07		

CS 170 EXTERNAL REFERRALS

During treatment, an individual's needs are continually assessed and coordinated. External program referrals and/or transfers may be recommended or requested by the client or staff. At times, clients are referred to external referrals because of serious threats of harm or harassment.

Chestnut Family Health Center (CFHC) is the medical home for its patients. CFHC will manage referrals for its patients for, but not limited to, medical specialty and diagnostic testing services. The procedures for referral management are included in the CFHC program manual. When a client needs additional care, treatment, or services not offered by Chestnut, referrals are made and documented in the medical record. Such services may include but are not limited to:

- Emergency Medical Services
- Dental Services
- Speech and Hearing Services
- Vocational Rehabilitation Services
- Spiritual Services
- Medical Specialty Services
- Diagnostic Testing Services
- Vision Services
- Recovery home and shelters
- Educational Services

It is the responsibility of the client's primary staff to coordinate appropriate referrals. Prior to the referral, an appropriate Disclosure Authorization to the service provider must be obtained to facilitate exchange of information. All referrals shall be documented in the client's medical record.

Emergency medical services for clients are provided by local hospitals and are available 24 hours a day, seven days a week.

Programs will maintain appropriate community resource information to the services in their area.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 180 Linkage and Referral Agreements		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CS 26 Special Arrangement or Referral Source		
Citation(s):			

CS 180 LINKAGE AND REFERRAL AGREEMENTS

When needed, a bi-directional Linkage or Referral Agreement shall define the working relationship between Chestnut and agencies, to which frequent referrals are made for client services. Copies of signed agreements are maintained by Chestnut.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 200 Staffing Plan Purpose		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):			
Citation(s):	HRSA Health Center Compliance Manual Chapter 5: Clinical Staffing		

CS 200 STAFFING PLANS

Staffing plans are designed to support the clinical services provided by Chestnut. They are intended to ensure patient safety, quality, and professional services, and to facilitate the effective use of staff resources. Staffing plans are outlined in program budgets.

Regardless of the treatment setting, there is a need for qualified staff to provide clinical interventions. Clinical management staff, recognizing all regulatory requirements, have identified the certification, licensure, and competency requirements for performing various treatment activities. Individual staff members must meet these requirements to perform that activity. Designated Human Resources staff will be responsible for verifying relevant certification and/or licensure.

Each program will establish appropriate staffing patterns relative to the intensity and type of services provided. Caseloads may vary, based upon the intensity of services provided. Management staff in each program are responsible for monitoring their staff's individual caseloads.

Programs should provide a sufficiently diverse selection of treatment options to meet the needs of the population served. The appropriate balance and mixture of services is determined by the Program Directors with the approval of the Chief Executive Officer, Chief Clinical Officer, Vice President(s) of Integrated Care, Medical Director(s), and/or Board of Directors, as appropriate.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 230 Clinical Supervision		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☒Clinical	
Policy Cross Reference(s):	CP 150 Delineation of Service Areas		
Citation(s):	Joint Commission Behavioral Health HRM.01.04.01		

CS 230 CLINICAL SUPERVISION

The Chestnut Family Health Center Director, Integrated Wellness Clinical Director, or Vice President(s) of Integrated Care or designee, in consultation with the Chief Executive Officer, Medical Director(s) and Chief Clinical Officer are responsible for all treatment services. The Vice Presidents of Integrated Care report to the Chief Clinical Officer.

Physicians shall receive supervision in a manner to not interfere with their ability to make independent decisions in accordance with applicable state laws and regulations. All treatment services are provided under the direct supervision of the Vice President(s) of Integrated Care or Designee, Medical Director(s), Chief Clinical Officer, Program Director, or a designated supervisor. Only individuals who meet the qualification, experience and competency requirements for these job functions will be placed in these roles. Clinical supervision of direct service staff shall be provided on an ongoing basis to ensure adequate supervisory oversight and guidance. Supervision of treatment services can be provided in either group or individual settings. Program Directors will determine the mode, method and frequency of supervision for clinical staff working in their programs. Supervision will minimally occur per the standards of licensing and regulatory entities.

Case staffings shall be conducted by program directors or designated supervisors or staff. The treatment progress of individuals served is reviewed during supervision, case staffings, continuing stay reviews, individual treatment plan reviews and assessment updates. Case staffings are routinely held for all residential clients, and for intensive outpatient and outpatient clients receiving substance use services.

The Medical Director(s), staff physicians, consulting physicians, advanced practice registered nurses, and registered nurses shall be available for emergency consultation as defined by program need. The physicians shall supervise all medical services provided and the psychiatrists shall be responsible for the supervision of medical psychiatric treatment. The Medical Director(s) shall be responsible to the Chief Clinical Officer.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 250 Evaluation of Treatment Staff Practices		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☒Clinical	
Policy Cross Reference(s):	CP 280 Peer Review CS 230 Clinical Supervision RI 110 Completeness of Client Records		
Citation(s):	Joint Commission Behavioral Healthcare HRM.01.06.03		

CS 250 EVALUATION OF TREATMENT STAFF PRACTICES

The primary mechanism for the review, evaluation, and monitoring of treatment staff practices is with the Quality Management Processes. Additional mechanisms for evaluation of treatment staff practices include clinical protocol adherence review, peer review, clinical supervision, case consultation, and review of individual client treatment records.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Clinical Services		
Policy Name and Number:	CS 300 Mandated Reporting Responsibility		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☐Clinical	
Policy Cross Reference(s):	CR 15 Mandated Reporting RM 60 Incident Reporting		
Citation(s):			

CS 300 MANDATED REPORTING RESPONSIBILITY

Staff are responsible to be familiar with and adhere to mandated reporting responsibilities and guidelines, related to one's professional credentials and/or to the program and services provided while performing one's job duties. All mandated reporting events are reported to appropriate authorities in accordance with Chestnut policy, law, and regulations. Staff will refer to the Chestnut Policy Handbook, Client Rights, CR 15 Mandated Reporting section, for specific reporting information.

Chestnut Health Systems
Corporate Compliance

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CHESTNUT
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Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 10 Adherence to the Code of Conduct		
Revision Date:	06/25/2014		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	☒Administrative
Policy Cross Reference(s):	Personnel Policy Code of Conduct and Ethics		
Citation(s):			

CC 10 ADHERENCE TO THE CODE OF CONDUCT

Staff are expected to abide by the Chestnut Health Systems ("Chestnut") Code of Conduct and Ethics as written in the Personnel Polices.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 20 Corporate Compliance Program		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	☒Administrative
Policy Cross Reference(s):	Personnel Policy Code of Conduct and Ethics		
Citation(s):			

CC 20 CORPORATE COMPLIANCE PROGRAM

In the fulfillment of our mission, Chestnut is dedicated to adhering to the highest ethical standards and, accordingly, recognizes the importance of compliance with all applicable state and federal laws. To evidence this dedication, our Board of Directors has adopted, developed, and implemented a Corporate Compliance Program. Our Corporate Compliance Program is a part of the fabric of Chestnut's routine operations. Our Compliance Program:

- promotes an organizational culture that encourages ethical conduct and a commitment to compliance with the law;
- endeavors to assure compliance with the standards set forth in the Code of Conduct and Ethics and the Corporate Compliance Program;
- provides a response and correction mechanism in the event of an actual or potential violation of the Code of Conduct and Ethics or the Corporate Compliance Program;
- detects and deters actual or potential violations of the law:
- endeavors to communicate to all personnel the organization's intent to comply with applicable laws;
- provides educational opportunities regarding compliance requirements and train personnel to conduct their job activities in compliance with laws, regulations, and according to established policies and procedures;
- assesses Chestnut's business activities and consequent legal risks;
- utilizes a reporting system to address problems in an efficient and timely manner;
- ensures that contractual obligations and requirements are fulfilled and services are provided in accordance with applicable state laws;
- establishes processes and mechanisms for effective, clear and open lines of communication; and

- includes enforcement components to ensure that personnel take their compliance responsibilities seriously.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 30 Staff Reporting and Responsibilities		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CC 30 STAFF REPORTING AND RESPONSIBILTIES

This policy is intended to provide guidance to Chestnut staff for the handling of reports of dishonest or illegal activities or actual or potential violations of the Chestnut Code of Conduct and Ethics and Corporate Compliance Program. This policy is also intended to promote good and honest business practices and articulate Chestnut's commitment to ethical behavior. This policy is not intended to replace existing reporting mechanisms. Rather, the reporting mechanism for the Corporate Compliance Program shall be used to report actual or potential violations of the law, including statutes, regulations and contract conditions or any good faith belief that a violation has, may or will occur. Other ethical or policy violations should be reported through existing reporting mechanisms and supervisory chains of command.

Chestnut's Corporate Compliance Program is an integral part of the Code of Conduct and Ethics. One of the goals of the Code of Conduct and Ethics and the Corporate Compliance Program is to detect and deter actual or potential violations of the law. Therefore, each staff has an individual responsibility for reporting any activity that the staff knows or in good faith believes may or will violate applicable laws, rules, regulations and the Code of Conduct and Ethics.

1. All staff are responsible for reporting activities by another staff, contractor or agent that appear to violate applicable laws, rules and regulations and that he or she knows or reasonably believes to have occurred.

2. If a staff member knows or reasonably believes that a staff, contractor or agent has solicited participation in a work-related crime or informs another staff that they are contemplating committing a work-related crime, it must be reported.

3. If a staff knows of any act by another staff, contractor or agent that violates, or appears to violate, a provision of the Code of Conduct and Ethics or Corporate Compliance Program, the staff must report it.

4. Under no circumstances is criminal conduct by any staff, contractor or agent considered within the scope of his or her employment, engagement or authority.

5. Any staff who knowingly fails to report actual or potential violations as described above will face appropriate disciplinary action.

6. Staff are encouraged to initially contact an immediate supervisor or supervisory staff. The supervisor may request written documentation from the reporting staff. The reporting staff shall receive written confirmation that the matter is being addressed if it is judged to be a substantial violation or the staff requests such confirmation. All compliance related issues reported to a supervisor should also be reported to the Corporate Compliance Officer and entered into EthicsPoint by the Corporate Compliance Officer or designee. The Compliance Officer is Jessica Barnes and can be reached at: **jcbarnes@chestnut.org or 309-820-3545**

7. If a staff perceives his or her immediate supervisor or supervisory staff as having a conflict of interest, or does not receive a satisfactory response, then he or she may file a report themselves through EthicsPoint.

8. To file a report, EthicsPoint can be accessed by using one of these three methods:

   - Telephone at 1.888.264.0747
   - Public Internet at www.ethicspoint.com
   - Chestnut's Intranet: Corporate Compliance section

   Anonymous reports are permitted. However, if a reporter does not respond to requests for additional information within stated timeframes, or to the satisfaction of the Corporate Compliance Officer, the report may be closed. All efforts will be made to preserve the confidentiality of the reporting staff's identity and the contents of the report, to the extent permitted based on the reported facts and circumstances and as permitted by law.

   When making a report, the staff should follow the EthicsPoint on-screen or Intake Specialist's instructions. The reporter should specify what type of report is being made from available choices (i.e. Accounting & Auditing Matters, Patient Care, Confidentiality, etc.).

   To complete the report, provide information about the incident/concern including:

   - Persons who are engaged in the incident, including titles
   - What specifically occurred
   - The time and duration of the incident

   After making the report, the reporter should return to the EthicsPoint system to see if the Compliance Officer or designee has any follow-up questions or requests. The reporter should provide any further information requested about the incident.

9. Upon receipt of a report, the Corporate Compliance Officer will determine whether to involve the General Counsel, Internal Auditor or others. In the event of a conflict of interest involving the Corporate Compliance Officer, the General Counsel will assume the responsibilities of the Corporate Compliance Officer under these policies. The Corporate Compliance Officer will also determine whether an inquiry or investigation is appropriate and may recommend subsequent actions, if warranted in response to such inquiry or investigation. The process for conducting investigations is further described in the Response and Correction to Staff Reports Policy.

10. The Corporate Compliance Officer will make every effort to preserve the confidentiality of the reporting staff's identity and the contents of the report, but will have authority to release the information to:

    - the General Counsel;
    - such third parties, including outside counsel and consultants, as shall be determined by the Corporate Compliance Officer;

- Chestnut managers, officers and directors who are not the subject of the report and whose duties and responsibilities, in the opinion of the Corporate Compliance Officer, require them to be told about the report or the results of the subsequent investigation of the report;
- the appropriate Board committee, if applicable;
- law enforcement officials, as appropriate; and
- government agencies and licensing authorities, as appropriate.

11. No retaliation will be tolerated against any staff who has filed a report based on a good faith belief that another staff, contractor or agent has violated the Code of Conduct and Ethics or Compliance Program.

12. Any staff who attempts to take or takes retaliatory action against a staff reporting an actual or suspected violation will face appropriate disciplinary action.

13. Any staff who makes a false accusation will face appropriate disciplinary action.

14. Any staff who authorizes or participates in any work-related criminal conduct or violation of the Code of Conduct and Ethics or Corporate Compliance Program will face appropriate disciplinary action.

15. Any staff who is the subject of a report or investigation who refuses to cooperate in an inquiry or investigation will face appropriate action. There will be no retribution against anyone because of his or her cooperation with an investigation. Persons who are the subject of a report or investigation may be disciplined in accordance with this policy.

16. Assuring compliance with the standards set forth in the Code of Conduct and Ethics and the Corporate Compliance Program is an important Chestnut objective and requires all staff to take seriously their obligations as outlined above. All violators will be subject to appropriate action. The precise corrective action utilized will depend on the nature, severity and frequency of the violation. The corrective actions listed below are not progressive discipline steps, nor do such actions need to be taken in any sequence. The corrective action may result in any one or combination of the following actions:

    - probation
    - demotion;
    - restitution;
    - suspension with or without pay;
    - training;
    - referral to employee assistance program;
    - transfer;
    - verbal warning;
    - written warning;
    - referral for possible criminal prosecution/civil action; and/or
    - termination

17. Reporting Concerns to The Joint Commission:
    While all staff are encouraged to utilize Chestnut's established procedures for dealing with suspected illegal or unethical behavior or unsafe conditions, including utilizing the Corporate Compliance Program reporting structure, any staff who believes that Chestnut has not responded appropriately to their report and believes that Chestnut continues to perform in illegal, unethical or unsafe ways, may report those concerns directly to The Joint Commission without fear of retribution.

The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
1.630.792.5000

As with reporting through the Corporate Compliance Program, no retaliation will be tolerated against any staff who has filed a report based on a good faith belief that a staff member, contractor or agent of Chestnut has violated the Code of Conduct and Ethics or the Corporate Compliance Program.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 40 Response and Correction to Staff Reports		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CC 40 RESPONSE AND CORRECTION TO STAFF REPORTS

Chestnut has implemented a Corporate Compliance Program, which is an integral part of the Code of Conduct and Ethics. One of the goals of the Code of Conduct and Ethics and the Corporate Compliance Program is to provide for a response and correction mechanism in the event of actual or potential violations of the Code of Conduct and Ethics or the Corporate Compliance Program.

Inquiries/Investigation

Upon reports of reasonable indication of suspected non-compliance, the Corporate Compliance Officer will promptly initiate steps to act upon the conduct in question. The Corporate Compliance Officer may involve the General Counsel, Internal Auditor or others as he/she deems appropriate. The Corporate Compliance Officer may involve or refer matters to the Director of Human Resources. The Corporate Compliance Officer may initiate an inquiry into the matter to determine whether a formal investigation is required.

After due inquiry, the Corporate Compliance Officer may initiate a formal investigation into reports of reasonable indication of suspected non-compliance. The Corporate Compliance Officer will initiate steps to investigate the conduct in question.

The purpose of an investigation is to:

- determine whether, to a reasonable degree of certainty, the reported conduct occurred;
- determine if the conduct in question has resulted in a material violation of applicable law or the requirements of the Corporate Compliance Program;
- identify individuals who may have knowingly or inadvertently caused violations of applicable laws, rules or standards;
- facilitate the correction of any practices not in compliance with the applicable laws, rules and standards;
- implement those procedures necessary to ensure future compliance;
- protect Chestnut in the event of civil or criminal enforcement actions; and
- preserve and protect Chestnut's assets.

The Corporate Compliance Officer, with approval from the Chief Executive Officer, may solicit the support of external auditors, consultants or other external resources with knowledge of the applicable laws and regulations and required policies, procedures and standards that relate to the specific problem in question.

The Corporate Compliance Officer may also solicit the support of other internal resources with knowledge of the applicable laws and regulations, and required policies, procedures and standards that relate to the specific problem in question.

The Corporate Compliance Officer will make a determination of the extent of investigation required, depending upon the nature of the alleged violations. The Corporate Compliance Officer is responsible for determining the involvement and extent of involvement of supervisory staff during an investigation. An investigation may include interviews of relevant persons, review of relevant documents, and may also include external auditors and consultants. Notification of the party being investigated will be at the discretion of the Corporate Compliance Officer. If, as a result of an investigation, the Corporate Compliance Officer concludes that a staff has violated a rule of law or ethics or Chestnut policy, he/she will present such conclusions to the Director of Human Resources or designee and the applicable staff's supervisor, together with the minimum amount of information necessary to substantiate such conclusions if deemed appropriate by the Corporate Compliance Officer. The Corporate Compliance Officer will present recommendations for disciplinary action. The Director of Human Resources and the applicable staff's supervisor, in consultation with the Corporate Compliance Officer, will have ultimate authority to determine appropriate disciplinary action against the staff.

The Corporate Compliance Officer, or his/her designee, will prepare and submit a closeout report through EthicsPoint inclusive of the measures taken upon discovery to address the problem and prevent future problems. The closeout report will provide an overview, finding of facts, and recommendations. The following information will be included as appropriate to the investigation, except to the extent that the Corporate Compliance Officer, in consultation with the General Counsel, believes inclusion would negate an established privilege (for example, attorney-client privilege) attached to such information:

- a description of efforts to investigate and document the incident or practice (e.g., use of internal or external legal, audit or consultative resources);
- a description in detail of the chronology of investigative steps taken in connection with the internal inquiry into the disclosed matter including the following:
- a list of all individuals interviewed, including each individual's business address and telephone number, and their positions and titles during both the relevant period and at the time the disclosure is being made. For each individual interviewed, the dates of interviews and the subject matter of each interview, as well as summaries of the interview. There should also be included a list of those individuals who refused to be interviewed and the reasons therefor;
- a description of files, documents, and records reviewed with sufficient particularity to allow their retrieval, if necessary; and
- a summary of auditing activity undertaken and a summary of the documents relied upon in support of the estimation of losses.
- a description of the actions taken or recommended to be taken to stop the inappropriate conduct;
- a description of all efforts to prevent a recurrence of the incident or practice;
- a description of any disciplinary action taken against corporate officials, staff and agents as a result of the disclosed matter; and
- a description of appropriate notices, if applicable, provided to government agencies and licensing authorities in connection with the matter.

Organizational Response

1. If the Corporate Compliance Officer recommends to the Chief Executive Officer that credible evidence of misconduct exists and, after a reasonable investigation, has reason to believe that the misconduct violated criminal law, the Chief Executive Officer must report, after seeking advice from the General Counsel, the existence of misconduct to the appropriate governmental authority not more than 30 days after determining that there is credible evidence of a violation.

2. If the misconduct violates criminal, civil or administrative law, the behaviors leading to the violations must either be stopped or corrected immediately.

3. In the following circumstances, the Chief Executive Officer will immediately notify (after advice from the General Counsel) appropriate governmental authorities prior to, or simultaneous with, commencing an investigation:

    - Clear violation of criminal law
    - Significant negative adverse effect on the quality of care provided to clients
    - Evidence of a systemic failure to comply with applicable laws

4. A report made to the governmental authorities must contain information relevant to the alleged violations of law and the potential cost impact, if applicable.

5. If applicable, there will be a calculation and repayment to the appropriate governmental entity for duplicate payments or improper payments resulting from the defective practices or procedures.

6. Appropriate personnel will initiate such corrective action, if any, as may be appropriate given the facts and circumstances, and in conjunction with existing staff policies and procedures. The precise corrective action utilized will depend on the nature, severity, and frequency of the violation. The corrective actions listed below are not progressive discipline steps, nor do such actions need to be taken in any sequence. The corrective action may result in any one or combination of the following actions:

    - probation;
    - demotion;
    - restitution;
    - suspension with or without pay;
    - training;
    - referral to staff assistance program;
    - transfer;
    - verbal warning;
    - written warning;
    - referral for possible criminal prosecution/civil action; and/or
    - termination

    Any staff that refuses to cooperate in an inquiry or investigation will face appropriate action. There will be no retribution against anyone because of his or her cooperation with an investigation.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 45 Compliance Reports to the Board of Directors		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CC 45 COMPLIANCE REPORTS TO THE BOARD OF DIRECTORS

In recognition that effective oversight and management is critical to an effective Corporate Compliance Program, this policy outlines the reporting requirements and timeframes of the Corporate Compliance Officer to the Chief Executive Officer and the Board of Directors.

The Corporate Compliance Program promotes an organizational culture that encourages ethical conduct and a commitment to compliance with the law. The Corporate Compliance Officer has the day-to-day operational responsibility, by authority of the Board of Directors, to oversee the implementation and day-to-day operations of this Compliance Program and to prevent, detect and investigate questionable criminal conduct within the organization. At all times, the Corporate Compliance Officer has direct access to the Chief Executive Officer and the Chair of the Board.

To ensure that the Board maintains its current active leadership role and remains knowledgeable in the content and operation of the Corporate Compliance Program, the Corporate Compliance Officer shall make reports consistent with this policy as follows:

1. Every quarter, the Corporate Compliance Officer shall provide a written report to the Board summarizing corporate compliance trainings and consultations, incidents and investigations, and all other significant related corporate compliance activities, which occurred within the organization during the previous quarter.

2. The Corporate Compliance Officer shall meet periodically or at least annually with the Chief Operating Officer regarding status updates of corporate compliance trainings and consultations, incidents and investigations, and all other significant related corporate compliance activities.

3. On a case by case basis, the Corporate Compliance Officer shall immediately report all significant compliance issues to the Chief Executive Officer. The Chief Executive Officer shall immediately inform the Chair of the Board of the status and/or outcome of the significant compliance issues and continue to keep the Chair apprised of the status of the issues through final resolution. The Chair of the Board and the Chief Executive Officer shall report these issues to the Board of Directors in a timely manner.

4. At the request of the Chief Executive Officer or the Chair of the Board, the Corporate Compliance Officer shall appear directly before the Board on an as needed basis.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 50 False Claims Reporting/Whistleblower Protection		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CC 30 – Staff Reporting and Responsibilities		
Citation(s):	Federal False Claims Act Illinois Whistleblower Act Illinois False Claims Act Missouri False Claims Act Missouri Whistleblower Protection Act		

CC 50 FALSE CLAIMS REPORTING/WHISTLEBLOWER PROTECTION

Chestnut has implemented a Corporate Compliance Program, which is an integral part of the Code of Conduct. As part of this Corporate Compliance Program all staff and contractors are required to comply with all applicable laws and regulations, including those concerning fraud and abuse.

This policy is designed to alert staff to specific laws which must be complied with, including the Federal False Claims Act (the "False Claims Act"), as well as the Illinois False Claims Act and the Illinois Whistleblower Act, the Missouri False Claims Act and the Missouri Whistleblower Protection Act (collectively, (the "State Acts"). This policy will also outline remedies available under these Acts and how staff and others may make a report under these Acts. Additionally, this policy will inform our staff and others about whistleblower protections that are available to anyone who makes a claim concerning a possible violation of the False Claims Act or the State Acts.

A. False Claims Act

1. All staff have a duty to comply with the False Claims Act, and may not knowingly submit, or cause another person or entity to submit, false claims for payment of government funds. Examples of violations of the Act include:

   - knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval to any federal employee;
   - knowingly making, using or causing to be made or used a false record or statement to get a false or fraudulent claim paid;
   - conspiring to defraud the government by getting a false or fraudulent claim allowed or paid;
   - billing for treatment not provided;

- violation of another law, for example a claim submitted appropriately but for a service that was provided as the result of an illegal relationship between a physician and a treatment provider (i.e. a kickback for a referral); or

- falsifying information in the treatment record.

2. A violation of the Act may result in the filing of a federal false claims action by the Department of Justice, Civil Division and the U.S. Attorney General, the filing of a qui tam action by an individual, or a civil penalty of as much as $11,000 per false claim, plus three times the amount of damages incurred by the government.

3. False claims violations may be brought up to six years after the date of the violation, or three years after the date when material facts were known or should have been known by the government. However, an action may not be brought more than 10 years after the date on which the violation was committed.

B. Whistleblower Protections

1. Chestnut will also comply with all federal whistleblower protections, as well as the State Acts. No discrimination or retaliation of any kind will be taken against a staff because a staff initiated or otherwise assisted in a false claims action. Any staff who has been discriminated against may be entitled to all relief necessary to make the staff whole.

2. Chestnut will also not retaliate against any staff who in good faith reports an actual or suspected violation of law or Chestnut's policies regardless of whether or not, after investigation, a violation is found to have occurred.

C. Training

Chestnut will provide training to all new staff, contractors and agents regarding all federal and state false claims acts and also provide periodic updates for existing staff, contractors and agents. All staff are required to participate in this training. In addition, the training will be provided annually to all clinical and billing staff.

All contractors and agents are also required to review and acknowledge any information given to them by Chestnut or to participate in scheduled trainings, as determined by Chestnut.

D. Who to Contact

Staff who have a question regarding this policy, or Chestnut's Corporate Compliance Program or Code of Conduct and Ethics, or who observe practices that appear to violate this policy, the law, or contractual obligations should contact their supervisor or the Corporate Compliance Officer.

E. Reporting Violations

Staff are expected to report any actual or potential violations of the law in accordance with Policy CC 30 Staff Reporting.

No retaliation will be tolerated against any staff who has filed a report based on a good faith belief that a staff or contractor of Chestnut has violated this Policy, the Code of Conduct and Ethics or any provision of the Corporate Compliance Program.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 51 Mandatory Reporting of Medicaid Over-Payments or Billing Errors – Illinois' SMART Act		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CC 30 – Staff Reporting and Responsibilities		
Citation(s):	Save Medicaid Access and Resources Together (SMART) Act, Public Act 097-0689		

CC 51 MANDATORY REPORTING OF MEDICAID OVER-PAYMENTS OR BILLING ERRORS-SMART ACT

Chestnut has implemented a Corporate Compliance Program, which is an integral part of the Code of Conduct and Ethics. One of the goals of the Code of Conduct and Ethics and the Corporate Compliance Program is to detect and deter actual or potential violations of the law. Therefore, each staff has an individual responsibility for reporting any activity that appears to violate applicable laws, rules, regulations and the Code of Conduct and Ethics.

The Save Medicaid Access and Resources Together (SMART) Act, Public Act 097-0689, required the Illinois Department of Healthcare and Family Services (HFS) to establish a protocol for disclosing actual or potential violations of Medicaid program requirements. This process shall be also used for any Missouri Medicaid Overpayments.. Accordingly, all staff members are required to comply with the following.

1. If a staff member discovers or suspects a Medicaid overpayment or erroneous Medicaid billing, he or she must immediately, but no later than 2 business days from his or her discovery or suspicion, file a report through EthicsPoint. Refer to CC 30 for how to access EthicsPoint and what information to report. If a staff member is unsure about whether conduct needs to be reported, he or she should report it.

2. The Corporate Compliance Officer will, within 14 days of notification by staff member through EthicsPoint, complete an investigation to determine if an overpayment exists or if billings were submitted erroneously (even without overpayment). The reporter and other staff will cooperate with the Corporate Compliance Officer throughout the investigation.

3. The Corporate Compliance Officer, together with the General Counsel, will determine whether a repayment warrants a self-disclosure to HFS or Missouri Medicaid Audit & Compliance ("MMAC"),, or simply correction through the administrative billing process. Generally, the following issues will warrant self-disclosure: substantial routine errors, systematic errors, patterns of errors, and potential violations of state and federal Medicaid laws and regulations. On the other hand, simple occurrences of overpayment should be handled through the administrative billing process.

4. If self-disclosure to HFS or MMAC is warranted, the Corporate Compliance Officer, together with the General Counsel, will prepare and submit to HFS or MMAC a written Disclosure Report and

supporting documentation as soon as possible, but no later than: (a) 60 days from the date of the overpayment or erroneous billing, or (b) the date any corresponding cost report is due, whichever is sooner. The Disclosure Report and supporting documentation will contain information required by HFS or MMAC according to their Provider Self-Disclosure Protocols.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 52 Mandatory Reporting of Violation of Certain Federal Laws – OIG Provider Self Disclosure		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CC 30 – Staff Reporting and Responsibilities CC 51 – Mandatory Reporting of Medicaid Over-Payments or Billing Errors – Smart Act		
Citation(s):	OIG "Health Care Fraud Self-Disclosure" protocol (SDP)		

CC 52 MANDATORY REPORTING OF VIOLATION OF CERTAIN FEDERAL LAWS – OIG PROVIDER SELF DISCLOSURE PROTOCOL

Chestnut has implemented a Corporate Compliance Program, which is an integral part of the Code of Conduct and Ethics. One of the goals of the Code of Conduct and Ethics and the Corporate Compliance Program is to detect and deter actual or potential violations of the law. Therefore, each staff has an individual responsibility for reporting any activity that appears to violate applicable laws, rules, regulations and the Code of Conduct and Ethics.

On April 17, 2013, the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) published its Provider Self-Disclosure Protocol for voluntarily disclosing potential fraud involving Federal health care programs. On November 8, 2021, the Department of Health & Human Services (HHS) Office of Inspector General (OIG) released a revised and renamed Provider Self-Disclosure Protocol: the OIG "Health Care Fraud Self-Disclosure" protocol (SDP). Accordingly, all members are required to comply with the following.

1. If a staff member discovers or suspects conduct that might be a violation of any Federal criminal, civil, or administrative law, he or she must immediately, but no later than 2 business days from his or her discovery or suspicion, file a report through EthicsPoint. Refer to CC 30 for how to access EthicsPoint and what information to report. If a staff member is unsure about whether conduct needs to be reported, he or she should report it. The following are examples of types of conduct that should be reported:

    - Submission of a potentially improper claim to Federal health care programs (as opposed to simple overpayment or erroneous billing, which should be reported according to CC 51.

    - Referrals of patients for services that are covered by a Federal health care program (including Medicare and Medicaid services) in exchange for anything of value, in violation of the Federal anti-kickback statute.

- Referrals of Medicare or Medicaid patients by a physician to an entity that the physician, or a member of his or her family, has a financial relationship with, in violation of the Federal Stark law.

2. The Corporate Compliance Officer, together with the General Counsel, will as soon as reasonably possible complete an investigation to determine whether, in their reasonable assessment, a potential violation of a Federal criminal, civil or administrative law has occurred, and whether the violation is one for which civil monetary penalties are authorized.

3. If the Corporate Compliance Officer and the General Counsel determine a potential violation has occurred, they will take necessary action(s) to stop the conduct that gave rise to the potential violation. In the case of a potential violation of the Federal anti-kickback statute, they will ensure that the corrective action will be taken and the potentially improper arrangement will be terminated within 90 days of disclosure to HHS of the potential violation.

4. Once the Corporate Compliance Officer and the General Counsel have taken corrective action, they will work together to make the necessary disclosure to the HHS OIG pursuant to its Self-Disclosure Protocol. If the disclosure relates to a potentially improper claim submitted to a Federal health care program, the disclosure will be made within 60 days from the date of potentially improper claim.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 60 Provider Federal Certification and Assurance		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Program Fraud Civil Remedies Act (PHS-5161-1)		

CC 60 PROVIDER FEDERAL CERTIFICATION AND ASSURANCE

Chestnut will provide certification and assurances that its business practices shall be in compliance with the U.S. Department of Health and Human Services' Public Health Service (PHS) Grants Policy Statement upon request.

Chestnut, through the acceptance of Federal Block Grant Funds, acknowledges the Program Fraud Civil Remedies Act (PHS-5161-1). Chestnut staff shall refrain from any actions that may constitute fraudulent claims to the Federal Government for money (including money representing grants, loans or other benefits).

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 70 Anti-Corruption and Anti-Bribery		
Revision Date:	06/29/2016		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CC 30 – Staff Reporting and Responsibilities		
Citation(s):	United States Foreign Corrupt Practices Act of 1977		

CC 70 ANTI-CORRUPTION AND ANTI-BRIBERY

Chestnut, and all of its subsidiaries, conducts its business in accordance with the United States Foreign Corrupt Practices Act of 1977 and all amendments implemented since its inception ("FCPA"). All Chestnut staff are expected to comply with the foregoing and to abide by the general principles set forth in this CC 70.

Expectations

All Chestnut staff are expected to adhere to the following tenets:

- Staff will not pay bribes or kickbacks to government officials to secure any improper advantage in order to obtain or retain business either directly or through agents or third parties.
- Staff will avoid the appearance of paying bribes through such other means as meals and entertainment or gift giving that exceeds cultural norms or Chestnut standards.
- Staff will maintain detailed and accurate books and records and internal controls and will not conceal or fail to document payments, gifts, or other benefits given to government officials.
- Staff will not accept bribes or kickbacks from anyone anywhere in the world.
- Staff will not use personal funds to accomplish what is prohibited by this CC 70.
- Staff will not improperly influence an act or decision of a government official, political party, or political party candidate in its, his or her official capacity.
- Staff will not induce a government official, political party, or political party candidate to do or fail to do an act in violation of their lawful duty.
- Staff will not induce a government official, political party, or political party candidate to use its, his or her influence with a government or instrumentality in order to provide Chestnut, or any of its subsidiaries, an improper advantage for Chestnut, or any of its subsidiaries, to obtain or retain business.

Inquiries and Reporting

Staff should contact their supervisor if they are unsure whether or not a potential act will violate this CC 70. Supervisors should contact the Corporate Compliance Officer for additional guidance as needed. Similarly, staff should refer to CC 30 (Staff Reporting) if they know of or suspect a violation of this CC 70 or the FCPA.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 80 Executive Compensation Decisions		
Revision Date:	06/24/2015		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	FS 70 - Payroll PP 1550 – Pay Period		
Citation(s):			

CC 80 EXECUTIVE COMPENSATION DECISIONS

Consistent with our ongoing commitment to transparency and to operating in the best interest of our clients and the community, this policy establishes the guidelines under which the Executive Committee making the executive compensation determinations adequately documents the basis for its determination.

Executive Compensation Determinations and Documentation

The Chief Executive Officer receives an annual performance evaluation from the Board of Directors, comprised of disinterested individuals. The Chair of the Board solicits input into the evaluation with specific questions and issues posed to Board members, executives, other key management, as well as the Chief Executive Officer. The Executive Committee of the Board is authorized to make recommendations to the Board regarding executive compensation. The evaluation is assembled and written by the Executive Committee, and submitted to the full Board for review and discussion outside of the presence of the Chief Executive Officer.

Only those members of the Executive Committee who are free of conflicts of interest may be involved in evaluation of executive compensation.

The Executive Committee should also, to the extent reasonably available, rely upon appropriate data as to comparability prior to making its recommendation, and shall contemporaneously place such data and other reasons for its recommendation in the minutes. To assist the Executive Committee in its evaluation, Chief Executive Officer Compensation is researched annually by the General Counsel or his/her designee and a report is submitted to the Board of Directors.

The General Counsel or his/her designee compiles objective salary surveys containing comparative data from multiple resources for Chief Executive Officer compensation for other behavioral health care organizations and non-profit organizations on a local, statewide, and national basis and reviews Internal Revenue Service Form 990s of similarly situated organizations. The report also includes a discussion of market and economic trends in Chief Executive Officer Compensation. This comparability data is used and relied upon by the Board. The Board then thoroughly documents its rationale and the reasonableness of the compensation in a combination of the following documents: the performance evaluation, executive compensation report, Executive Committee minutes and Board of Directors minutes.

Alternatively, if the Executive Committee is not able to locate sufficient data as to comparability, it shall document any other basis for believing the proposed compensation is reasonable. The Executive Committee shall make this determination at least once annually.

Final Board Action

Only those directors who are free of conflicts of interest may vote on executive compensation.

Other Compensation Determinations

The compensation of other officers or key employees is reviewed via the standard annual employee performance evaluation process which is written by the Chief Executive Officer or other members of executive management. Pay adjustments are determined by performance, budget guidelines, and internal and market factors. The Director of Human Resources reviews all evaluations and compensation adjustments for employees in this category. Internal and market analysis of these positions by Human Resources occurs on a periodic basis or at the request of the Chief Executive Officer.

See also FS 70, Payroll and PP 1550, Pay Period.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 90 Public Reporting		
Revision Date:	06/23/2010		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CC 90 PUBLIC REPORTING

Chestnut believes in transparency and accountability to its Board, staff, clients and the public by making available information on Chestnut's governance structure, governance policies and documents and financial condition as reflected in audited financial statements and major programs. This policy implements Internal Revenue Service requirements regarding public disclosure of Chestnut's IRS form 990 (or 990-T if applicable) as well as any applicable IRS 1023 forms.

Information Available to the Public

Upon request, Chestnut shall provide any documents required to be disclosed to the public or refer the requesting party to a third party website from which Chestnut's Form 990 can be obtained. Chestnut shall post on its website a list of the current officers and directors of Chestnut. Chestnut may also provide, from time to time, other materials concerning governance issues as it determines appropriate.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 100 Corporate Relationships		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	FS 190 - Investments		
Citation(s):			

CC 100 CORPORATE RELATIONSHIPS

Chestnut values its collaborations and relationships with other organizations. This policy provides guidance as to participation by Chestnut, directly or through any of its controlled entities (together with Chestnut, the "Chestnut Entities"), in a Joint Venture or similar arrangement with any for-profit or private interest. For purposes of this policy, "Joint Venture" means any joint ownership or contractual arrangement through which there is an agreement to undertake a specific charitable or business enterprise. This policy does not apply to passive investments of cash or marketable securities. Refer to FS 190 for Chestnut's policy pertaining to such investment activities.

Tax-Exempt Status

Provisions must be included in the terms of any Joint Venture arrangement covered by this policy that are sufficient to protect the tax-exempt status of the Chestnut Entity participating in the Joint Venture.

All Joint Venture operating agreements or similar organizational documents must contain clear, binding provisions sufficient to ensure that Chestnut charitable purposes are furthered by Joint Venture activities and that the participating Chestnut Entity does not cede control of Joint Venture activities to for-profit interests.

- A Chestnut Entity may participate in a Joint Venture that furthers Chestnut's charitable purposes and in which it at all times maintains majority voting control.

- However, a Chestnut Entity may participate in a Joint Venture that furthers Chestnut's charitable purposes and in which it maintains less than majority voting control, provided the operating agreement or similar organizational document(s) contain adequate reserved powers and safeguards to establish that the Chestnut Entity does not cede control of Joint Venture activities to for-profit interests.

- Chestnut's General Counsel or his/her designee shall review all Joint Venture operating agreements or similar organizational documents prior to execution and shall determine the adequacy of provisions governing majority voting or applicable reserved powers after considering the effect of any other applicable governance provisions or arrangements, including, without limitation, any management agreements.

- A Chestnut Entity shall not participate in any Joint Venture covered by this policy that is not described above without advance approval of the Chestnut Board of Directors.

Transactions with Joint Ventures

All transfers of property or existing charitable or business activity to any Joint Venture by a Chestnut Entity shall be valued at fair market value and such Chestnut Entity shall receive fair market value consideration or appropriate credit to its capital account for such transfer. Any provision of services to any Joint Venture covered by this policy by any Chestnut Entity shall be at fair market value.

Financial Terms

No Chestnut Entity shall participate in any Joint Venture covered by this policy that is treated as a partnership for tax purposes and involves allocations other than proportional allocations of items of income and loss without approval of the Chestnut Board of Directors.

No Chestnut Entity shall make any loan to any Joint Venture or to any other participant in any Joint Venture without approval of the Chestnut Board of Directors as required by Chestnut resolutions.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Compliance		
Policy Name and Number:	CC 101 Legislative Mandates Restricting the Uses of Federal Grant Funds		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	HRSA Grants Policy Bulletin 2024-02E		

CC 101 LEGISLATIVE MANDATES RESTRICTING THE USES OF FEDERAL GRANT FUNDS

1. Statement of Background and Purposes

The Further Consolidated Appropriations Act, 2024 (Public Law 118-47) , signed into law on March 23, 2024, includes provisions that restrict U.S. Department of Health and Human Services' Health Resources and Services Administration ("HRSA") grantees from using federal grant funds to support certain defined activities. These limitations are commonly referred to as the "Legislative Mandates."

Chestnut Health Systems, Inc. ("Chestnut") is committed to high standards and compliance with all applicable laws and regulations. The purpose of this Legislative Mandates Restricting the Uses of Federal Grant Funds Policy (the "Policy") is to provide safeguards to ensure Chestnut's compliance with the Legislative Mandates.

The current Legislative Mandates, which remain in effect until a new Appropriations Act is passed, include the following:

Division E, Title VII
- (1) Confidentiality Agreements (Section 742)

Division H, Title II
- (2) Salary Limitation (Section 202)
- (3) Gun Control (Section 210)

Division H, Title V
- (4) Anti-Lobbying (Section 503)
- (5) Acknowledgment of Federal Funding (Section 505)
- (6) Restriction on Abortions (Section 506)
- (7) Exceptions to Restriction on Abortions (Section 507)
- (8) Ban on Funding Human Embryo Research (Section 508)
- (9) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section 509)
- (10) Restriction of Pornography on Computer Networks (Section 520)
- (11) Restriction on Distribution of Sterile Needles (Section 526)

A complete description of the Legislative Mandates for fiscal year 2024 is included in HRSA Bulletin 2024-02E (April 23,2024), which is attached to this Policy as Exhibit A.

2. Policy

(1) Salary Limitation

Chestnut shall not use federal grant funds to pay the salary of an individual at a rate in excess of Executive Level II.1[1]

(2) Gun Control

Chestnut shall not use federal grant funds to advocate or promote gun control.

(3) Anti-Lobbying

A. Chestnut shall not use federal grant funds, other than for normal and recognized executive legislative relationships, for the following:

i. For publicity or propaganda purposes;

ii. For the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself;

B. Chestnut shall not use federal grant funds to pay the salary or expenses of any employee or agent of Chestnut for activities designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

C. The prohibitions in subsections A and B include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

(4) Acknowledgment of Federal Funding

When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with federal money, Chestnut shall clearly state and/or otherwise refer to:

A. the percentage of the total costs of the program or project which will be financed with Federal money;

B. the dollar amount of Federal funds for the project or program; and

C. percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

(5) and (6) Restrictions on Abortions, and Exceptions to these Restrictions

[1] As of January 2024, the Executive Level II Salary is set at $221,900

Chestnut shall not use federal grant funds for any abortion or for health benefits coverage that includes coverage of abortion. These restrictions shall not apply to abortions (or coverage of abortions) that fall within the Hyde amendment exceptions.[2]

(7) Ban on Funding of Human Embryo Research

Chestnut shall not use federal grant funds for (i) the creation of human embryos for research purposes; or (ii) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(8) Limitations on Use of Grant Funds for Promotion of Legalization of Controlled Substances

Chestnut shall not use federal grant funds to promote the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act.

(9) Restriction on Distribution of Sterile Needles

Chestnut shall not use federal grant funds to distribute sterile needles or syringes for the hypodermic injection of any illegal drug.

(10) Restriction of Pornography on Computer Networks

Chestnut shall not use federal grant funds to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

(11) Confidentiality Agreements

Chestnut shall not require its employees or contractors seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information

3. Procedure

1. Review and Updates of this Policy and Procedure

The Chief Operating Officer and General Counsel shall review this Policy upon the passage of a new HHS Appropriations Act or issuance of HRSA guidance regarding the Legislative Mandates, and shall ensure this Policy is updated as necessary. As appropriations acts are generally enacted annually, this Policy will generally require annual review. Any modifications to this Policy will require review and approval by Chestnut's Board of Directors (the "Board") or by an individual or individuals to which the Board as duly delegated such authority.

2. Legislative Mandates Training

The Chief Executive Officer shall ensure that the key management personnel and Finance Department staff will receive training regarding the Legislative Mandates and the procedures set forth in this Policy.

3. Compliance Manual

This Policy will be incorporated into Chestnut's Compliance Program.

4. Financial Management

[2] The Hyde Amendment exceptions include (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

The Chief Financial Officer ("CFO") shall ensure that Chestnut's financial management systems and procedures are structured to ensure that no federal grant funds are used for purposes that are impermissible under this P&P. As necessary, the CFO may establish cost centers/accounts for the accumulation and segregation of such costs. The CFO may use any practical means to do so, consistent with Chestnut's financial management policies (including by establishing appropriate cost centers and associated accounts to accumulate and segregate the following costs where necessary). Through this process, Chestnut will adhere to the Legislative Mandates restrictions on use of federal funds for:

i. "Lobbying" or other "advocacy" activities that may meet the definitions of the applicable Legislative Mandate sections (as well as 45 C.F.R. § 75.450) (including certain advocacy relating to gun control, legalization of controlled substances, consumer products, and other advocacy);
ii. Payment of a salary (or associated fringe benefits) at a rate in excess of the Executive Level II pay scale;
iii. Abortions or health benefits coverage that includes coverage of abortion (this restriction shall not apply to abortions (or health benefits coverage of abortions) that fall within the Hyde Amendment exceptions);
iv. Activities related to distribution of sterile needles for hypodermic injection of any illegal drug;
v. Human embryo research; and
vi. Business transactions with (including the funding of) the Association of Community Organizations for Reform Now ("ACORN").

5. Acknowledgment of Federal Funding

All statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with federal money will be reviewed. Chestnut shall ensure that such written material include and/or otherwise refer to the following:

> "This [publication/procurement] is issued in furtherance of Chestnut's federally funded health center project. This year, the Chestnut's health center project received $ [insert] of federal assistance, which is estimated as constituting [insert] percent of project costs. Of total project costs for this year, Chestnut estimates [insert] percent will be financed with nongovernmental sources."

6. Restriction of Pornography on Computer Networks

Chestnut's computer network is and shall remain configured to block the viewing, downloading, and exchange of pornography. The CEO, in collaboration with the Director of MIS, shall ensure appropriate information technology assets and support are made available to ensure continued compliance.

7. Confidentiality Agreements

Chestnut's Chief Operating Officer and General Counsel shall review any and all confidentiality agreements entered into between Chestnut and its employees and/or contractors and, prior to execution, shall confirm that such agreements do not prohibit or otherwise restrict the employee/contractor from lawfully reporting waste, fraud, or abuse to (i) federal law enforcement or other federal investigative personnel, or (ii) other representatives of federal departments and agencies.

CHESTNUT HEALTH SYSTEMS

EXHIBIT A

HRSA GRANTS POLICY BULLETIN: 2024-02E

LEGISLATIVE MANDATES IN GRANTS MANAGEMENT FOR FY 2024

Grants Policy Bulletin
Legislative Mandates in Effect for FY 2024

Bulletin Number: 2024-02E
Release Date: April 23, 2024
Related Bulletins: 2023-02E Legislative Mandates in Grants Management for FY23
Issued by: Office of Federal Assistance and Acquisition Management (OFAAM)

Purpose

This grants policy bulletin outlines the legislative mandates that limit the use of funds for HRSA grants and cooperative agreements.

Background

The Further Consolidated Appropriations Act, 2024 (Public Law 118-47) was signed into law on March 23, 2024, and provides funding to HRSA for the fiscal year ending September 30, 2024. This law contains provisions that limit the use of FY 2024 funds for HRSA grants and cooperative agreements. The FY 2024 list of legislative mandates is similar to the FY 2023 list.

Implementation

HRSA recipients must have policies and procedures in place to ensure compliance with the legislative mandates. When an organization applies for federal financial assistance, the Authorizing Official certifies they will comply with all applicable requirements of all federal laws governing financial assistance awards.

The FY 2024 Legislative Mandates in effect are as follows:

Division B, Title VII
(1) Confidentiality Agreements (Section 742)

Division D, Title II
(2) Salary Rate Limitation (Section 202)
(3) Gun Control (Section 210)

Division D, Title V
(4) Anti-Lobbying (Section 503)
(5) Acknowledgment of Federal Funding (Section 505)
(6) Restriction on Abortions (Section 506)
(7) Exceptions to Restriction on Abortions (Section 507)
(8) Ban on Funding Human Embryo Research (Section 508)

(9) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section 509)
(10) Restriction of Pornography on Computer Networks (Section 520)
(11) Restriction on Purchase of Sterile Needles (Section 526)

Division B, Title VII

(1) Confidentiality Agreements (Section 742)

(a) None of the funds appropriated or otherwise made available by this or any other Act may be available for a contract, grant, or cooperative agreement with an entity that requires employees or contractors of such entity seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

(b) The limitation in subsection (a) shall not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

Division D, Title II

(2) Salary Rate Limitation (Section 202)

"None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II: *Provided*, That none of the funds appropriated in this title shall be used to prevent the NIH from paying up to 100 percent of the salary of an individual at this rate."

Note: The Executive Level II salary is $221,900 as of January 2024.

(3) Gun Control (Section 210)

"None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control."

Division D, Title V

(4) Anti-Lobbying (Section 503)

"(a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation,

administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control."

(5) Acknowledgment of Federal Funding (Section 505)

"When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state—

> (1) the percentage of the total costs of the program or project which will be financed with Federal money;
>
> (2) the dollar amount of Federal funds for the project or program; and
>
> (3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources."

(6) Restriction on Abortions (Section 506)

"(a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term "health benefits coverage" means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement."

(7) Exceptions to Restriction on Abortions (Section 507)

"(a) The limitations established in the preceding section shall not apply to an abortion—

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

(d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."

(8) Ban on Funding of Human Embryo Research (Section 508)

"(a) None of the funds made available in this Act may be used for—

(1) the creation of a human embryo or embryos for research purposes; or

(2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(b) For purposes of this section, the term "human embryo or embryos" includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cell."

(9) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section 509)

"(a) None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications.

(b) The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage."

(10) Restriction of Pornography on Computer Networks (Section 520)

"(a) None of the funds made available in this Act may be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

(b) Nothing in subsection (a) shall limit the use of funds necessary for any Federal, State, tribal, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities."

(11) Restriction on the Purchase of Sterile Needles (Section 526)

"Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: *Provided,* That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law."

Resources

- Further Consolidated Appropriations Act, 2024

Inquiries

Office of Federal Assistance and Acquisition Management
Division of Grants Policy
Email: DGP@HRSA.gov

Chestnut Health Systems
Corporate Structure and By-Laws

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CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Corporate Structure and By-Laws		
Policy Name and Number:	CSB 10 Organizational Charts		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Chestnut Health Systems Organizational Chart		

CSB 10 ORGANIZATIONAL CHARTS

Chestnut Health Systems, through the program Pingboard, maintains organizational charts indicating positions within the organization, the names of staff members who occupy those positions, and Chestnut's supervisory and reporting hierarchies. Maintaining up-to-date charts is important, as charts are included in grant funding proposals and are used to ensure that training requirements are met. The Human Resources Department provides updated information on staff member and position title changes. The Marketing and Communications Department manages the Pingboard account. A link to the charts is posted to the Chestnut Intranet site.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Structure and By-Laws		
Policy Name and Number:	CSB 30 Executive Leadership Council		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CSB 30 EXECUTIVE LEADERSHIP COUNCIL

An Executive Leadership Council (ELC) will consist of the following members:

- Chief Executive Officer
- Chief Operating Officer and General Counsel
- Chief Clinical Officer
- Chief Financial Officer
- Chief Administrative Officer
- Vice President of Strategy and Innovation
- Vice Presidents of Integrated Care
- Director of Lighthouse Institute
- Director of Missouri Business Development
- Director of Human Resources
- Director of MIS
- Director of Marketing and Communications
- Director of Quality and Compliance
- Director of Facilities
- Associate Director of Lighthouse Institute

Members may be added or removed at the discretion of the Chief Executive Officer.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Structure and By-Laws		
Policy Name and Number:	CSB 35 Leadership Council		
Revision Date:	06/23/2012		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CSB 35 LEADERSHIP COUNCIL

A corporate-wide Leadership Council (LC) will consist of key management and leadership staff. The LC will meet three times per year to discuss and collaborate on corporate management issues and receive education about Chestnut's programs and services. The ELC determines membership.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Structure and By-Laws		
Policy Name and Number:	CSB 40 Clinical Management Committees		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1160 – Reimbursement for Professional Licenses		
Citation(s):			

CSB 40 CLINICAL MANAGEMENT COMMITTEES

Region-based Clinical Management Committees will consist of the regional program directors. The Committees will meet at least monthly to discuss program-related issues and interdepartmental issues and to address any clinical concerns. In accordance with PP 1160, the applicable regional Vice President of Behavioral Health or his/her designee shall serve as Chairperson of a regional Committee and shall determine the composition of the regional Committee.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Structure and By-Laws		
Policy Name and Number:	CSB 45 Responsibilities of Leadership		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CSB 45 RESPONSIBILITIES OF LEADERSHIP

The responsibilities of the Clinical Management and Medical Directors are described in the Clinical Privileges section of the Policy Handbook.

Executive Leadership staff are responsible for providing the effective functioning of Chestnut programs and services with a focus on quality and safety. To accomplish this, Executive Leadership staff are expected to:

- Ensure collaboration between and within departments to plan and implement structures and processes that focus on safety and quality;
- Provide structure for internal and external communication;
- Plan and implement process improvement strategies to increase safety and/or quality;
- Ensure organizational compliance with law and regulation as it pertains to Chestnut's business entities;
- Provide oversight on policies and procedures that guide and support care, treatment, and/or services through annual review and approval of all department specific procedures by the appropriate ELC member;
- Ensure a culture at Chestnut that enables fulfillment of Chestnut's mission and goals through empowerment of staff;
- Develop and implement strategic goals and objectives focused on safety, quality and growth through the quality management system;
- Monitor safety, quality and risk data;
- Monitor the implementation of the budget and long-term capital expenditure plan; and
- Provide oversight on policies and procedures that guide corporate structure and support including but not limited to personnel, safety, privacy and security, information systems and corporate compliance policies.

Program Directors are responsible for identifying the services to be provided, maintaining their program's procedural manuals, service coordination within programs, developing clinical procedures and the supervision of the daily operations of the program services. Program Directors are expected to:

- Maintain census/service projections;
- Conduct program operations within the budgetary constraints established by the Board of Directors;
- Monitor key program performance indicators
- Recommend program and operational improvements;
- Recommend adequate clinical staffing pattern and determining the qualifications and competency of clinical staff;
- Recommend space and other resources needed by the program;
- Assure program compliance with the supervision requirements specified in the Clinical Services Policies;
- Conduct and supervise annual performance evaluation for assigned staff;
- Conduct required staff meetings;
- Maintain compliance with The Joint Commission and state certification and licensing requirements;
- Supervise case assignments;
- Coordinate and develop referral sources;
- Facilitate client access to Chestnut continuum of care;
- Report program activities monthly to the Board of Directors;
- Establish and submit annual goals and objectives to the Board of Directors; and
- Submit progress report to the Board of Directors.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Structure and By-Laws		
Policy Name and Number:	CSB 80 Corporate By-Laws		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CSB 80 CORPORATE BY-LAWS

AMENDED AND RESTATED
CORPORATE BYLAWS
OF
CHESTNUT HEALTH SYSTEMS, INC.

Approved by the Board of Directors on June 28, 2023

ARTICLE 1
CORPORATION

Section 1-1 Corporate Name

The name of the corporation shall be Chestnut Health Systems, Inc. (the "Corporation" or "Chestnut"), an Illinois not-for-profit corporation.

Section 1-2 Corporate Mission

The mission of the Corporation is: "Making a Difference: Improving Quality of Life through Excellence in Service."

Section 1-3 Corporate Purposes

The purposes of the Corporation are to operate exclusively for charitable, educational and scientific purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended from time to time, or any corresponding provision of any future United States Internal Revenue Law (the "Code"), including, but not limited to the following:

(a) To improve health outcomes for underserved and vulnerable individuals and facilitate access to comprehensive health and social services for such individuals by operating as a Federally Qualified Community Health Center (the "FQHC") for the provision of primary and preventative healthcare services to patients regardless of ability to pay in accordance with Section 330 of the Public Health Services Act, 42 U.S.C. 254b and its implementing regulations;

(b) To provide health, education and human services founded in a commitment to the highest standards of professional practice, innovative in their nature, effective in their delivery, enabling clients to maximize their potential;

(c) To develop, implement and conduct research on state-of-the-art behavioral health treatment programs and intensive case management models throughout the world;

(d) To provide comprehensive domestic and international Employee Assistance Workplace Services including, but not limited to counseling, case management, crisis intervention services training, disease management, health coaching and wellness programs for participants of various group plans and self-insured employers, health maintenance organizations, preferred provider organizations, insurance, labor trusts, Employment Retirement Income Security Act ("ERISA") plans and government sponsored plans;

(e) To participate in the creation of comprehensive managed care networks that provide a full continuum of services and programs for adults, adolescents, children and families;

(f) To conduct and provide research, training, scientific studies and education in the behavioral health care field;

(g) To foster housing for persons with mental illness or co-occurring disorders;

(h) To furnish adequate facilities, equipment, personnel and professional staff for the rendering of treatment services and other related services to clients, regardless of race, color, religion, gender identity, gender expression, sex, national origin, disabilities, age, sexual identity, marital status or other factors prohibited by law;

(i) To secure, raise and arrange capital to provide for the development, implementation, and support of such facilities, programs and services consistent with the purposes and mission of the Corporation; and

(j) Invest in other activities which are consistent with and in furtherance of the charitable, educational, and scientific purposes and mission of the Corporation and engage in any other activities which may be pursued by an organization organized under Section 501(c)(3) of the Code and as permitted by the Illinois General Not-For-Profit Corporation Act, as now or hereafter amended (the "Act").

Section 1-4 Not-for-Profit Organization

All assets and earnings of the Corporation shall be used exclusively for charitable, educational and scientific purposes within the meaning of Section 501(c)(3) of the Code, in the course of which operation:

(a) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its Directors, Officers, or other persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein;

(b) No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene (including the publishing or distribution of statements), in any political campaign on behalf of or in opposition to any candidate for public office except as authorized under the Code, or the corresponding section of any future tax code; and

(c) Notwithstanding any other provisions of the Corporation's Articles of Incorporation (the "Articles of Incorporation") and these Corporate Bylaws of Chestnut Health Systems, Inc. (these "Bylaws"), the Corporation shall not carry on any other activities not permitted to be carried on (1) by a corporation exempt from federal income taxation under Section 501(c)(3) of the Code, or (2) by a corporation the contributions to which are deductible under Section 170(c)(2) of the Code, or the corresponding section of any future tax code.

Section 1-5 Dissolution

Upon the dissolution or liquidation of the Corporation, the Board of Directors of the Corporation (the "Board") shall (1) pay or make provision for the payment of all of the liabilities of the Corporation, and (2) transfer or convey all the property and assets of any nature of the Corporation to such organization or organizations organized and operated exclusively for charitable, educational or scientific purposes which shall at the time qualify as an exempt organization or organizations under Section 501(c)(3) of the Code, and as the Board shall determine in accordance with the Act or any other applicable law. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction in the County in which the principal office of the Corporation is located, exclusively for such purposes or to such organization or organizations as such court shall determine, which are organized and operated exclusively for such purposes.

Section 1-6 Offices

The Corporation shall maintain its principal office in the City of Bloomington, County of McLean, State of Illinois. The Corporation may maintain such other offices, either within or without the State of Illinois, as the Board may determine, or as the affairs of the Corporation may periodically require.

The Corporation shall establish and continuously maintain a registered office in the State of Illinois, and a registered agent at that registered office, as prescribed by the terms of the provisions of the Act. The registered office may be, but need not be, identical with the principal office of the corporation in the State of Illinois, and the address of the registered office, or the registered agent, may be periodically changed by the Board.

ARTICLE II
MEMBERSHIP

Section 2-1 Members

The Corporation shall have no members.

ARTICLE III
BOARD OF DIRECTORS

Section 3-1 General Powers and Duties

The control and management of the affairs of the Corporation, and the distribution of its assets and its funds, shall be managed by the Board, which shall constitute the governing Board of the Corporation. The Board shall stay abreast of public and corporate policy issues to establish the strategic direction and policies to support Chestnut's programs. The Board shall adopt a policy regarding specific duties and responsibilities relating to FQHC operations. The Board shall review and adopt an annual budget for the Corporation and require and approve an annual audit in accordance with Article IX herein. The Board shall require periodic reports on operations from the Chief Executive Officer (the "CEO") and from the various Committees of the Board.

Section 3-2 Board Orientation

Upon the appointment of a new Board member, the Chair, and such other individuals as may be appointed by the Chair, shall conduct a Board orientation which may include information concerning the Corporation's mission and history, the roles and responsibilities of the Board and staff, the schedule of Board meetings for the year, an organizational chart of the Corporation, specific concerns of a not-for-profit organization, conflict of interest issues, the Board Code of Ethics, and how the Board conducts its regular and annual meetings.

Section 3-3 Directors

The Board shall consist of no fewer than nine (9) and no more than thirteen (13) members (sometimes referred to herein individually as a "Director" and collectively as the "Directors"). The Corporation will make every effort to have its Directors reside in or near the FQHC service area. The Board shall also be comprised of Directors from a variety of disciplines to benefit the Corporation by their respective skills, expertise and perspectives.

At all times when the Corporation operates as a FQHC, the Directors shall also meet the following requirements:

(a) At least fifty-one percent (51%) of the Directors are patients served by the FQHC. A patient is an individual who has received at least one (1) service in the past twenty-four (24) months that generated a health center visit, where both the service and the site where the service was received are within the FQHC's HRSA-approved scope of project. For purposes of this Section 3-3(a), a Director will also be considered a patient if the Director is the legal guardian of a patient who is a dependent child or adult, a person who has legal authority to make health care decisions on behalf of a patient, or a legal sponsor of an immigrant patient. Collectively, these patient Directors shall represent the individuals being served by the FQHC in terms of demographic factors such as race, ethnicity and gender;

(b) The other Directors (the "Non-User Directors") shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions,

social services, and other commercial, industrial and community concerns, and shall be representative of the individuals who are served by the FQHC;

(c) No more than one-half (1/2) of the Non-User Directors at any given time may be individuals who derive more than ten percent (10%) of their annual income from the health care industry; and

(d) No Director shall be an employee of the FQHC, or a spouse, child, parent, or sibling (by blood, marriage, or adoption) of an employee of the FQHC.

Section 3-4 Election and Term of Office

The Board shall be divided into three (3) classes that will be kept as nearly equal as practical. At each annual meeting of the Board, one (1) class comprising approximately one-third (1/3) of the Board shall be elected by the Board after submission of nominations by the Nominating Committee.

Each annual class shall be elected for a term not to exceed three (3) years. A Board member may not be elected for more than three (3) successive terms. A Board member who reaches his or her term limit may again be elected to the Board, but only after one (1) year of not serving on the Board.

Section 3-5 Vacancies

Vacancies on the Board occurring between annual meetings may be filled by election by the remaining Directors after submission of candidates by the Nominating Committee. The individuals so elected shall hold office until the next annual meeting, at which time they shall be eligible for reelection, subject to the limitations set forth in Section 3-4 of these Bylaws.

Section 3-6 Resignation

A Director may resign at any time by written notice delivered to the Board, the Chair of the Board, or to the Secretary. A resignation is effective when the notice is accepted by the Chair of the Board, unless the notice specifies a future date. The pending vacancy may be filled before the effective date, but the successor shall not take office until the effective date.

Section 3-7 Removal

A Director may be removed with or without cause by the affirmative vote of a majority of the Directors then in office present and voting at a meeting of the Board at which a quorum is present. Causes for removal include, but are not limited to, failure to attend three (3) consecutive Board meetings without adequate explanation, conduct detrimental to the interests of the Corporation, or refusal to act in a manner consistent with the Corporation's mission and priorities. The Board may not remove a Director at a special meeting of the Board unless written notice of the proposed removal is delivered to all Directors at least twenty (20) days prior to such meeting.

Section 3-8 Annual Meetings

The annual meeting of the Board shall be held each year in November at a time and place to be decided upon by the Board for the election of Directors and for the transaction of such other business as may properly come before the Board.

Section 3-9 Regular Meetings

The Board shall meet at least monthly at times and at places specified by the Chair of the Board. The Board may specify, by resolution, the time and the place, either within or without the State of Illinois, to hold additional regular meetings of the Board without other notice than such resolution.

Section 3-10 Special Meetings

Special meetings of the Board may be called by or at the request of the Chair of the Board, CEO or one more than half of the current Directors. The person or persons authorized to call special meetings of the Board may fix any place, either within or without the State of Illinois, as the place to hold any special meeting of the Board called by such person or persons.

Section 3-11 Notice

Written notice of any annual or special meeting of the Board shall be delivered to each Director at least five (5) days in advance. Such notice shall be delivered to each Director at his or her address as then appearing in the records of the Corporation. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail in a sealed envelope so addressed, return receipt requested with postage thereon prepaid or deposited by overnight mail with Federal Express, UPS, Airborne Express or another reputable carrier. If notice is delivered by facsimile or e-mail, such notice shall be deemed delivered when verification is received that the facsimile or e-mail has been sent. The attendance of a Director at any meeting shall constitute a waiver of notice of such meeting, unless a Director attends a meeting with the express purpose of objecting to the transaction of any business on the basis the meeting is not being lawfully called or convened. Neither the business to be transacted, nor the purpose of any meeting of the Board, need be specified in the notice or waiver of notice of such meeting, unless otherwise required by law or by these Bylaws.

Section 3-12 Waiver of Notice

Whenever any notice is required to be given under the provisions of the Act, the Articles of Incorporation, or these Bylaws, a waiver of such notice in writing signed by the person or persons entitled to notice, whether before or after the time stated in such waiver, shall be deemed equivalent to the giving of such notice.

Section 3-13 Quorum

One-third (1/3) of the Directors shall constitute a quorum to transact business at any meeting of the Board; however, if less than one-third of the Directors are present at that meeting, one-third (1/3) of the Directors present may adjourn the meeting without further notice.

Section 3-14 Manner of Acting

Unless otherwise stated herein or required by law, the act of a majority of the Directors present and voting at a meeting at which a quorum is present shall be the act of the Board.

Section 3-15 Compensation

No Director shall receive any compensation in exchange for his or her services rendered as a Director; however, members of the Board may be reimbursed for reasonable expenses incurred for attendance at Board meetings and other Board or Board Committee activities. Nothing contained herein shall be construed to preclude any Director from serving the Corporation in any other capacity and receiving reasonable compensation therefor or to supersede or be inconsistent with the provision of Section 15.2 of these Bylaws.

Section 3-16 Informal Action by Directors

Any action required by law to be conducted at a meeting of the Board, or any action which may be conducted at a meeting of the Board, may be conducted without a meeting if a consent in writing, setting forth the action so conducted, is signed by all of the Directors entitled to vote with respect to the subject matter thereof. The action taken shall be effective when all such Directors have approved the consent, unless the consent specifies a different effective date. Any such consent signed by all the Directors shall have the same effect as a unanimous vote, and may be stated as such in any document filed. Additionally, action by means of unanimous consent may also be taken through the use of e-mail transmission provided all Directors have email accounts and access to a computer.

The following procedure shall be used when unanimous consent by e-mail is sought. Only the Chair of the Board or CEO is authorized to initiate a proposal for unanimous consent by e-mail in the form of a resolution, which shall also provide that such unanimous consent may be manifested in counterparts. Each Director must affirmatively agree to receive e-mail communications from the Corporation, and must provide a valid e-mail address to which correspondence may be sent. If such informal action is taken by e-mail a Director, when giving consent, must choose "reply all" so that all Directors are aware of and have a record of the Director's consent. The Secretary or his/her designee shall keep a record of all consents given by e-mail together with the resolution.

Section 3-17 Telephonic Meetings

Directors may participate in and act at any meeting through the use of a conference telephone or other communications equipment by means of which all persons participating in the meeting can communicate effectively with each other. Participation in such a meeting shall constitute attendance and presence at the meeting of the person or persons so participating.

Section 3-18 Non-Applicability of Illinois Open Meetings Act

In accordance with guidance issued by the Illinois Attorney General, neither annual, regular, nor special meetings of the Board, nor any meetings of Board Committees, are subject to the Illinois Open Meetings Act, 5 ILCS 120/. Therefore, no meeting of the Board or Board Committee is open to the public.

ARTICLE IV
OFFICERS

Section 4-1 Officers

The officers of the Board ("Officers") shall consist of a Chair of the Board, Vice Chair of the Board, Secretary and Treasurer, whose duties shall be those usually performed by such officers and those specified in these Bylaws, in addition to such other duties as the Board may prescribe.

Section 4-2 Election and Term of Office

Officers shall be elected biennially. At the next regular Board meeting following each annual meeting of the Board in every even-numbered year, Officers shall be elected by the Board after submission of nominations by the Nominating Committee. If the election of Officers is not held at this meeting, such election shall occur as soon thereafter as is convenient. Each Officer shall be elected for a term not to exceed two (2) years. An Officer may not be elected to any given office for more than two (2) successive terms.

Each Officer shall hold a particular office until his or her successor is duly elected and qualified, until his or her death, until he or she resigns or is removed, or until he or she reaches his or her term limit described in this Section 4-2. The election to an office shall not, in and of itself, create contract rights between an Officer and the Corporation.

Section 4-3 Vacancies

Vacancies in any office occurring between biennial meetings at which Officers are elected shall be filled by election by the Board, after submission of candidates by the Nominating Committee. Any candidate considered must be a member of the Board. The individuals so elected shall hold office until the next biennial meeting at which Officers are elected, at which time they shall be subject to reelection, subject to the limitations set forth in Section 4-2 of these Bylaws.

Section 4-4 Resignation

An Officer may resign at any time by written notice delivered to the Board, the Chair of the Board, or to the Secretary. A resignation is effective when the notice is accepted by the Chair of the Board, unless the notice specifies a future date.

Section 4-5 Removal

An Officer may be removed with or without cause by the affirmative vote of a majority of the Directors then in office present and voting at a meeting of the Board at which a quorum is present. Such removal may occur whenever, in the judgment of the Board, the best interests of the Corporation would be served thereby. However, such removal shall be without prejudice to the contract rights, if any, of the Officer so removed.

Section 4-6 Chair of the Board

The Chair of the Board shall be responsible for providing effective leadership for the functioning and operation of the Board. The Chair shall preside at all meetings of the Board, including the annual meeting; with the approval of the Board, appoint the Chairs of all Committees of the Board; be an ex-officio member of all standing Committees of the Board; have the authority to sign contracts and obligations on behalf of the Corporation; and have the authority to delegate such signatory authority to the CEO or other appropriate

agents of the Corporation in accordance with Section 7-1 of these Bylaws. The Chair of the Board shall cast a vote only in case of a tie.

Section 4-7 Vice Chair of the Board

The Vice Chair of the Board shall assist the Chair of the Board in the discharge of his or her duties as the Chair of the Board may direct, and shall perform such other duties as may be periodically assigned to him or her by the Chair of the Board or the Board. In the absence of the Chair of the Board, or in the event of his or her inability to act or refusal to act, the Vice Chair of the Board shall perform the duties of the Chair of the Board and, when so acting, shall possess all the powers of, and be subject to all the restrictions upon, the Chair of the Board.

Section 4-8 Secretary

The Secretary shall certify the Bylaws, minutes of meetings of the Board and any Committees thereof, resolutions of the Board and Committees thereof, and other documents of the Corporation as true and correct copies thereof; perform such duties incident to the office of the Secretary; and perform such other duties as may be periodically assigned to him or her by the Chair of the Board or the Board. Another Officer designed by the Chair of the Board or the Board may also certify the aforementioned documents as true and correct copies thereof.

Section 4-9 Treasurer

The Treasurer shall perform all duties incident to the office of the Treasurer and such other duties as may be periodically assigned to him or her by the Chair of the Board or the Board. If required by the Board, the Treasurer shall furnish to the Corporation a bond to ensure the faithful discharge of his or her duties**,** in such sum and with such surety or sureties as the Board may periodically determine.

ARTICLE V
COMMITTEES

Section 5-1 Membership of Committees

From the membership of the Board, the Chair of the Board shall appoint the Chair and all members of the standing and any ad hoc Committees. There shall be a minimum of three (3) members on each Committee. Each Committee shall transact such business as may be delegated to it in these Bylaws or by resolution of the Board. Except for the Executive Committee, each Committee shall submit its reports for the approval of the Board before taking any action. The Chair of the Board may also appoint non-Board members to a Committee; however, such appointment shall not negate Section 3-18 of these Bylaws.

Section 5-2 Term of Office

Each member of a Committee shall continue as such until the January meeting of the Board or until a successor is appointed, unless the Committee is earlier terminated, such member is removed therefrom, or such member ceases to qualify as a member thereof.

Section 5-3 Vacancies

Vacancies in the membership of any Committee may be filled by appointment in the same manner as the original appointments to a Committee.

Section 5-4 Quorum

Unless otherwise specified by resolution of the Board forming or designating a Committee, one-half (1/2) of Committee members shall constitute a quorum, and the act of a majority of members present and voting at a Committee meeting at which a quorum is present shall be the act of the Committee.

Section 5-5 Executive Committee

The Executive Committee shall consist of the Officers and CEO and, should the Chair of the Board so choose, one additional member appointed by him or her. The CEO shall be an ex-officio non-voting member. The Executive Committee shall perform the functions of the Board in the routine management of the affairs of the Corporation during the intervals between meetings of the Board and shall act consistent with established Board policies and/or direction. All actions taken by the Executive Committee shall be reported at the next meeting of the Board. In the case of Executive Committee actions involving programs operated under Section 330 of the Public Health Services Act, the Board must approve the Executive Committee minutes ratifying actions and record such approvals in the Board meeting minutes**.** The Executive Committee shall be responsible for the selection of the CEO and for making associated recommendations to the Board, which shall be responsible for appointing the CEO. The Executive Committee shall also conduct an annual evaluation of the CEO. The Executive Committee shall have no power or authority to (a) adopt, amend, or repeal the Articles of Incorporation or these Bylaws; (b) adopt a plan of merger, consolidation or dissolution or authorize the sale, lease, exchange or mortgage of all or substantially all of the property or assets of the Corporation; (c) fill vacancies on the Board; or (d) elect or remove any Officer or Director.

Section 5-6 Budget and Finance Committee

The Budget and Finance Committee shall recommend to the Board a yearly budget and serve in a consultative capacity on other financial matters. The Budget and Finance Committee's function shall be to review and make recommendations with respect to the finances of the Corporation and its affiliated entities. The Budget and Finance Committee shall recommend to the Board policies and actions concerning fundraising efforts, duties of the Corporation's Treasurer and other operating officers of the Corporation and its affiliated entities regarding fiscal and budgetary matters, operating and capital budgets, and other financial management and planning issues. It shall make such reports regarding income and expenditures as the Board or the Executive Committee may direct, and be responsible for the audit of such reports.

Section 5-7 Audit Committee

The Audit Committee shall be authorized to consider matters related to:

(a) the financial statements of the organization and other official financial information provided to the public;

(b) the systems of internal controls, including overseeing compliance by management with applicable policies and procedures and risk management; and

(c) the annual independent audit process, including the recommended engagement of and receiving of all reports from the independent certified public accountants.

The Audit Committee shall have such other authority and perform such other duties as may be delegated to it by the Board.

The members of the Audit Committee shall possess sufficient financial experience and ability to enable them to discharge their responsibilities of monitoring the Corporation's internal controls and compliance.

Section 5-8 Sites and Facilities Committee

The Sites and Facilities Committee shall assist Corporation staff with and advise the Board on the development and maintenance of all facilities necessary for the effective and efficient operation of the Corporation and its various programs.

Section 5-9 Personnel Committee

The Personnel Committee shall recommend to the Board policies and procedures concerning staff. It shall recommend to the Board standard procedures covering job descriptions, qualifications, employee benefits, leaves, employee grievances, equal opportunity practices, and all other matters relating to the administrative relationship of which staff is a part. It shall also periodically review the Corporation's Personnel Policies and related practices and recommend changes when appropriate.

Section 5-10 Nominating Committee

The Nominating Committee shall evaluate membership needs of the Board and assist in the recruitment of Board members, including the evaluation of candidate qualifications. The Nominating Committee shall also recommend to the Board at its annual meeting a slate of Directors to be elected and at the next regularly scheduled meeting after the annual meeting in each even-numbered year a slate of Officers to be elected, in accordance with Sections 3-4 and 4-2 of these Bylaws, respectively. The Nominating Committee shall also accept and make nominations throughout the year to fill any vacancies on the Board or of any office, in accordance with Sections 3-5 and 4-3 of these Bylaws, respectively.

Section 5-11 FQHC Committee

The Board shall have one or more FQHC Committees, organized by operational region. Each FQHC Committee shall include consumers of the regional Chestnut Family Health Center ("CFHC"). The FQHC Committee(s) shall meet regularly with the CEO to review and make suggestions with respect to the operations of the regional CFHC. The Chair of each FQHC Committee may invite non-voting staff members to participate in FQHC Committee meetings.

Section 5-12 CCBHC Committee

Chestnut's operations in its central and southern regions are each separately designated by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration as a Certified Community Behavioral Health Clinic ("CCBHC"). As a CCBHC, each region provides a comprehensive range of mental health and substance use disorder services to vulnerable individuals. For so long as each region operates as a CCBHC, the Chair of the Board shall appoint members to two (2)

regional CCBHC Committees. Each of the two (2) regional CCBHC Committees will be representative of the communities served by the CCBHC; fifty-one percent (51%) of CCBHC Committee members shall be adult consumers with mental illness, adults recovering from substance use disorders, and/or family members of CCBHC consumers. Each regional CCBHC Committee will meet regularly and provide meaningful input to the Board about the CCBHC's policies, processes, and services. The Chair of each regional CCBHC Committee may invite non-voting staff members and other third parties to participate in CCBHC Committee meetings.

Section 5-13 Ad Hoc Committees

The Chair of the Board may create and appoint members to other ad hoc Committees as he or she determines to be appropriate from time to time.

ARTICLE VI
CHIEF EXECUTIVE OFFICER

Section 6-1 General Duties and Responsibilities

The CEO shall carry out the policies of the Board in accordance with accepted standards of professional and administrative procedures. He or she shall have responsibility for the administration of the Corporation. He or she shall be directly accountable to the Board of Directors.

The CEO shall be an ex-officio non-voting member of all Committees of the Board. The CEO shall not be a member of the Board. It is the responsibility of the CEO to report to the Board on behalf of the administrative and professional staff.

The CEO shall also have the following duties, powers and responsibilities:

(a) implementing Chestnut's mission and determining that the mission correlates with Chestnut's safety and quality goals;

(b) possessing the decision-making authority to execute and implement strategies and policies for Chestnut;

(c) being responsible to the Board for the overall effectiveness and outcomes for actions and strategies;

(d) advising and assisting the Chair of the Board and other Officers in fulfilling the duties and responsibilities of their respective offices;

(e) reporting to the Officers as necessary to keep them apprised of the activities of their respective offices;

(f) reporting to the Officers and Board as necessary to keep them apprised of the activities and conditions of Chestnut;

(g) managing and directing the business affairs of Chestnut, including the distribution of funds received;

(h) executing all contracts, agreements, certifications and commitments on behalf of Chestnut in accordance with these Bylaws;

(i) designating such staff positions as he or she shall deem necessary to assist in the direction of the operations, administration and programs and services of Chestnut; and

(j) performing such other duties and have such other responsibilities as may be delegated by the Board.

ARTICLE VII
CONTRACTS, CHECKS, DEPOSITS AND FUNDS

Section 7-1 Contracts and Other Instruments

The Board may authorize any Officer or Officers, or other agent or agents of the Corporation to enter into any contract, lease, deed, mortgage, bond or other instrument or to execute and to deliver any instrument in the name of and on behalf of the Corporation, and such authority may be general or confined to specific instances. The Chair of the Board may also delegate to the CEO or other appropriate agents the authority to enter into contracts on behalf of the Corporation.

Section 7-2 Checks and Drafts

All checks, drafts or other orders for the payment of money, notes or other evidence of indebtedness, issued in the name of the Corporation, shall be signed by such Officer or Officers, or such other agent or agents of the Corporation, and in such manner as shall be periodically determined by a resolution of the Board. In the absence of such a determination by the Board, such instrument shall be signed by the Treasurer and countersigned by the Chair of the Board or the Vice Chair of the Board.

Section 7-3 Loans

No loans or borrowing shall be contracted for or on behalf of the Corporation unless authorized by a resolution of the Board. No loans shall be granted to any Officer or Director.

ARTICLE VIII
BOOKS AND RECORDS

Section 8-1 Books and Records

The Corporation shall maintain accurate and complete books and records of account, and shall, in addition, record, distribute, and maintain minutes of the proceedings of the Board and its Committees, and shall maintain, at the principal office of the Corporation, a record of the names and addresses of the Directors. All books and records of the Corporation may be inspected by any Director, or any agent or any attorney of any Director, in pursuance of any proper purpose upon reasonable notice during reasonable business hours.

ARTICLE IX
AUDIT

Section 9-1 Audit

The books of the Corporation shall be audited annually by a certified public accountant approved by the Board in accordance with all requirements of the Internal Revenue Service that are applicable to not-for-profit organizations. The audit of programs operated under Section 330 of the Public Health Services Act will be in compliance with Federal requirements. The auditor's report shall be filed with the records of the Corporation. A summary of this report shall be presented for action annually at a regularly scheduled Board meeting.

ARTICLE X
FISCAL YEAR

Section 10-1 Fiscal Year

The annual reporting period of the Corporation shall be the fiscal year July 1st to June 30th.

ARTICLE XI
NON-DISCRIMINATION

Section 11-1 Non-discrimination

The Corporation is committed to promoting and seeks to promote inclusiveness and equal opportunity within Chestnut to reflect diversity and enrich programmatic effectiveness. The Board shall support a commitment to non-discrimination and equal opportunity and shall work with the Corporation's Executive Leadership Council ("ELC") to promote inclusiveness in its hiring, retention, promotion and Board recruitment decisions and to serve clients without regard to sex, race, color, religion, gender identity, gender expression, national origin, age, sexual identity, marital status, disabilities, genetics or other factors prohibited by law.

ARTICLE XII
CONFERRING CLINICAL PRIVILEGES

Section 12-1 Conferring Clinical Privileges

The Board shall have the authority and responsibility for granting clinical privileges. The Board delegates to the Corporation's Clinical Privileging Committee the responsibility for evaluating and recommending to the Board the assignment of clinical privileges.

ARTICLE XII
QUALITY IMPROVEMENT AND SAFETY

Section 13-1 Quality Improvement and Safety

The Board shall have the authority and responsibility for providing oversight and conducting a review of all of Chestnut's quality and safety initiatives. The Board, in conjunction with the CEO, shall correlate Chestnut's mission and purposes with Chestnut's safety and quality goals.

CHESTNUT HEALTH SYSTEMS

ARTICLE XIV
CONFLICT OF INTEREST

Section 14-1 Conflict of Interest Policy

The Board shall adopt and keep in force at all times a Conflict of Interest Policy. The Board shall, from time to time, review such Policy for possible modification.

Section 14-2 Conflict of Interest Procedures

Any duality of interest or possible conflict of interest on the part of any Director must be disclosed to other members of the Board and made a matter of record, either through an annual procedure or when this interest becomes a matter of Board action. Any Director having a duality of interest or possible conflict of interest on any matter should not vote or use personal influence on the matter and should not be counted in determining the quorum for the meeting, even when permitted by law. The minutes of the meeting should indicate that a possible conflict of interest was disclosed, that the appropriate Director(s) abstained from voting and left the meeting while the possible conflict of interest was discussed and voted on, and that a quorum was present. The foregoing requirements should not be construed as preventing a Director with a potential conflict of interest from briefly stating a position on the matter, nor from answering pertinent questions of others on the Board, since this knowledge may be relevant to the business of the Corporation.

ARTICLE XV
LIMITED LIABILITY

Section 15-1 Limited Liability

No Director or Officer shall be held liable for their duties and responsibilities as such Director or Officer to the extent permitted under the Act.

ARTICLE XVI
INDEMNIFICATION

Section 16-1 Indemnification

The Corporation shall indemnify a Director, Officer, employee of the Corporation, or agent of the Corporation to the fullest extent permitted under the Act.

ARTICLE XVII
INSURANCE

Section 17-1 Insurance

The Corporation may purchase and maintain insurance on behalf of any person who is a member of the Board, an Officer, or a manager of the Corporation or who is or was serving at the request of the Corporation as a Director, Officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against such person and incurred by such person in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have the power to indemnify such person against such liability under the provisions of this Section.

ARTICLE XVIII
AMENDMENTS

Section 18-1 Amendments

The Articles of Incorporation or these Bylaws may be amended, altered or repealed by a majority vote of a quorum at any meeting of the Board, provided that notice of the proposed amendment is sent to all Directors not less than five (5) days before the meeting and provided that a copy of the proposed amendment accompanies such notice. No provision of these Bylaws concerning the regulation or management of the Corporation is intended to be, nor shall it be construed to be, inconsistent with applicable laws or regulations, including the Act, or with the Articles of Incorporation.

CHESTNUT HEALTH SYSTEMS

APPENDIX 3-1
SPECIFIC DUTIES AND RESPONSIBILITIES RELATING TO FQHC OPERATIONS

The Board shall have authority with respect to, and be responsible for, the establishment of policy in the conduct of programming designated under the scope of Section 330 of the Public Health Services Act. Specifically, but without limitation, the Board shall:

a) approve the selection, dismissal and conduct the performance evaluation of Chestnut's Chief Executive Officer;

b) develop, adopt, and periodically update personnel policies and procedures, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices;

c) adopt financial policies that assure accountability for FQHC resources, approval of the annual budget and annual budget procedures, organizational and budget priorities, eligibility for services, including criteria for sliding fee scale, fee schedule for services, partial payment, and long-range financial planning;

d) monitor organizational performance, quality improvement activities, and programmatic activities, including service utilization patterns, productivity, patient satisfaction, achievement of objectives and the process for hearing and resolving patient grievances;

e) assure that Chestnut and the FQHC activities are operated in compliance with applicable federal, state, and local laws and regulations;

f) develop, adopt, and periodically update healthcare policies, including but not limited to scope and availability of services, location, hours of operation, and quality of care audit procedures;

g) on an annual basis, measure and evaluate progress in programmatic and financial goals, FQHC achievements, and patient satisfaction surveys;

h) develop and approve a strategic plan at least once every three (3) years, which includes an ongoing review of the FQHC mission, Chestnut's corporate bylaws, and these duties and responsibilities relating to FQHC operations;

i) approve any grant application or change in scope of services and location under Section 330 of the Public Health Services Act, including the annual project budget submitted as part of any such grant application; and

j) evaluate itself periodically for efficiency, effectiveness, and compliance with the requirements of Section 330 of the Public Health Services Act.

No third party may be granted approval or veto rights regarding any of the aforementioned authorities.

Approved on June 28, 2023

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Structure and By-Laws		
Policy Name and Number:	CSB 640 Board Approval of Policy Handbook		
Revision Date:	05/25/2005		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CSB 640 BOARD APPROVAL OF POLICY HANDBOOK

In accordance with the Bylaws of the Corporation, the Chief Executive Officer carries out the policies of the Board in accordance with accepted standards of professional and administrative procedures. The Executive Leadership Council shall compile and continually update a policy manual. The policy manual shall be reviewed and approved by the Board of Directors at least annually.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Structure and By-Laws		
Policy Name and Number:	CSB 650 Board Approval Procedures		
Revision Date:	05/25/2005		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CSB 650 BOARD APPROVAL PROCEDURES

The Chief Executive Officer or his/her designee may authorize the inclusion of specific policy and procedure statements in the policy manual to assure that the handbook is continuously updated as required by various professional standards. Approval and review of specific policies by the Board of Directors is documented in the minutes of the Board meetings.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Structure and By-Laws		
Policy Name and Number:	CSB 655 Program Specific Procedures		
Revision Date:	06/23/2010		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CSB 655 PROGRAM SPECIFIC PROCEDURES

The Chestnut Corporate Policy Handbook acts as an overall guide to govern the implementation of policy. Staff should be knowledgeable of the corporate Policy Handbook. Individual program and/or business units should describe how these overall policies are implemented through procedures in program and/or business unit manuals. Prior to modifying program and/or business unit manuals, supervisors must ensure that program procedures do not contradict corporate policy.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Corporate Structure and By-Laws		
Policy Name and Number:	CSB 660 Policy and Procedure Library		
Revision Date:	06/23/2012		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

CSB 660 POLICY AND PROCEDURE LIBRARY

A library of Chestnut's policies and procedures documents will be maintained for each region by the Corporate Director of Quality Improvement or designee. Program Directors or supervisors that revise their procedures are to submit the approved procedures to the Corporate Director of Quality Improvement or designee.

Chestnut Health Systems
Fiscal Policy

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 1 Accounting Systems		
Revision Date:	8/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 1 ACCOUNTING SYSTEMS

Chestnut Health Systems shall maintain an accounting system that meets contemporary professional business practices and shall regularly update any implemented accounting software to allow Chestnut's accounting system to follow United States Generally Accepted Accounting Principles (US GAAP).

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 10 General Ledger		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 10 GENERAL LEDGER

Fiscal management is conducted in accordance with United States Generally Accepted Accounting Principles (US GAAP). All items of revenue and expense are recorded on the accrual basis of accounting. The general ledger is maintained to provide accurate and timely reports to management and the Board of Directors so they may assess organizational performance and plan for the future. All entries to the general ledger including journal entries are reviewed and approved for accuracy under the direction of the CFO. General ledger balance sheet accounts and sub-ledgers will be reconciled monthly by the Controller.

A system will be maintained to provide a chart of accounts that reflects revenues and expenses tracked to profit centers and sub-profit centers for grant reporting, and assets and liabilities tracked to the corporate level. The CFO and/or Controller will maintain an appropriate chart of accounts.

Fiscal staff, under the direction of the CFO, will complete monthly and annual tasks to allow generation and distribution of all financial reports and information to management and board in a timely manner.

When Chestnut Health Systems is involved in a contract to act as the banker for specific pass-through set-aside funds, transactions will be handled according to the contractual arrangement. The accounting department will ensure that all transactions are timely and accurately reflected in the general ledger. Chestnut Health Systems may be compensated to administer the fund. Revenue is booked appropriately to the general ledger.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 20 Internal Control		
Revision Date:	06/26/2013		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 20 INTERNAL CONTROL

Chestnut Health Systems will maintain an effective system of internal control to monitor compliance with policies and procedures. Chestnut Health Systems is committed to comporting with all regulatory requirements, compliance assurances and certifications. It is recognized that controls described in this policy are implicit in a variety of other policies and include such areas as auditing, purchasing and use of purchase orders, check disbursements, accounts payable, cash receipts, accounts receivable, petty cash, and management information services.

Chestnut shall implement controls to assure integrity of financial, management information, human resource, purchasing, and other administrative records. Chestnut's system shall be designed to segregate duties so that no employee is positioned to exercise authority over processes which allow the employee to avoid or divert appropriate and necessary controls.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 30 Audits and Required Regulatory Filings		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 30 AUDITS AND REQUIRED REGULATORY FILINGS

Beyond being a requirement of funders, an audit will provide evidence that corporate operations are being fairly and accurately represented to internal and external sources and that identified problems are being adequately addressed by the company.

An annual audit is conducted by an independent, Certified Public Accountant (CPA) in accordance with United States Generally Accepted Auditing Principles (US GAAP). The report will also contain the CPA's opinion regarding the financial statements as well as any additional reporting as determined by Chestnut. The audit firm reviews the final results of the audit including any management recommendations with the key administrative staff and the audit board committee responsible for accounting records. The Board of Directors has final authority to accept the audit report and review and accept any corrective plans. In connection with completing the audit, the CPA firm may also prepare corporate tax and other forms as required or as requested by Chestnut. All filings are maintained in the administrative offices of Chestnut Health Systems.

Auditors are retained by the Board of Directors and report to the board. Chestnut Health Systems will bid the audit every five to seven years or pursuant to direction from the Audit Committee and/or Board of Directors.

All required state or federal reports and returns are completed annually by internal/external accountants or auditors for any and all subsidiaries of Chestnut. All returns and filings for the subsidiaries are maintained in the administrative offices of Chestnut Health Systems.

Accounting or auditing firms may be retained to complete an audit or annual review of retirement, health, or flexible benefit plans of the corporation. An external or internal accountant will prepare any state or federal report required.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 40 Cash Management		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	FS 190 Investments		
Citation(s):			

FS 40 CASH MANAGEMENT

Chestnut Health Systems shall maintain an effective system of cash management to meet immediate cash needs and maintain adequate controls over checks and cash received. Chestnut Health Systems shall establish and maintain bank and investment accounts to meet the needs of the organization and to build relationships with banking institutions and investment houses. Accounts will be established in the General Ledger (GL) and presented on the Balance Sheet. Balances will be reconciled on a monthly basis by the designated accounting staff.

A sufficient level of cash should be available to meet anticipated day-to-day expenditures, plus a reasonable reserve for emergencies. Excess cash will be invested consistent with guidance provided by the Board of Directors. (See FS 190 Investments)

In the management of federal awards, Chestnut will assure that the drawdown of funds under the U.S. Department of Health & Human Services (HHS) Payment Management System (PMS) will be limited to the minimum amount needed to cover allowable project costs, be timed in accordance with the actual immediate cash requirements of carrying out the award and will only be drawn down in advance for expenditures to be made within the next 72 hours.

Chestnut accepts payments by credit card, debit card, check and cash. Cash and checks received are deposited at a minimum of once per week with any undeposited cash and checks kept in a secure location. Adequate controls shall be implemented to protect against misappropriation. Only staff authorized by the CFO shall be permitted to access any electronic payment system used to reimburse Chestnut for services rendered. Only authorized personnel shall have access to cash receipts.

Bank reconciliation will be completed monthly to permit information to be verified and included in monthly financial reports. Chestnut shall maintain a system to regularly review outstanding checks during the bank reconciliation process.

Assumption of debt shall be authorized by the Board of Directors.

Petty cash or change funds are established with the approval of the CFO or Controller. Petty cash funds are to be used for incidental expenses when requesting an accounts payable check is not practical. Petty cash funds must be reconciled at least monthly and appropriate documentation sent to Accounts Payable for processing.

In certain circumstances Chestnut Health Systems may act as Representative Payee. All funds received by Chestnut shall be managed in the same financial manner no matter the payer source. This shall include, but is not limited to Social Security, Veteran's benefits, funds from family member(s) or another payee. When Chestnut assumes Payeeship responsibilities all funds that originate from Social Security shall be managed in accordance with regulations in the Social Security Administration "Guide for Representative Payees". Veteran's funds will be managed in accordance with regulations defined by the Veteran's Administration. Payeeships will also be managed in accordance with the Department of Human Services Network Guidelines. Representative payee accounts must be reconciled at least monthly and appropriate documentation sent to the Controller for review and approval.

Gift cards can be used in various programs as incentives for clients to participate in treatment or research. Program staff are required to track gift card purchases and disbursements for audit purposes. Gift card purchases and disbursements must be reconciled at least monthly and appropriate documentation sent to the Controller for review and approval.

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 50 Budget		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Chestnut's Cost Allocation Plan		

FS 50 BUDGET

Chestnut Health Systems shall engage in a collaborative planning process, which results in developing a budget for overall corporate programs and for 330 program services. Such budgets will be reviewed and approved by the Budget and Finance Committee prior to submitting to the Board of Directors for approval. The budget is a tool against which program financial performance can be measured.

The budget process is coordinated by the CFO and will involve senior program staff in projecting expenses and revenues under their supervision for the period being forecast. The Chestnut Health Systems Board of Directors will approve a fiscal year budget for overall corporate purposes prior to the beginning of the new fiscal year unless extenuating circumstances exist. Should extenuating circumstances exist and a new budget cannot be approved prior to the start of a new fiscal year, the Board of Directors can extend the current fiscal year budget until such time as a new budget can be approved.

Certain costs are allocated to profit centers based on approved allocation formulas as outlined in Chestnut's Cost Allocation Plan. These formulas include, but are not limited to, Bed Days, Revenue, Staff Hours, Square Footage, and Salaries.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 60 Revenue Cycle		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 60 REVENUE CYCLE

Accounts receivable arise from the provision of products or services to consumers. Accounts receivable records should be accurate, complete and maintained in a manner to indicate the length of time the debt has been outstanding.

Chestnut Health Systems will establish billing rates for all services delivered by its programs, including rates for core clinical programs that are available to the general public. Billing rates for the Chestnut Family Health Center will be established by reviewing cost of services, insurance contract rates and applying a Board approved percentage to the Medicare allowed rate and/or a Board approved percentile of local prevailing rates. Executive leadership will review and approve rates no less than annually and shall obtain Board of Directors approval for any rates as required by funders.

Contracting with employee assistance programs, insurance vendors, managed care vendors or other third-party payers for core clinical programs is conducted by assigned staff in various affected programs. Contracting activities include but are not limited to: contract review and negotiations, rate review and negotiations and preparation of any additional required documents for individual agreements, facility agreements and/or single case agreements. All such contracts require approval of CEO or COO and General Counsel.

All Chestnut clinical staff that bill services are required to create and maintain an account with Chestnut's third-party credentialing vendor, in addition to obtaining a National Provider Identifier (NPI). Once established, the identification numbers should be forwarded to the Revenue Cycle Credentialing Specialist for use in contracting. In addition, every Chestnut location where services are being performed is required to have a Facility NPI.

Chestnut Health Systems will establish HIPAA compliant billing codes for all services delivered by its core clinical programs. Chestnut will obtain financial information to ensure that appropriate payers are assigned and billed. Chestnut staff will provide information to the client about the payment policy, standard fees, the payment authorization, and possible alternate funding sources for which the client may qualify. Chestnut will also obtain a written payment responsibility and authorization.

Bills or other reporting information required by payers will be reviewed to ensure they represent accurate amounts owed and will be sent in a timely manner. If any state grant funds are received prior to incurring the related expense, any interest earned on those funds will be used for the same purpose as the grant.

Accurate charges are posted to appropriate accounts or general ledger reflecting services or products provided to the consumer. An accurate aging of the accounts receivable subsidiary ledger will be maintained. A monthly reconciliation of the general ledger to the accounts receivable ledger will be conducted by fiscal staff. An accounts receivable is relieved by posting receipts from the cash receipt's journal, by approved credit memos for allowances, write-offs from uncollectible accounts, or other appropriate transactions. Payments received for goods or services are entered into the subsidiary account in a timely manner to assure that the most accurate and current balance information is available. Certain circumstances may require payment plans to be implemented for clients or discounts or other settlements may be necessary to resolve an account.

Chestnut Health Systems expects that all amounts due be paid in a timely manner including payment at the time of service for certain core clinical services. A late fee may be assessed for delinquent accounts. Chestnut Health Systems staff will, in accordance with standard billing practices, make every effort to collect amounts owed pursuant to a Collections Procedure maintained by the Revenue Cycle department.

Chestnut Health Systems will handle all credit balances in a timely, appropriate and consistent manner. Overpayments will be promptly refunded to the appropriate party upon identification and validation of the overpayment.

Chestnut Health Systems will assess a fee for checks returned for non-sufficient funds.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 70 Payroll		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Time Off Form Time Sheet		

FS 70 PAYROLL

Chestnut Health Systems will provide an accurate and timely payroll for all employees including payment of taxes and other deductions in accordance with federal and state laws and with Chestnut's existing benefit and pay schedule.

Payroll will be issued at regularly defined intervals and will be paid only at authorized and accurate rates of pay for individuals employed by the company. Rates are determined either by an hourly rate or by an annual salary divided by the number of pay periods over the course of the year. Any changes in pay levels must be authorized by a supervisor and the Human Resources Department.

All hourly, non-exempt employees are required to maintain an accurate daily record of their time worked and to document this time on a time sheet or digital timecard. All absences from work schedules should also be appropriately recorded on the time sheet or digital timecard. Management is responsible for ensuring that employees maintain accurate time sheets or digital timecards, accounting for all hours worked and taking the mandatory unpaid meal periods when applicable. Management is also responsible for reviewing the accuracy of the employee's timesheet or digital timecard. All time sheets or digital timecards must be approved by management and submitted to the Payroll Department by noon on the Monday following the pay period end date. Chronic failure to comply with payroll recordkeeping standards and timelines may be grounds for disciplinary action. Deliberate misrepresentation of submitted timesheet or digital timecard data may be grounds for dismissal.

Salaried, exempt employees' time off (e.g. sick, personal, vacation or other approved leave) should be approved by management and submitted to the Payroll Department no later than the end of the pay period in which the time off falls.

Each employee is assigned a department and position code. Each department and position code combination is assigned a General Ledger allocation to ensure accurate reporting of salary and wage expense to the appropriate profit center. At a minimum, an annual review of allocations will be completed in conjunction with the budget process.

All necessary payroll reports are filed in accordance with federal, state, and local regulations. All compulsory and voluntary deductions will be calculated and remitted to the appropriate third parties accurately and timely.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 80 Accounts Payable		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	FS 100 Purchasing		
Citation(s):			

FS 80 ACCOUNTS PAYABLE

The payment for goods and services should be organized to ensure that no unauthorized payments are made, that complete and accurate records are made of each payment, and that payments are recorded in the appropriate periods.

The accounting department will be responsible for maintaining the vendor file. Vendor files will be reviewed to assure that they are complete and provide information necessary to process accurate payments. W-9's will be required prior to any payment being made to a vendor. In addition, any vendor with a contract/subaward in excess of $25,000, whereby a portion (or all) of the associated expense will be charged to a federal award must be checked through the System for Award Management (SAM) for suspension or disbarment. These documents will be scanned into the accounting system for record-keeping purposes.

The organization will pay its outstanding invoices on a timely basis, designing a system which allows payment as close to the payable due date without incurring interest or service charges. Chestnut Health Systems will have in place sufficient security protocols to ensure that all payments are accurate and risks for fraud or inaccuracies are minimized. Proper documentation and approval of all invoices is required prior to any payment (refer to FS 100 - Purchasing for invoice approval limits). All invoices and approval documentation will be scanned into the accounting system for record-keeping purposes. Electronic payment (EFT/ACH) of invoices will be the preferred method of payment for the organization.

The Board of Directors will determine the board members and staff who will have the authority to designate banks with which the organization will do business, to make withdrawals from such banks on behalf of the organization, and otherwise carry on business with such banks on behalf of the organization. The Chief Financial Officer (CFO) and/or Chief Operating Officer (COO) and General Counsel shall designate the staff members who will have authority to endorse checks on behalf of the organization. However, no such staff member is permitted to endorse checks or approve electronic payments (EFT/ACH) payments on which he or she is listed as payee.

Two signatures or facsimiles are required on all checks or electronic payments (EFT/ACH) in the amount of $1,000 or greater. All Chestnut Health Systems disbursement checks will be pre-numbered; all checks shall be accounted for whether used as intended or voided. Proper signatures or facsimile shall be obtained for all disbursements and associated documentation.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 90 Business and Travel Expenses		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Lost/Missing Receipt Waiver		

FS 90 BUSINESS TRAVEL AND EXPENSES

Overview

Employees are reimbursed for reasonable and necessary expenses incurred while performing assigned job responsibilities and/or when conducting business on behalf of Chestnut Health Systems. Chestnut Health Systems is a not-for-profit corporation. Travelers should contact the Chestnut Accounting department to receive information and evidence of tax-exempt status when making travel plans.

Authorized Business and Travel Expense

Chestnut will reimburse employees for authorized business and travel expenses incurred while on Chestnut business. Employees should neither lose nor gain personal funds as a result of traveling on Chestnut business.

Employees are responsible for understanding and complying with company policies, accurately documenting expenses on his/her expense report, attaching appropriate itemized receipts, and submitting requests for reimbursement to his/her supervisor within the timelines prescribed by policy.

Supervisors are responsible for ensuring that employees understand the travel policy, and for prompt review and approval for reimbursement of all reasonable and necessary expenses incurred on behalf of the company. Supervisors are also responsible for ensuring that requests for reimbursement are submitted to the Accounts Payable Department within the timelines prescribed by policy (refer to section “Request for Reimbursement of Expenses” for submittal timelines).

If an authorized business and travel expense is reimbursed solely from sponsored program funds, reimbursements are governed by the stated terms and conditions of the individual grant or contract.

Non-exempt employees must have advance written approval by their supervisor or Program Director prior to making arrangements for any overnight travel in conjunction with their position.

Employees who use their personal funds to pay for expenditures in advance such as conference registration, hotels and/or transportation will not be reimbursed until the conference has been attended or the trip has been completed except with advance approval of the CFO.

Meals and Entertainment Expenses

An employee will be reimbursed for the cost of personal meals purchased while engaged in official overnight Chestnut business and/or travel. Meals or incidentals purchased prior to or after actual travel has occurred will not be reimbursed. For example, breakfast at the airport prior to boarding a departing flight will not be reimbursed; however, breakfast at the airport prior to boarding a return flight will be reimbursed because the employee, at that point, will still be considered engaged in business travel. Travelers on company business will be reimbursed for meal expenses according to actual costs. Snacks are not reimbursable.

Business meals, whether while on official overnight business travel or not, are reimbursable if documentation supporting the requested reimbursement clearly establishes that the meal is directly and legitimately associated with the active conduct of company business and at which a bona fide business discussion takes place. Business meals may include non-Chestnut employees, business associates and/or other professional colleagues. Business meal receipts must document the purpose of the business meal and those in attendance.

Costs incurred for alcoholic beverages (including tax and tip) are not reimbursable unless approved by an ELC member. If the employee seeking approval for same is an ELC member, then approval must be sought from a corporate officer.

An employee attending a day-long (i.e., not overnight) conference or meeting, or traveling between Chestnut regions (e.g. central region to southern region or central region to Chicago) for the day will be reimbursed for one meal on that day.

Local meals, snacks or refreshments with or for Chestnut staff only (e.g. staff meetings or trainings) are not reimbursable or provided by Chestnut unless approved in advance by an ELC member. If the employee seeking approval for same is an ELC member, then approval must be sought from a corporate officer.

Gratuities

Gratuities are acceptable for food servers, taxi or Uber drivers, luggage curb service, or any other instances where a gratuity is deemed to be reasonable and necessary. Gratuities that are claimed as travel/business expense should be consistent with the standards for the specific type of service in that geographic location and should not exceed 20% of the pre-tax bill.

Lodging

When overnight accommodations are necessary employees are expected to obtain the most commercially reasonable room rates available. For employees traveling between regions, an overnight stay is considered “necessary” when an employee’s first meeting or obligation in the destination region begins before 9:00 a.m. unless approved in advance by an ELC member. If the employee seeking approval for same is an ELC member, then approval must be sought from a corporate officer. When possible, travel should be planned in advance in order to take advantage of the most reasonable rates. The employee should confirm the rate by asking for a confirmation number and verifying the cancellation policy. Employees traveling for corporate business are expected to exercise the same economical practices they would exercise in personal business. At checkout travelers are responsible for reviewing the invoice to ensure accuracy of charges incurred.

Standard purchasing procedures should be followed for payment of lodging. Charges for movies, mini-bars, gym memberships, and other lodging related incidentals are not reimbursable. Lodging with relatives/friends is not reimbursable.

Hotel Cancellations

Travelers are responsible for canceling hotel rooms and should verify the cancellation policy with the hotel. Travelers will cancel any guaranteed reservations by the appropriate time to avoid “no show” charges. The traveler will be responsible for any expenses incurred by failing to cancel hotel reservations according to the hotel cancellation policy. However, cancellations due to emergencies or situations beyond the employees control that result in late cancellation charges may be reimbursed with the approval of the CFO.

Combining Business and Personal Travel

Expenses associated with the travel of family members of Chestnut employees are not reimbursable. When personal and business travel is combined, expenses must be clearly documented and may not exceed the lowest available cost of a direct or uninterrupted route. If the traveler uses an indirect route or interrupts travel for personal convenience, any additional expenses incurred are the sole responsibility of the traveler. Expenses related to vacation or personal days while on a business trip are non-reimbursable expenses.

Travel Advances

Travel advances will be considered for multi-day travel when expenses are a hardship to the employee. The appropriate ELC member must approve the advance reimbursement request.

At least seven (7) days’ notice must be provided for a travel advance. Within five (5) days after the travel is completed, the employee must submit to the Accounts Payable Department a General Expense Reimbursement Form with appropriate documentation including detailed receipts showing actual items purchased. Any unused cash advance funds must be returned with the reimbursement form in cash or personal check. If any excess monies are not returned within 15 days of the return from travel, no further travel by the employee will be allowed and repayment options will be implemented. Costs incurred by the traveling employee over and above the cash advancement shall be reimbursed following the standard request for business expense reimbursement procedures.

Accident, Injury, or Illness While Traveling

For all vehicle accidents while on Chestnut business, notify the local police authority and complete the forms required by the insurance or rental-car company when appropriate. Furnish copies of all reports to the Director of Facilities and Procurement and Chief Operating Officer and General Counsel. In addition, accidents involving personal injury must be reported to Chestnut’s Human Resources department as soon as possible following the occurrence. Settlement of claims will be processed according to applicable worker’s compensation law.

Personal Vehicle Usage-Mileage Reimbursement

Using a personal vehicle must be the most cost effective method for conducting business activity. Employees using a personal vehicle for conducting business activity will be reimbursed at the Chestnut authorized mileage rate, which recognizes the cost of gas, oil, and normal vehicle wear and tear. The Chestnut mileage reimbursement rate for all employees shall be set at 90% of the current IRS reimbursement rate.

Mileage Reimbursement Guidelines

The mileage reimbursed will be the lesser of either the actual miles driven or the actual miles between the employee's regular place of Chestnut employment and the employee's destination(s).

Commuting mileage, including travel from home to office, must not be reported and will not be reimbursed per IRS regulations. Fully remote employees who are required to come to a Chestnut office by their supervisor will be reimbursed for their mileage to and from their home to the office at the Chestnut mileage reimbursement rate.

It is Chestnut's policy not to reimburse employees for transportation costs relating to travel for Chestnut sponsored parties, office outings and other Chestnut-sponsored social activities.

Mileage between Chestnut offices will be reimbursed for round-trip travel.

Miscellaneous Travel Expense

Actual tolls and parking fees incurred while using a personal vehicle on Chestnut business will be reimbursed. Expenses including, but not limited to, automobile repairs, parking and traffic fines or citations, charges for car wash, theft or damage in an accident are not reimbursable.

Use of Personal Vehicle in Lieu of Airline Travel

When employees choose to travel in a personal auto, the reimbursement of personally owned automobile expenses will be provided at the Chestnut mileage rate to the extent that the cost of automobile transportation and related travel expenses (in route lodging, meals, miscellaneous expenses, parking fees and toll charges, etc.) do not exceed the cost of a fourteen-day advance-notice coach class air fare plus related travel expenses.

Employees using a personal vehicle while on Chestnut business are required to carry statutorily-acceptable automobile liability insurance coverage. State-set liability limits are the minimum required and should not be construed as necessarily providing adequate insurance protection for employees in connection with all personal automobile use.

Personal Use of Company Vehicles

No employee shall drive a Chestnut vehicle for personal use without the written authorization of the CEO or CFO. When an employee is issued a Chestnut vehicle, the value of the personal use and reimbursed personal expenses will be included in the employee's bi-weekly payroll. The amount included will be calculated based on an annual estimate of personal versus business mileage. This information must be submitted to the Controller by December 15th for the upcoming calendar year. Failure to submit the estimated mileage to the Controller by December 15th will result in the value of the personal use to be determined under the automobile lease value rule of IRS section 1.61-21(d). Under this valuation rule, the value of personal use is 100% of the annual lease value. Employees must document the purpose of the personal travel, date of travel and mileage driven.

Safe Driving Guidelines

Because Chestnut values the safety of its employees, these guidelines are being published to communicate the company's expectations related to safe driving behavior. The vehicle operator shall be aware of and comply with all local, state and national laws. The vehicle shall be operated in a courteous, responsible, and defensive manner at all times.

Use of Chestnut Vehicles and Auto Rental

When the use of personal vehicles for business purposes is impractical or not preferred, employees should use a Chestnut owned vehicle when available. If a Chestnut vehicle is unavailable, an employee may use a rental vehicle with the approval of the CFO. Travelers will make use of any available discount rates for rental vehicles when traveling.. The size and type of the rental car should be appropriate for the number of people in the car and the road conditions on which it will be used.

Insuring Rented Vehicles

Employees are sometimes required to rent vehicles when on Chestnut business. Chestnut's automobile liability insurance policy has been endorsed to include protection for rented vehicles. Therefore, purchase of additional liability insurance for domestic car rental from a rental agency will not be reimbursed. Daily roadside assistance service should also not be purchased on rental vehicles. Instances where roadside assistance is necessary will be reimbursed by Chestnut on a case-by-case basis.

When renting cars internationally, travelers should purchase rental car insurance at the time of rental (some policies depend on the country). Local customs and laws may not be familiar to you and local insurance may be the only insurance that is recognized in that country. In the event of an accident, travelers should immediately contact the Director of Facilities and Procurement and Chief Operating Officer and General Counsel.

Using Public Transportation

When public transportation is required, reimbursement for rail transportation is limited to the lowest first-class rate. Business class may be used for rail travel with ELC approval.

If rail or bus is used instead of air travel for personal convenience, reimbursement of actual expenses including the fare, cost of meals, lodging, tolls, parking, etc. shall not exceed the sum of the total allowable airfare (if air travel had been used), and the normal cost of ground transportation to and from common carrier terminals. Travelers may use personal miles or coupons to upgrade, or a traveler may opt to pay personally for the price difference.

Local Public Transportation

The cost of local transportation (e.g. taxi, Uber, bus, subway) to and from the employee's accommodations and business locations or appointments is considered a necessary business expense and will be reimbursed.

Group Travel

For safety reasons, when business conditions would allow, groups of key individuals should not travel together in the same automobile or on the same aircraft, bus, or train.

Transportation Accommodations and Upgrades

It is expected that the most economical form of transportation will be utilized for all business-related travel, including, without limitation, cars, trains, flights, taxis, and ride shares. When public transportation is required, coach accommodations are to be used. Transportation arrangements should be made at least 14 days in advance to achieve the greatest cost efficiency. Travelers should be cognizant of the need to book transportation accommodations with the lowest cost, within reasonable convenience. Travelers may use business class on international flights when total flying hours are equal to or greater than six (6) hours or when approved in advance by an ELC member. If the employee seeking approval for same is an ELC member, then approval must be sought from a corporate officer.

Personal miles or coupons can be used to upgrade, or a traveler may opt to pay personally for the price difference. Exceptions to this policy must be approved by a corporate officer.

Personal Airline Frequent Flyer Miles

Employees may retain personal frequent flyer program benefits; however, participation in these programs must not influence flight selection, which would result in Chestnut paying more for the airfare than normal based on recommended class of service.

Cancellations, Unused, Voided Airline Tickets

When a trip is cancelled after the ticket has been issued, the traveler should inquire about using the same ticket for future travel or ask the airline to issue a credit slip or similar document, rather than accepting a check or cash. Unused airline tickets or flight coupons must never be discarded or destroyed as these documents may have a cash value.

Travel Insurance

Purchase of travel insurance will not be reimbursed.

Denied Boarding Compensation

If travelers are denied boarding due to airline overbooking or are voluntarily “bumped”, the denied boarding compensation may be retained by the employee for company or personal use including any voucher for free travel or frequent flyer miles. Employees should never volunteer to be “bumped” if it would negatively impact the business trip. No additional expenses associated with a volunteer bump are reimbursable.

Chestnut Purchased Private Airline Club Membership

Chestnut may elect to purchase or use company owned frequent flyer miles for private airline club memberships. Annual memberships can be purchased with the approval of the COO and General Counsel or CFO. Employees will not be reimbursed for day passes to private airline clubs while traveling.

Excessive Baggage

Excessive baggage rules of airlines vary and the charges for excess baggage can be high. Only charges for a reasonable amount of baggage are reimbursable.

Lost, Damaged or Delayed Luggage

When luggage is lost or damaged, the traveler is responsible for filing a formal claim with the airline before leaving the airport and for keeping copies of the claim form and baggage check ticket in a safe place until the matter is resolved. Travelers will not be reimbursed for clothing, incidentals or other personal items purchased due to “delayed” or “misdirected” luggage due to flight delays or other flight issues, or forgotten items.

Telephone Usage

Employees should use their best judgment in limiting personal calls from a hotel phone while traveling. They should use the company issued phone whenever possible; a hotel phone should only be used when a company issued phone or phone card is not serviceable.

Internet Service

Internet connections while traveling on company business should be reasonable with regard to quantity and cost. When requesting reimbursement, explanations must include a brief reason for the expense. Inflight internet service will be reimbursed if used for business purposes only.

Foreign Currency and Purchases

Employees traveling internationally are expected to make the most cost effective choices when exchanging foreign currency to avoid undue cost to the company. Whenever possible, travelers should use a company credit card when traveling internationally. Chestnut will not reimburse for foreign transactions fees on non-corporate credit or debit cards.

Expense Reporting Foreign Currency

Expenditures must be reported in the currency incurred for each transaction. If available, documentation of the actual conversion rate from US dollars to local currency will be used. If not, the conversion rate will be determined by the rate reported on an exchange rate website designated by Chestnut.

Passport/Visa

Travelers are responsible to ensure their passport is current with at least six (6) months validity and that appropriate visas have been obtained. Fees for visas are reimbursable when required for travel on behalf of Chestnut. Visa documentation should be submitted for processing at a minimum of one month in advance of any travel. Approval by an ELC member is required for any visa rush processing fees.

Loss/Stolen Passport

Travelers will report the loss of a passport to the nearest U.S. Embassy or consulate immediately as it may take days to have a new passport issued. The traveler should carry a photocopy of his/her birth certificate, Visa and passport information page to facilitate re-issuance of the passport. The embassy will advise the traveler of the best way to report the loss to the local police.

Immunization and Medical Requirements

Employees are expected to consult their local health department or primary care physician upon knowledge of a trip to determine and comply with the list of immunization requirements by country. The cost of the immunizations, if required, is reimbursable.

Customs/Duties

Customs and duties charges are reimbursable only when levied on company material or property.

Request for Reimbursement of Expense

Employees are responsible for completing the Chestnut Health Systems General Expense Reimbursement Form in an accurate and timely manner. Employees who routinely travel as part of their job must submit expense reimbursement forms to Accounts Payable every 30 days. Employees who infrequently travel must submit a request for reimbursement to Accounts Payable within 30 days of completion of the travel or date of incurred expense, but not to exceed 60 days from the date the expense was incurred. Expense reports are directed to his/her immediate supervisor for approval and signature. An employee cannot approve his or her own reimbursement of expenses. Any request for reimbursement that is 60 days or older from the date the travel was completed, or expense was incurred must be approved for payment by the CFO. An explanation as to why the reimbursement request is over 60 days old also needs to be attached to the payment request. To be eligible for reimbursement, all requests for reimbursement of expenses with all receipts and approval signatures affixed must be received by the Accounts Payable department no later

than July 31st following the fiscal year end. Any request for reimbursement of expenses on a General Expense Reimbursement Form for the previous fiscal year that is received after July 31st will not be reimbursed unless approved by the CFO.

Documentation of Expenses

Chestnut's General Expense Reimbursement Form must be filled out accurately and completely by the employee and signed by the supervisor to be eligible for reimbursement. All reimbursement forms must include the date of travel or expense incurred, destination/explanation for reimbursement, program charged, number of personal miles to be reimbursed and other incidental expenses related to the travel.

Employees who use their personal car for company business must specify their destination and explanation of reimbursement. Beginning and ending destinations must be documented. Explanations of reimbursement must include, but are not limited to, ID numbers of clients seen, topic of meeting or conference attended or business purpose of travel.

An original, detailed receipt listing actual items purchased, in addition to any credit card charge slips should be attached to the General Expense Reimbursement Form. If meals are purchased, the receipt should include an itemized bill for what was ordered. In addition, the purpose of the meal and the number of people should also be noted on the receipt. Staff who sign disbursement checks are authorized to return to the appropriate staff any employee reimbursement form for additional review and authorization or for valid signature.

Lost/Missing Receipts

When an original receipt is lost and the traveler is unable to obtain a duplicate then a Lost/Missing Receipt Waiver form must be completed and attached to the expense reimbursement form as evidence of the expense prior to the expense being reimbursed. Use of this form should be minimal.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 100 Purchasing		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	ISS 1100-1114		
Citation(s):			

FS 100 PURCHASING

Any purchase made by Chestnut employees requires proper authorization. Chestnut Health Systems will implement procedures to provide internal control and ensure an adequate audit trail for all transactions.

All purchases require prior approval. Purchases and repairs will be made in a timely manner to provide adequate supplies, equipment, and facilities to meet the need of day-to-day operations of the organization. Chestnut will implement procedures providing internal control to assure an adequate audit trail for all transactions.

Stock items (e.g. office supplies, IT accessories, janitorial supplies, Health Center medical supplies, client food orders on residential unit) are considered consumable items with a low individual unit cost. Request forms for stock items are maintained by the Purchasing department. Requests for stock items require an employee's direct supervisor's approval prior to being sent to the Purchasing department for fulfillment.

For *non-stock items* the following approvals are required prior to purchase:

1) Leadership Counsel (LC) Members: Approval for individual items/services or group purchases up to $2,499.99

2) Executive Leadership Counsel (ELC): Approval for individual items/services or group purchases up to $4,999.99

Any individual item/service or group purchase over $5,000 must be approved by the CEO, CFO or COO and General Counsel.

Procurements that are below the micro-purchase threshold ($10,000) are, whenever possible and practical, distributed among qualified suppliers. Soliciting competitive quotes is not necessary if management considers the price for the goods or services to be reasonable. Small purchase procurements are those that fall below the Simplified Acquisition Threshold of $250,000. For these types of procurements, Chestnut will solicit price or rate quotes from at least three qualified sources to determine the most qualified supplier. Bids will be written in a way that does not restrict competition (e.g. clear and accurate description of the technical requirements for the material, product or service to be procured; all requirements which offerors must fulfill; and all other factors to be used in evaluating bids or proposals). For procurements over the Simplified Acquisition Threshold, sealed bids will be publicly solicited, and a firm fixed price contract is

awarded to the responsible bidder whose bid conforms to the material terms and conditions of the invitation for bids. Executive management will have final approval of sealed bids. Whenever possible, Chestnut will engage in affirmative efforts to utilize small businesses, minority-owned firms, and women's business enterprises and full and open competition in its procurement processes.

Consistent with 2 CFR §200.214, Chestnut will ensure that vendors it selects for goods or services to be paid for by funds received from the Illinois Department of Human Services ("IDHS") are not debarred, suspended, or otherwise excluded from or ineligible for participation in Federal assistance programs or activities.

Purchases made without prior authorization are subject to review and approval *before* reimbursement. Reimbursement will not be authorized unless paid receipts are attached to the expense voucher. If a purchase is made and determined inappropriate, the employee will not be reimbursed.

Capital Acquisitions are items of furniture, fixtures or equipment with a unit cost of $5,000 or greater. Requests for capital expenditures require approval by the CEO, CFO or COO and General Counsel. accordance with prescribed procedures. Three bids are required for all capital purchase requests except when waived by the CEO, CFO or COO and General Counsel.

Chestnut recognizes that certain job functions require that an employee be accessible when away from the office or during times outside scheduled working hours. For this reason, Chestnut may provide, solely at Chestnut's discretion, assignment of Chestnut-owned devices (e.g. smartphones, other cellular telephones, tablets, or other similar digital devices) to select employees. Employees assigned a Chestnut-owned device are expected to comply with ISS Policies 1100-1114.

Chestnut Health Systems may purchase a fleet of vehicles to be used in its operations. All vehicles purchased by Chestnut Health Systems are intended to be used for business-related travel. However, at the discretion and direction of the CEO, a vehicle may be:

1. Dedicated to an employee for business and personal use. This employee will be permitted to have use of the vehicle at all times. In accordance with federal tax law, the employee will be required to record and report, at Chestnut's request, all personal use of the Chestnut-owned vehicle;

2. Dedicated to an employee or employees for business use only. The vehicle shall not be used for an employee's personal use. These vehicles shall only be housed at a Chestnut facility when not being used for business purposes; or

3. Dedicated to a program or function within Chestnut. All vehicles purchased for the use of a specific program or group of programs shall not be used for an employee's personal use. These vehicles shall only be housed at a Chestnut facility when not being used for business purposes.

When necessary and appropriate, vehicles will be traded in exchange for credit against the purchase of a new vehicle. The CEO,CFO or COO and General Counsel will approve the trade in in connection with the new purchase.

In the event that a vehicle owned by Chestnut is to be removed from the fleet, but not traded in, Chestnut may offer the vehicle in a sealed bid process to its employees. The vehicle shall be offered as is and Chestnut reserves the right to reject any and all bids. The buyer will be responsible to pick up the purchased vehicle at the facility where it is located.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 110 Reporting to Funders		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 110 REPORTING TO FUNDERS

The organization shall provide required information to funders based on the most current and accurate data reflecting program and organizational operations. Chestnut Health Systems will prepare and distribute performance and financial reports as required and information will be processed timely to ensure compliance with grants and contracts. When federal funds are involved, Chestnut Health Systems will follow and comply with 2 CFR 200 Subpart E - Cost Principles.

Before Chestnut seeks reimbursement from a funder, it will ensure that all costs are reviewed for allowability, allocability, and reasonableness. Costs that do not meet these requirements according to the applicable funders cost principles or other terms and conditions contained in the award are not included in the expense reports for reimbursement. Chestnut will maintain a Cost Allocation Plan which will be used to allocate costs to various programs, grants, contracts and agreements. For each funding award, Chestnut will maintain records that allow for a comparison of expenses with approved budget amounts.

Expense reports are prepared monthly for grants and projects unless directed otherwise by the funder. Expense reports shall be completed and reviewed by Chestnut fiscal staff using financial information from the reporting period in question and as reflected in the general ledger. Exceptions shall only be made with the approval of the Chief Financial Officer. Fiscal reports shall also be reviewed and approved by the appropriate program staff prior to invoices being submitted to the funder for payment or federal funds being drawn down from the Payment Management System. When fiscal staff are unable to meet submission deadlines as set by funders, Chestnut staff shall seek an extension from the funder.

Chestnut will submit financial and performance reports as prescribed by the funder. This includes, but is not limited to, Periodic Financial Reports (PFR), Close out Reports, Federal Financial Reports (FFR), and Periodic Performance Reports (PPR).

Chestnut will maintain an accurate accounting of an employees' time and effort charged to various grants or projects. Chestnut will ensure that no employee is being charged more than 100% across all grants or projects and the effort reported accurately reflects the worked performed on the grant or project.

The Chief Financial Officer will be responsible for developing and submitting Chestnut Health Systems' Nonprofit Indirect Rate Proposal and negotiating with the cognizant agency, the Department of Health and Human Services (DHHS) Cost Allocation Services.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 120 Contract Negotiations		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 120 CONTRACT NEGOTIATIONS

The handling of contract negotiations reflects on Chestnut and its staff. Therefore, contract negotiations will be conducted in an ethical and professional manner. Staff should never withhold vital information, provide misleading information, or otherwise act in a manner that would provide Chestnut with an unfair advantage. If any staff have a personal relationship with the other contracting party or any other conflict of interest that may impair the contracting process, this should be brought to the attention of their supervisor or appropriate management personnel immediately. Furthermore, other than the CEO, COO and General Counsel and CFO, no Chestnut staff member is authorized to execute any contract on behalf of Chestnut or its affiliates.

Contracts with funding agencies may contain conditions that must be met in order to remain in compliance with the contract and satisfy the contractual relationship. These conditions may include service expectations, reporting requirements, financial requirements, clinical or recordkeeping requirements or any other activities that may be set forth in the contract.

Funding contracts must be reviewed to determine the conditions within the contract that must be met as well as to identify appropriate Chestnut staff who are responsible for meeting these requirements. A comprehensive contract database will be maintained which will include for each contract, at a minimum, the following information: contracted entity, category, contract name, contract tracking number, address, applicable Chestnut region, effective date, lapse date, fiscal year, current status, Chestnut signatory, and individual responsible for monitoring compliance.

All organizations that have entered into a subcontractor relationship with Chestnut through a subcontractor agreement shall be monitored by Chestnut staff to ensure compliance with the subcontractor agreement. Subcontractors will be required to adhere to applicable requirements of the prime contract.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 130 Capitalization and Depreciation		
Revision Date:	08/28/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 130 CAPITALIZATION AND DEPRECIATION

Chestnut Health Systems has established a financial accounting capitalization and depreciation policy that applies to land, building and building improvements, leasehold improvements, equipment and furnishings, vehicles, and leases used in the operations of the organization. The policy will be used to promote proper accounting for Chestnut assets in conformity with United States Generally Accepted Accounting Principles (US GAAP).

All costs connected with the acquisition of land should be capitalized. Acquisition costs include but are not limited to the purchase price (or fair market value if donated), real estate commissions, legal fees, escrow fees, title investigations, title insurance, etc. Costs directly related to the preparation of the land for its intended purpose (i.e. excavation, fill, grading, and drainage) will also be capitalized.

All costs associated with the acquisition or construction of a building should be capitalized. Building acquisition costs include but are not limited to the cost of professional services, appraisals and title insurance. Construction costs include but are not limited to professional services, materials, labor, and site preparation.

Building improvements (i.e. parking lot paving, roof replacement, HVAC equipment replacement, flooring, etc.) should be capitalized if they are significant alterations or structural changes that a) cost greater than $5,000 and b) meet one or more of the following conditions:

A. Extends the useful life of the building beyond what was originally scheduled.
B. Changes the use or purpose of the original space.
C. Expands the total square footage of the building.

Leasehold improvements are additions, alterations, remodeling or renovations performed on leased property. All leasehold improvements should be capitalized and amortized over the remaining life of the lease term or the life of the improvement (whichever is shorter). Upon termination of the lease, such improvements will become the property of the owner (lessor) without any cost or obligation.

The cost of equipment and furnishings should be capitalized if the following criteria are met:

A. The item cost is at least $5,000 (excluding shipping costs), and
B. The useful life of the item is at least one year.

An exception to the above criteria is the capitalization of computers. Computers are defined as a processor and related equipment that is needed to function as a desktop or laptop for an individual or group of individuals. This definition does not include servers or other large IT equipment. All computers will be considered an expensed item.

In certain circumstances, the purchase of equipment and furnishings are capitalized even though the individual unit cost is less than $5,000. This is considered a "group purchase". A "group purchase" is defined as an acquisition of 10 or more units of the ***same, identical item*** being made using a ***single requisition***. The purchase must have a total cost of $10,000 or greater. For example, the decision was made to remodel common areas in a building and use the same type of chair throughout the entire area. This will require 60 chairs. Individually the chairs cost $200; however, the aggregate cost of the 60 chairs will be $12,000. This purchase is capitalized as a "group purchase".

All vehicles purchased by Chestnut Health Systems will be capitalized.

Each lease should be reviewed to determine whether it should be expensed or capitalized. If a lease meets any one of the following classification criteria, it is a capital lease:

A. The lease transfers ownership of the asset by the end of the lease term.
B. The lease contains an option to purchase the leased asset at a bargain price. A bargain price represents a price that is sufficiently lower than the expected fair value of the asset at the date the option becomes exercisable.
C. The lease term is equal to or greater than 75% or more of the estimated useful life of the asset.
D. The present value of the lease payments exceeds 90% of the fair market value of the leased asset.

Leases classified as capital leases shall be recorded as an asset and a liability equal to the lesser of either the fair market value of the asset at the inception of the lease or the present value of the lease payments during the life of the lease.

Disposal of capital assets should occur with the proper authorization to preserve the accuracy of records, ensure that assets are safeguarded, avoid improper disposal of assets, and ensure the best possible terms are received upon disposal of the asset. The book value of the asset will be removed from the accounting system when disposed of or sold.

Depreciation is recorded in the financial accounting system to reflect the net asset value of building and building improvements, leasehold improvements, equipment and furnishings, and vehicles during their useful lives. The useful life of an asset is determined from the following schedule:

	Range (In years)	
	Low	High
Building	5	30
Building Improvements	5	30
Leasehold Improvements		10
Equipment and Furnishings	3	20
Vehicles	5	5

Capital assets will be depreciated over their useful lives using the straight-line method of depreciation with an assumed salvage value of zero. Chestnut Health Systems will maintain a record of the existence of and a schedule of depreciation for all capital assets.

Property inventory shall be conducted as per a schedule recommended by auditors in conjunction with United States Generally Accepted Accounting Principles (US GAAP). The inventory listing of supplies or equipment purchased with grant funds having a consumable life over one year must include the following elements: Description of the Item(s), Unique Identification or Serial Number, Location, Cost, Purchase or Acquisition Date, Funding Source (Including In-Kind), Disposition of Property Date, Use, and Condition.

Policy Handbook Section: Fiscal Policy

Policy Name and Number: FS 140 Lease Standards

Revision Date:

Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☒Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	

Policy Cross Reference(s):

Citation(s):

FS 140 LEASE STANDARDS

Chestnut follows Accounting Standards Codification (ASC) 842, *Leases,* and evaluates each lease at inception to determine whether the lease meets the criteria of either an operating lease or financing lease (under ASC 842) or if the lease is exempt from ASC 842 given that it is a short-term lease (i.e. less than 12 months). The Controller will ensure the lease is properly accounted for in the Chestnut accounting system.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 180 Sliding Fee Schedules		
Revision Date:	06/29/2016		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 180 SLIDING FEE SCHEDULES

It is Chestnut Health Systems policy that no patient, including patients served through the Chestnut Family Health Center, will be denied services based solely on the individual's inability to pay for such services. Further, it is Chestnut Health Systems policy that Program Directors be given the ability to grant fee waivers for qualified patients on a case-by-case basis based on Board approved hardship guidelines established by the organization.

Chestnut Health Systems will provide a sliding fee scale to eligible patients based on the patient's ability to pay. Ability to pay is determined by the number of dependents or household size and annual income relative to a discount schedule based on federal poverty guidelines. The number of dependents or household size is defined as the number of dependents living in the patient's immediate household as well as any for whom financial responsibility exists. Annual income is defined as all projected annual gross income per calendar year.

Fiscal staff will be responsible for updating sliding fee scales with changes in federal poverty guidelines. Executive leadership will review and approve sliding fee scales no less than annually and shall obtain Board of Directors approval for any sliding fee scales as required by funders.

In addition to updating sliding fee scales with changes to federal poverty guidelines, patient eligibility will be updated when new information concerning dependents or household size and/or annual income becomes available. At a minimum, patient eligibility will be reviewed annually.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 190 Investments		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 190 INVESTMENTS

The Board of Directors has sole authority over the direction of Chestnut Health System's investment policy. Funds are to be invested in a manner that limits risk to Chestnut and minimizes the risk from capital fluctuations. The Board will adopt and maintain an Investment Policy Statement ("IPS") consistent with the foregoing principle. The IPS will also establish the CEO's, CFO's and COO and General Counsel's authority with respect to investment accounts. Any investment documents will be properly controlled to ensure safety of investment proceeds. The CEO, CFO, and COO and General Counsel are responsible for monitoring and reporting to the Board the status of investment accounts, consistent with the IPS.

Endowments or capital considered by the organization to be long term investments in perpetuity are not governed by this policy.

The Board of Directors will, by Board resolution, authorize staff to open, maintain, and close any necessary bank or investment accounts.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 200 Corporate Credit Cards		
Revision Date:	07/24/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

FS 200 CORPORATE CREDIT CARDS

Corporate Credit Card Management

Corporate credit cards are intended to support employees who travel on agency business and/or are required to make urgent purchases on behalf of Chestnut Health Systems. Credit cards are not a replacement for existing purchasing policies and procedures. Personal use of a company credit card is prohibited. Employees who routinely travel on Chestnut business or are authorized to make purchases may request a company sponsored credit card by formally providing a written request to his/her supervisor. The supervisor is responsible for approving the employee's request and submitting the formal request for a corporate credit card to the CFO for review and approval.

Chestnut will state who their corporate credit card vendor is. The CFO has the final authority to issue or terminate corporate sponsored credit cards. A periodic review of credit card use patterns will be made including number of transactions, appropriateness of transactions, and compliance with applicable policies and procedures. Termination of privileges offered by a corporate sponsored credit card may result due to low usage or violations of policies and procedures.

Billing/Payment

Credit card accounts will be reconciled with all receipts attached on a monthly basis. Cardholders are responsible for obtaining his/her statement and reviewing to assure legitimacy of all charges. The cardholder will submit the statement with receipts attached for review and approval to his/her immediate supervisor. A cardholder cannot approve his or her own credit card statement. Detail receipts indicating actual items purchased must be attached. If meals are purchased, the receipt should include an itemized bill for what was ordered. In addition, the purpose of the meal and the number of people should be noted on the receipt. When an original credit card receipt is lost and the employee is unable to obtain a duplicate then a Lost/Missing Receipt Waiver form must be completed and attached to the credit card statement as evidence of the expense. Use of this form should be minimal. Supervisors are responsible for reviewing the expenses to assure policy compliance, signing the statement attesting to the appropriateness of expenditures, and directing the statement to the Accounts Payable department for payment. Approved credit card statements are to be submitted to the Accounts Payable department no later than the 8th day of the following month. Late submittal of credit card statements to the Accounts Payable department three months in a row can result in the termination of an employee's corporate credit card.

Lost, Stolen or Damaged Cards

Cardholders should promptly report a lost, stolen or compromised corporate credit card by calling the corporate credit card customer service number and to the office of the CFO.

Card Holder Employee Termination

Upon termination of employment, cardholders or their supervisor are responsible for returning the employee's credit card to the CFO. The CFO will be responsible for destroying the employee's credit card and terminating the employee's account in the corporate credit card system. The cardholder must promptly reconcile their credit card account and submit any itemized receipts to their supervisor for approval and payment.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 210 Changes in Program Services		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CSB 160 – General Powers and Duties		
Citation(s):			

FS 210 CHANGES IN PROGRAM SERVICES

Chestnut is committed to continually improving and strengthening its programs to meet the needs of those we serve. Chestnut believes in transparency and accountability and the decisions which further its mission. Therefore, Chestnut shall conduct periodic reviews of any significant program service changes that must be reported on the IRS Form 990. Any changes will be reported by the CEO or CFO to the Audit Committee of the Board of Directors. Chestnut's program services will also be included on Chestnut's website.

At least annually, as part of the annual Financial Audit, the Audit Committee shall also review these changes and the exempt purpose achievements for the organization's program services. The Audit Committee shall also work with Chestnut's auditors, accountants and financial team as necessary to ensure any such program changes as stated herein are reported on Form 990 if required by law and or IRS regulation. The Audit Committee and Chestnut's auditors shall provide a report concerning any recommended changes.

See also CSB 160 General Powers and Duties.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Fiscal Policy		
Policy Name and Number:	FS 211 Restrictions on the Use of Federal Grant Funds		
Revision Date:	04/15/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CC 101 - Legislative Mandates Restricting the Uses of Federal Grant Funds		
Citation(s):			

FS 211 RESTRICTIONS ON THE USE OF FEDERAL GRANT FUNDS

Refer to CC 101 Legislative Mandates Restricting the Uses of Federal Grant Funds.

CHESTNUT
HEALTH SYSTEMS

Chestnut Health Systems
Information Systems and Security

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 100 General Policies		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 100 GENERAL POLICIES

Wherever appropriate, Chestnut Health Systems will make computing, communications, and information systems available to staff which collect, store, transfer, report, and secure information necessary to effectively support the operation of the enterprise. Toward that end, these ISS policies define the role of the Information Technology (IT) department and govern the use of information systems by all staff members, and the security of corporate data and systems.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 101 Internal Procedures		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 101 INTERNAL PROCEDURES

With the consent of the Executive Leadership Council, IT staff will create and implement policies and procedures to define appropriate use, access, and sharing of information by Chestnut staff. At the request and recommendation of the Director of IT, the ELC will establish guidelines for enforcement of these policies and procedures.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 102 Keeping Current with Technology		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 102 KEEPING CURRENT WITH TECHNOLOGY

Under the direction of the Director of IT, IT staff, and senior managers, Chestnut will take appropriate measures to maintain technologies at contemporary standards. Implementation of upgrades and enhancements will be determined by measuring the a) supportability, b) reliability, and c) performance of Chestnut's existing technology, while taking costs (both short term and long term), potential return on investment (ROI), organizational needs, and other factors into consideration.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 103 Selection and Standardization		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 103 SELECTION AND STANDARDIZATION

The IT department will evaluate, identify, and implement computing hardware technologies and software applications to help the organization fulfill its mission in the most efficient manner possible. “Software” includes applications of all types, from end-user software to system administration tools. “Hardware” includes computing and networking equipment of all types. IT will also select and oversee management of computing services and consultants; department-specific exceptions must be approved after consultation with the Director of IT.

1. Standardization: To the greatest extent possible and appropriate, Chestnut will standardize its operations on a core set of software applications. These include data systems and tools, desktop application suites, email applications, web browsers, report writing tools, back-end applications of all types, and other classes of software. Chestnut will also standardize its computing hardware and operating systems, as well as its networking hardware. Exceptions to this standardization policy must be approved by the Director of IT.

2. Needs Evaluation: When determining system needs and evaluating potential solutions, IT staff will: consult with Chestnut staff and managers, review technical literature, contact other organizations to hear their approaches to similar issues, consult with outside experts, test/evaluate software (where possible), and take any other steps that will improve the effectiveness of the evaluation process.

3. Selection: IT staff will make hardware and software recommendations and selections based on information gathered through the evaluation process.

4. Purchase and Implementation: The Director of IT must approve all hardware and software purchase requests to ensure that a) to the extent possible, standardization efforts are adhered to, b) Chestnut received the best possible pricing terms, c) investments are appropriate given Chestnut’s current business strategies.

5. Services and Consultants: For security-related and corporate-level projects, IT will select and direct IT consultants and their work. Where appropriate and after consultation with the Director of IT, departments may contract with consultants for department-specific projects or support.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 105 Data Privacy and Protections		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Notice of Privacy Practices Data Privacy Policy Statement		

ISS 105 DATA PRIVACY AND PROTECTIONS

Chestnut takes very seriously the obligation to protect sensitive data. Chestnut has implemented policies and procedures that govern the protection of data that are stored, processed, and transmitted by the organization. Such policies consist of a general Data Privacy Policy statement that covers personal information and a Notice of Privacy Practices that covers protected health information (PHI). These policies will be reviewed annually and will be made publicly available to consumers, customers and staff.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 110 Security: IT Standards and Safeguards		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as amended ("HIPAA"), including the Privacy Rule and Security Rule at 45 CFR Parts 160 and 164 Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) Comprehensive Accreditation Manual for Behavioral Health Care of The Joint Commission Comprehensive Accreditation Manual for Ambulatory Care of The Joint Commission		

ISS 110 SECURITY: IT STANDARDS AND SAFEGUARDS

Chestnut policies and procedures relating to security of electronic information systems are designed and maintained with standards set by Health Insurance Portability and Accountability Act of 1996 (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH) Act, industry-wide "best practices", and Chestnut's accrediting bodies, such as The Joint Commission, as their basis.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 111 Documentation of Security Policies and Measures		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	IT Security Policy & Procedures Manual		
Citation(s):			

ISS 111 DOCUMENTATION OF SECURITY POLICIES AND MEASURES

Chestnut and IT department will document its security policies and procedures, as well as keep them current. Procedures will be maintained and implemented by the Director of IT, Security Officer, and designee(s) in an “IT Security Policy & Procedures Manual” and associated documentation.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 112 Specific Security Responsibilities		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 112 SPECIFIC SECURITY RESPONSIBILITIES

Chestnut Health Systems will:

1. Designate a Security Officer, who shall report to the COO for issues relating to security of computing systems and electronic protected health information. The Lighthouse Institute (LI) will assign its own Security Officer for managing security of designated LI-specific departmental systems and processes; this LI role reports to the Director of LI on such security matters and will coordinate its departmental security efforts with the Security Officer.

2. Implement security policies and procedures developed by the Security Officer and/or Director of IT, with approval by the COO or the Executive Leadership Council as appropriate.

3. Create a Security Team for managing computing and data systems security. Designate other staff members to oversee aspects of information management security outside the scope of the Security Officer's duties.

4. Train all workforce members on the security policies and procedures; update training annually for all workforce members.

5. Take appropriate disciplinary action against a workforce member who violates a security policy or procedures.

6. If a security incident occurs, take any necessary corrective or remedial action.

7. Refrain from harassing or subjecting to adverse employment action any workforce member who reports a security incident or violation of a security policy that he or she, in good faith, believes has occurred.

8. Coordinate with Chestnut compliance and legal departments for review and maintaining copies of business associates agreements that comply with the Security Standards.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 120 Training and Support		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 120 TRAINING AND SUPPORT

Chestnut staff will receive appropriate technical training, technical support, and security training and notifications.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 121 Technical Training		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 121 TECHNICAL TRAINING

Chestnut staff will receive training on computing systems and software applications relevant to individual job functions. Such training may occur at a corporate or departmental level and will be coordinated and/or performed by IT staff, other designated staff or supervisors, training vendors or educational institutions, or consultants at the discretion of the Director of IT and other departmental managers as applicable.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 122 Technical Support		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 122 TECHNICAL SUPPORT

IT staff will provide or assist with coordination of technical support to Chestnut staff for computing hardware and many software applications, including applications identified as “standard” Chestnut applications. Support will be delivered in the most timely, efficient, and professional manner possible. Non-standard applications may or may not be supported by the IT department; at the discretion of the Director of IT, departments or individual staff members may be responsible for support of such specialized applications.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 123 Security Training and Reminders		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 123 SECURITY TRAININGS AND REMINDERS

IT will implement a security awareness and training program for all workforce members, including management. Security training will be included as part of the New Hire Orientation process.

IT will provide security reminders to workforce members to inform them of changes in policies and procedures, and to generally reinforce security awareness and training.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 200 Risk Management		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 200 RISK MANAGEMENT

IT staff, in cooperation with other Chestnut and/or consulting staff as assigned, will assess potential security risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information. The Director of IT and/or Security Officer, in conjunction with IT staff, will then develop, implement, and maintain reasonable and appropriate measures to mitigate those risks.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 201 Protection from Malicious Software		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 201 PROTECTION FROM MALICIOUS SOFTWARE

Chestnut shall take reasonable and appropriate measures to protect against the introduction of malicious software into its information systems. Malicious software means any software which, if introduced into the organization's information system, could result in loss of data, corruption of data, loss of use of one or more programs or systems, slowing of system response time, unauthorized transmission of data outside the system, or other impairment of system function.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 202 Physical Safeguards		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 202 PHYSICAL SAFEGUARDS

Chestnut shall implement measures to safeguard all facilities, equipment, and data stores from unauthorized access, tampering, or theft. That plan will include documented procedures developed and implemented by the Director of IT or his/her designee(s) to protect critical server and network rooms, to manage security camera systems and badge systems where implemented, to govern the proper storage and disposal of backup systems and media containing sensitive data, and to otherwise minimize risks to corporate data and related physical assets. General physical facility safety is managed by the Facilities department with oversight by the Safety Officer.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 203 Encryption Management		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 203 ENCRYPTION MANAGEMENT

Under the direction of the Director of IT and the Security Officer or their respective designees, Chestnut Health Systems shall establish policies and define mechanisms to determine when encryption should be implemented.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 204 System Passwords		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 204 SYSTEM PASSWORDS

IT will maintain a master password file to keep track of all critical systems passwords. This file will be properly secured to prevent loss or exposure to inappropriate persons. Departments may be responsible for accounts and passwords pertaining to systems managed by those departments. User passwords will not be stored, tracked, or shared for any purpose.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 300 Accounts and Access		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 300 ACCOUNTS AND ACCESS

Chestnut workforce members are granted access to the organization's information system(s) via the individual assignment of unique user IDs and passwords. IT will create and maintain procedures for administration of user accounts and access permissions.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 301 Restricted Access to Information		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 301 RESTRICTED ACCESS TO INFORMATION

Chestnut workforce members will be granted access to electronic information on an as-needed basis only. Such access will be determined either through the employee's job duties and department affiliation or by special approval by senior management. IT staff will establish and maintain related procedures including user ID assignment and management, password rules, access permissions, and security schemas. User IDs will be disabled and/or deleted upon termination of a workforce members' employment or other affiliation with the company.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 400 Backups and Recovery		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 400 BACKUPS AND RECOVERY

The Director of IT or designee(s) will develop and maintain data backup procedures to minimize loss of data and computer system downtime. IT staff will maintain backup copies of electronic protected health information, and other critical information, so that data can be retrieved if it is lost or corrupted.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 401 Secure Data Destruction and Disposal		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 401 SECURE DATA DESTRUCTION AND DISPOSAL

When no longer required for operational or regulatory reasons, Chestnut data, such as protected health information or other confidential or proprietary corporate information, will be securely destroyed or disposed to prevent unauthorized or accidental disclosure of such information. Disposal and/or destruction of data and electronic storage media shall be conducted in accordance with best practices, regulatory requirements, and Chestnut record retention guidelines. IT will maintain electronic data and media destruction procedures and provide direction and support for other departments as necessary.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 500 Information Systems Management		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 500 INFORMATION SYSTEMS MANAGEMENT

Chestnut will provide for the professional management of information systems. The IT department will implement and administer all Chestnut corporate information systems and infrastructure.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 501 Workstation, Server, and Network Management		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 501 WORKSTATION, SERVER, AND NETWORK MANAGEMENT

IT is responsible for the acquisition, administration, maintenance, security, and enhancement of corporate computers, networks, telecommunications, and related services. This includes: end-user devices such as PCs, laptops, and hand-held equipment such as smartphones; servers and storage equipment; networking, telephony, and security equipment and solutions; smart devices, including “Internet-of-Things” (IoT) and medical devices; telecom services.

When deemed necessary by the Director of IT, Chestnut will upgrade the company’s networks and systems to address performance, security, or functionality issues which require remediation. IT staff will implement fault-tolerance measures and redundant systems where appropriate and cost-effective.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 502 Data Systems Management		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 502 DATA SYSTEMS MANAGEMENT

Chestnut will administer, develop, secure, and deliver corporate data, data systems, reporting capabilities, applications, and related services to internal staff and external entities in the most accurate, efficient, and effective manner possible. IT has primary responsibility for managing Chestnut corporate information systems. Additionally, some departments may have responsibilities for managing data and systems related to department-specific operations. In such cases, department managers will coordinate with the Director of IT on technical, administrative, and security matters as deemed appropriate by the Director.

IT and other departments with data / systems management responsibilities will create and maintain comprehensive documentation and training programs for such systems.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 510 System Monitoring		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 510 SYSTEM MONITORING

IT staff will implement systems and procedures to regularly monitor logs, audit trails, and other measures for inappropriate system use or security breaches. Within reasonable cost constraints, software and hardware tools, as well as external consulting expertise, will be acquired and implemented to facilitate monitoring and improve security risk management.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 600 Contingency, Disaster, and Incident Planning		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 600 CONTINGENCY, DISASTER, AND INCIDENT PLANNING

1. Disaster Plan: Chestnut Health Systems will establish written plans to restore data lost through occurrence of a disaster and to maintain the confidentiality of electronic data during the duration of the disaster. This plan will be created and maintained by the Director of IT or designee(s) and reviewed by the COO.

2. Emergency Mode Operation Plan: Chestnut Health Systems shall establish written procedures to maintain functional continuity of information systems required to support patient care and other mission critical business functions, and to maintain the confidentiality of electronic data, while operating in emergency mode.

Both of these documents will coordinate with other emergency plan documents and policies maintained by other departments.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 700 IT Incident Response Plan		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 700 IT INCIDENT RESPONSE PLAN

Chestnut's IT Incident Response Plan outlines steps that IT and others will take upon discovery of a serious security event, including the potential breach of electronically stored information. In addition, in the event of a breach of personally identifiable health information (PHI), staff will comply with policies and procedures concerning breach notification requirements.

Security incidents that may require initiating the Incident Response Plan include:

- Breach of electronic PHI
- Denial of service attack (A type of network computer attack that attempts to render a particular service (e.g. web site) unavailable to its audience)
- Firewall breach
- Virus outbreak, including ransomware attack
- Other IT-related security incident as determined by the Security Officer

Incident Response Team

Chestnut will create an Incident Response Team comprised of key managers and technical staff. The Director of IT and Security Officer are responsible for coordinating team efforts and communications relating to implementation of the Incident Response Plan.

Incident Reporting

When a possible security incident is discovered, the following will occur:

1. Upon discovery of a confirmed or potential security threat or policy infraction, Chestnut staff members are required to report it to the Security Officer or other senior IT staff via pre-established security incident reporting procedures.

2. When a Security Incident affects electronically stored information collected, stored or otherwise held by Chestnut as part of a contractual relationship with another entity, Chestnut shall notify that entity in the event that the security incident has led to a breach of the security of that information. In the event of a breach of PHI, Chestnut will notify the entity in compliance with breach notification requirements.

Incident Response Plan

The Security Officer will maintain an Incident Response Plan for use during serious security events. Elements of that plan will include:

- Investigation of all security incidents and security policy violations, determining potential causes, recommendation of remediation measures, and incident documentation.
- Determination if unauthorized disclosure of PHI, data loss or corruption, or other negative outcome occurred. Remediation measures will be taken to mitigate the effects of the security incident to the extent possible and appropriate.

If an unauthorized disclosure of PHI has occurred, the Privacy Officer or designee shall be consulted, if appropriate, and Chestnut policies concerning mitigation of violations of privacy policies shall be followed. The Security Officer or designee may take any action deemed reasonably necessary to stop a presently occurring or imminent security incident or violation, including the immediate suspension of a workforce member's access to the information system(s). Where appropriate, the Security Officer, Compliance Officer, Director of IT, or their respective designee will refer the matter to Human Resources for follow-up, including the imposition of any discipline or sanctions that may be warranted.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 800 Special Systems Management		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 800 SPECIAL SYSTEMS MANAGEMENT

Other information, telecommunications, and related systems not explicitly noted in other ISS policies may also be managed by IT. Where applicable, the Director of IT and his/her designee(s) will provide for the management and documentation of such systems. IT will communicate internal policies and procedures to ELC members, department managers, and staff as deemed necessary by the Director of IT.

In instances where Chestnut uses cloud-based systems, department managers may be responsible for administration, account management, and support. In such cases, IT will provide assistance and/or oversight of these systems as determined by the Director of IT.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1000 Staff Appropriate Use		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 800-840		
Citation(s):			

ISS 1000 STAFF APPROPRIATE USE

Chestnut Health Systems policies and procedures for appropriate staff use of electronic / computing systems are located in PP 800 – 840 of the Personnel Policies Handbook.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1100 Electronic Device Management		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 800-840		
Citation(s):			

ISS 1100 ELECTRONIC DEVICE MANAGEMENT

Chestnut Health Systems, Inc. ("Chestnut") recognizes that certain job functions require that some employees be accessible when away from the office or during times outside scheduled working hours. For this reason, Chestnut may provide, solely at Chestnut's discretion, either (a) the option of secure email access for select employees from personally-owned devices securely managed by technologies and procedures established and administered by Chestnut's IT Department from time to time, or (b) assignment of Chestnut-owned devices to select employees. For purposes of this policy, the term "device" is defined as any handheld or wearable electronic device with the ability to receive and/or transmit voice, text, or data messages without a cable connection (including but not limited to smartphones, other cellular telephones, tablets, or other similar digital devices).

When using any device for business purposes, staff is expected to comply with all applicable Management of Information/Appropriate Use policies, set forth at Personnel Policies 800 through 840.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1101 Chestnut Owned Devices		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1101 CHESTNUT-OWNED DEVICES

Chestnut expects Chestnut-owned devices to be primarily used for business purposes. Chestnut also expects that a device be in the sole possession of the employee assigned to the device. If an employee's job responsibilities change and the device is no longer needed, the device must be returned to the employee's supervisor who will then forward it to IT Department for reissue or disposal.

All employees with Chestnut-owned devices must be aware of and comply with all local, state and national laws regarding usage, including those related to safe driving. Employees are expected to exercise reasonable care with regard to securing Chestnut equipment and minimizing risk of theft, damage, and data breach away from the office. Chestnut equipment of all kinds should not be left unattended whenever possible; staff are advised not to leave laptops, cell phones, and other devices in vehicles overnight or in high-risk locations.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1102 Eligibility and Approval		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1102 ELIGIBILITY AND APPROVAL

Managers may request a Chestnut-owned device for an employee by formally providing a written request to his/her Executive Leadership Council ("ELC") member or the ELC members designated department directors. The ELC member (or appropriate management designee) will then submit a written recommendation and justification to the Director of IT for review and approval. If approved, the Director of IT will either (a) designate an appropriate device from IT reserve for assignment, or (b) forward all approved device purchase requests to the Purchasing Department, which will then place all orders for the device and accessories with the contracted vendor and take delivery of the equipment. The IT Department will activate and configure the device and then contact the employee when the equipment arrives and provide the necessary orientation and training.

Chestnut-owned devices may be assigned to employees, provided that the following criteria are met:

1. Smartphone approval criteria:
    a. A business case need is established by one of the following:
        i. Electronic medical record or other critical system access in the field is needed (requiring tethering for cell data access); or
        ii. Other business need is identified and approved by Director of IT and/or CFO.
    b. Employee's personal smartphone plus email "container" application is determined to be insufficient for business need, or employee lacks an appropriate device and/or data plan; and
    c. ELC member approval.

Simple convenience is not a criterion for a Chestnut-owned device.

Requests for tablets or larger than standard cellular devices must be submitted in writing by ELC members, including specific justification of business need. The Director of IT and CFO will consult with the requesting ELC member and approve or deny the request.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1103 Cellular Service Vendors		
Revision Date:	03/29/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1103 CELLULAR SERVICE VENDORS

Chestnut may, in its discretion, enter into contracts with cellular telephone service providers. During the period when one or more of these contracts are in force, Chestnut will only purchase cellular telephones or cellular telephone service agreements for employee use on the basis of these contracts, unless a specific exception is granted by the CFO. The chosen plan(s) will be monitored and adjusted as appropriate should needs change and also to ensure that Chestnut is participating in the most efficient plan. All staff with a Chestnut-owned device are expected to cooperate with Chestnut in the administration of such contracts, including any changeovers.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1104 Personal Calls		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1104 PERSONAL CALLS

Chestnut expects Chestnut-owned devices to be primarily used for business purposes with limited personal use. Any excessive data or calling overage, long distance, roaming or other charges incurred by Chestnut as a result of an employee's personal use of a company-owned device shall be the responsibility of the employee.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1105 Other Restrictions		
Revision Date:	03/29/2018		
Applies To:	☒Employees ☐Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1105 OTHER RESTRICTIONS

An employee may not operate a personal business from a Chestnut-owned device.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1106 Handsets, Features and Accessories		
Revision Date:	06/29/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1106 HANDSETS, FEATURES AND ACCESSORIES

An employee wishing to have additional features or accessories for their Chestnut-owned device must have written recommendation and justification from their supervisor or ELC member, which must be submitted to the Director of IT for review and approval. The Director of IT will then forward all approved requests to the Purchasing Department for purchase and issuance.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1107 Damage, Loss or Theft		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1107 DAMAGE, LOSS OR THEFT

Any Chestnut-owned device damaged in the course of business should be returned to the IT Department. The IT Department will contact the vendor for replacement or repair.

Staff should take adequate precautions to safeguard electronic devices from loss or theft. Lost or stolen devices should be immediately reported to the employee's supervisor and the IT Department so the service can be cancelled. Chestnut reserves the right to charge the employee for devices that are damaged or lost due to negligence.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1108 Usage Monitoring		
Revision Date:	03/29/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1108 USAGE MONITORING

A review of Chestnut-owned device usage will be conducted periodically, including but not limited to a review of data and voice usage, number of calls and compliance with applicable policies and procedures. Termination of a Chestnut-owned device may result due to, for example, low usage or violations of policies and procedures.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1109 Removal of Devices		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1109 REMOVAL OF DEVICES

All Chestnut-owned devices are the property of Chestnut. As such, any Chestnut-owned device may be removed from an employee's possession at any time. The Director of IT and CFO have the final authority to terminate Chestnut-owned devices. The supervisor will be notified if the device is planned to be removed from an employee's possession.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1110 Employee Termination		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1110 EMPLOYEE TERMINATION

Upon termination of employment at Chestnut, an employee with a Chestnut-owned device is responsible for returning their device and any accessories to their supervisor. The supervisor is then responsible for forwarding the device and any accessories to the IT Department for reissue or disposal.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1111 Personal Purchases		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1111 PERSONAL PURCHASES

Where offered and available, employees may take advantage of Chestnut's contracted rates to establish personal accounts. Such personal accounts will be in the employee's name, all charges will be the responsibility of the employee, and all invoices will be sent directly to the employee's billing address.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1112 Personally-Owned Devices		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	BYOD Program Terms and Conditions		

ISS 1112 PERSONALLY-OWNED DEVICES

Chestnut may permit approved members of Chestnut's workforce to participate in Chestnut's "Bring Your Own Device" (BYOD) Program (each, a "Participant"). When approved by the Director of IT/Security Officer and the applicable ELC member or designee, this BYOD Program allows a Participant to use their personal electronic device(s) (iOS or Android) for corporate purposes, when managed by Chestnut, in order to accommodate a Participant's job responsibilities. Each Participant must (a) comply with BYOD Program Terms and Conditions and all other applicable Chestnut policies, including without limitation, Chestnut's privacy and security policies, in effect from time to time, and (b) agree to use a third party application installed on a Participant's personal electronic device(s) to access Chestnut-owned resources, such as email, calendars, contacts, and other systems and/or data as designed by Chestnut and/or Chestnut's IT Department.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1113 Bring Your Own Device (BYOD) User Agreement		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	BYOD Program User Agreement		

ISS 1113 BYOD USER AGREEMENT

As a condition of participation in the BYOD Program, a Participant must sign a user agreement maintained by the IT Department. This policy specifically refers to email access via Chestnut-approved applications which may store corporate email on the device. Without a signed user agreement, Chestnut email access via a personal smartphone will be terminated and Chestnut email will be removed from such device. Alternate email access may be separately allowed via other means provided securely by IT. All access must be approved by applicable Leadership Council (LC) members and the Director of IT. Use of 2-factor authentication solutions managed by IT may be required.

An employee who is assigned a Chestnut-owned device must access his/her Chestnut email from that device ONLY (i.e., the user cannot also have Chestnut email access from a personal device), unless approval has been given by the Director of IT.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1114 BYOD IT Security Management		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1114 BYOD IT SECURITY MANAGEMENT

The IT Department will approve and administer software (mobile device management (MDM) and/or email client software) used to securely access Chestnut email on personally-owned devices. Remote email, VPN, or other remote access will be restricted to approved employees ONLY.

Any exceptions to these rules must be approved by the Director of IT and/or Security Officer who will consult with appropriate ELC members as needed.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Information Systems and Security		
Policy Name and Number:	ISS 1115 Artificial Intelligence		
Revision Date:	08/21/2024		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

ISS 1115 ARTIFICIAL INTELLIGENCE

The purpose of this policy is to provide guidelines for the deployment and use of Artificial Intelligence (AI) technologies within our organization. This policy aims to ensure that AI is used in a responsible manner and will prioritize the safety and security of AI systems. This includes ensuring that AI technologies provide protection against unintended exposure of protected health information (PHI), staff / patient privacy data, as well as corporate proprietary and financial data. This AI policy supplements existing Chestnut information use and privacy policies and does not supersede any existing standards.

Chestnut recognizes that the use of AI tools can potentially assist employees with the performance of their job duties. However, there are many risks associated with this new technology. To ensure the protection of confidential information and the integrity of our operations, there will be clear lines of accountability for the development, deployment, and use of AI. All employees who wish to use AI tools must receive management approval and, if granted, comply with best known practices.

Evaluation of AI tools. Employees must evaluate the utility and security of any AI tool before using it. This includes reviewing the tool's security features, terms of service, and privacy policy. Employees are to also review the reputation of the tool developer and any third-party services used by the tool. Employees must receive first level approval by their Executive Leadership Council member prior to using any AI tool after explaining the way it will be used and the benefits to Chestnut. The approval will then be forwarded to the Director of Information Technology for final review, written approval (or disapproval), and record keeping.

Protection of confidential data. In using any AI tool, employees must not upload or share any confidential, proprietary, or protected data without prior written approval from first their Executive Leadership Council member and then by the Director of Information Technology . This includes data related to clients, employees, or partners. Similarly, employees must ensure that any AI tool does not utilize confidential or copyrighted information of a third party. The highest priority will be given to protect the privacy, data, and the rights of individuals in the use of AI technologies. Data collection, processing, and storage will be done in accordance with applicable Chestnut policies, laws, and regulations. Proper consent will be obtained

when required, and data will only be used for legitimate purposes. Staff will ensure that data is adequately protected against unauthorized access or misuse.

Access control. Employees must not give access to any AI tools approved for business use to anyone outside the company without prior approval by the Director of Information Technology and implementation of processes as required to meet security compliance requirements. This includes sharing login credentials or other sensitive information with third parties which is strictly forbidden.

Compliance with security policies. Employees must apply the same security best practices used for all company and client data. When applicable, this includes using strong passwords, keeping software up-to-date, and following Chestnut's data retention and disposal policies. All AI use must comply with applicable laws, regulations, and industry standards. This includes but is not limited to data protection, privacy, intellectual property, and employment laws.

Human Oversight and Decision-making. While AI can automate certain tasks, human oversight and decision-making will always be prioritized. Humans will have the ability to intervene, question, and override AI decisions, when necessary, especially in critical or sensitive areas.

Chestnut Health Systems

Marketing and Communications

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 310 Marketing		
Revision Date:	08/23/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MC 310 MARKETING

These Marketing and Communications Policies apply to all aspects of Chestnut Health Systems ("Chestnut") and all marketing and communications activities concerning any of its programs, divisions, and service lines.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 312 Placement of Advertising		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 840 – Social Media Policy MC 315 – Branding Guidelines		
Citation(s):			

MC 312 PLACEMENT OF ADVERTISING

All Chestnut advertising will be placed exclusively by the Marketing and Communications Department. This includes advertising in any medium or form, including without limitation, print, radio, television, billboard, digital, and social media. The Marketing and Communications Department shall also have the exclusive authority to publish special service announcements and community education pieces. The Marketing and Communications Department shall ensure that any advertising is consistent with Chestnut's branding guidelines, pursuant to MC 315.

Social media activity shall be governed by PP 840 titled, "Social Media Policy."

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 314 Promotional Items		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	MC 315 – Branding Guidelines		
Citation(s):			

MC 314 PROMOTIONAL ITEMS

All promotional and/or marketing items bearing Chestnut's name and/or logo, including those of any of its programs, divisions, or service lines, must be ordered through the Marketing and Communications Department. To the extent possible, the Marketing and Communications Department shall ensure such items' consistency with Chestnut's branding guidelines, pursuant to MC 315.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 315 Branding Guidelines		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MC 315 BRANDING GUIDELINES

The Marketing and Communications Department shall develop, maintain, and make available on Chestnut's Intranet site corporate-wide branding guidelines. It shall be the exclusive responsibility of the Marketing and Communications Department to create and maintain all Chestnut logos, including those for any of its programs, divisions, and service lines, and the use of logos shall be included in Chestnut's branding guidelines. Any and all printed Chestnut materials, including without limitation, media materials, advertising materials, brochures, newsletters, trainings, presentations, and promotional items, must be generated in accordance with such branding guidelines. The Marketing and Communications Department shall review and approve all such materials prior to use to ensure same.

All client company logos and branding guidelines must be requested and maintained by the Marketing and Communications Department. Any request for co-branding must be reviewed and approved by the Marketing Department in advance.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 316 Media Materials		
Revision Date:	08/23/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	MC 315 – Branding Guidelines MC 318 – Respecting Copyrights PP 220 – Proprietary Information MC 320 – Communications with the Media		
Citation(s):			

MC 316 MEDIA MATERIALS

All materials disseminated or communicated to the media, including without limitation, press releases, community education pieces, media advisories, photos, and videos, must be created by or at the direction of the Marketing and Communications Department, and subsequently approved by Chestnut's Director of Marketing and Communications prior to dissemination or communication. At the direction of Chestnut's Director of Marketing and Communications, the Marketing and Communications Department will be responsible for distribution to media contacts, including any newspaper, magazine, radio station, television station or online media outlet. When possible, the Director of Marketing and Communications shall provide to the Chief Executive Officer and Chief Operating Officer an advance copy of each press release or media advisory prior to dissemination.

All media materials must be prepared consistent with Chestnut's branding guidelines, in accordance with MC 315. In addition, all media materials must obey applicable copyright laws, in accordance with PP 318. Further, no media materials shall reveal any of Chestnut's proprietary information without the written authorization of Chestnut's Chief Executive Officer or Chief Operating Officer. Communications with the media shall be governed by MC 320 titled, "Communications with the Media."

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 317 Marketing Materials		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 220 – Proprietary Information MC 315 – Branding Guidelines MC 318 – Respecting Copyrights		
Citation(s):			

MC 317 MARKETING MATERIALS AND FORMS

All print and electronic marketing materials concerning Chestnut, and any of its programs, divisions or service lines, must be approved by the Marketing and Communications Department prior to final printing and dissemination, publication, or communication. The format of all Chestnut forms must also be approved by the Marketing and Communications Department. The Marketing and Communications Department is responsible for ensuring that all marketing materials and forms are prepared in accordance with Chestnut's branding guidelines, consistent with MC 315, and that copyrights are respected, consistent with MC 318. Further, no marketing materials or forms shall reveal any of Chestnut's proprietary information without the written authorization of Chestnut's Chief Executive Officer or Chief Operating Officer.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 318 Respecting Copyrights		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 220 – Proprietary Information		
Citation(s):			

MC 318 RESPECTING COPYRIGHTS

Third party information (i.e., information not owned, created, or directly made available by Chestnut) may include copyrighted material. This includes, without limitation, third party information made available in print or on the Internet and includes text, photographs and graphics, charts and graphs, music, etc. Therefore, reproduction of any third party information may only be done with the express written permission from the author or copyright holder. The Marketing and Communications Department must review and keep on file such written permission and review and approve the proposed reproduction prior to dissemination, publication, or communication.

In accordance with PP 220, all proprietary materials developed by Chestnut must contain a copyright notice. The Marketing and Communications Department will provide appropriate language and approval for use.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 320 Communication with the Media		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RM 10 – Emergency Communications		
Citation(s):			

MC 320 COMMUNICATION WITH THE MEDIA

Any and all communications with the media must be approved in advance by Chestnut's Director of Marketing and Communications. When possible, the Director of Marketing and Communications shall notify the Chief Executive Officer and Chief Operating Officer of any media inquiry received and of any scheduled communication with the media.

No Chestnut staff member is permitted to proactively pursue media interviews, news stories, or other relations with the media without the direct involvement of the Marketing and Communications Department. In all such cases, communications with members of the news media require prior notification to and approval by the Director of Marketing and Communications.

Any staff member participating in a panel discussion, public meeting, social media presentation, or other forum to which the media have been invited or are expected to attend shall notify the Marketing and Communications Department in advance.

Any Chestnut staff member contacted by the media shall refrain from providing any comment or information and shall immediately contact the Marketing and Communications Department. Interviews with the media, whether by staff members, clients, patients, or administrators, are at the discretion of and with input by the Director of Marketing and Communications.

The Marketing and Communications Department shall obtain and electronically store signed release forms from employees, patients and clients consenting to media interviews, photographs, and/or videotaping.

No Chestnut staff member may provide interviews on potentially negative, adverse, or controversial topics, including crisis situations, or articulate a position on Chestnut's behalf, without the express authorization of Chestnut's Director of Marketing and Communications. Crisis communications policies can be found in RM 10 titled, "Emergency Communications."
Staff members may engage with the media as private individuals on their personal time and on topics unrelated to their job duties. However, they must make it clear that their views do not represent the views of the organization and must not identify themselves as employees of the organization.

Staff members who are scheduled to speak to the media on behalf of the organization must meet with the Marketing and Communications Department in advance of the interview to ensure they can effectively communicate key messages and represent the organization's interests appropriately.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 330 External Meetings		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MC 330 EXTERNAL MEETINGS

Chestnut relies on the work of State government. As such, from time to time it is appropriate to meet with local legislators. Staff shall abide by the following whenever a meeting is proposed with a local legislator:

- Proposed meetings with local legislators in and around the Central Region require prior notification to and approval by the Chief Operating Officer via email at least forty-eight (48) hours in advance of the proposed meeting.
- Proposed meetings with local legislators in and around the Southern Region require prior notification to the Chief Executive Officer, the Chief Operating Officer, the Chief Financial Officer, and the Chief Clinical Officer via email as soon as possible, but no later than twenty-four (24) hours prior to the proposed meeting. Such notification shall include the purpose of the meeting and the names, titles, and business affiliations of meeting attendees.

External partnerships and collaborations are cornerstones of the work Chestnut does. In order to avoid duplication of efforts and to ensure external messaging remains consistent, staff shall use best efforts to inform their ELC member of material meetings with external parties (including without limitation, representatives of local government, health care providers, health and human service providers, community agencies, and other community players) and outcomes thereof. ELC members shall then apprise corporate officers as they deem appropriate`.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 340 Communication Material Management		
Revision Date:	08/23/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MC 340 COMMUNICATION MATERIAL MANAGEMENT

Copies of all materials created by or for Chestnut or any of its programs, divisions, or service lines, will be maintained in a central electronic storage area by the Marketing and Communications Department. These items include but are not limited to items created for client companies, brochures, websites, community education, and the like. All materials will be delivered to the Marketing and Communications Department in their original (working) electronic format or in a format requested by the Marketing and Communications Department.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Marketing and Communications		
Policy Name and Number:	MC 350 All-Staff Communications		
Revision Date:	08/25/21		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MC 350 ALL-STAFF COMMUNICATIONS

It may be necessary to occasionally communicate with all Chestnut staff members, with all Chestnut staff members in a given geographic region, or with all Chestnut staff members at a given location. Such communications would serve purposes including, but not limited to communicating emergency or safety information and providing updates on policies, procedures, or deadlines that impact the entire workforce, all employees in a specific geographic region, or all employees in a specific location. Such communications should be sent using the email list serves that exist within Microsoft Outlook and/or the EZText platform. Any all-staff communication should be sent with the knowledge and input of the appropriate ELC member and prior approval by one of the following: Chief Executive Officer, Chief Operating Officer, Chief Clinical Officer, or Chief Financial Officer.

Chestnut Health Systems
Mission and History

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Mission and History		
Policy Name and Number:	MH 1 Introduction to the Policy Handbook		
Revision Date:	8/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MH 1 INTRODUCTION TO THE POLICY HANDBOOK

Chestnut Health Systems' ("Chestnut") Policy Handbook is a resource for all Chestnut staff. The Policy Handbook is a compilation of corporate-wide policies, including the Personnel Policies.

There are several sections in the Policy Handbook. All staff are expected to be familiar with the Personnel, Management of Information, Safety, and Quality Management sections. Staff are also expected to be familiar with those sections that apply to their specific job functions. For example, those staff who have client contact should be familiar with sections such as Organizational Ethics, Client Rights, Clinical Services, Medical Services, and Risk Management.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Mission and History		
Policy Name and Number:	MH 10 Mission Statement		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MH 10 MISSION STATEMENT

Chestnut is dedicated to "Making a Difference: Improving Quality of Life Through Excellence in Service".

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Mission and History		
Policy Name and Number:	MH 20 Vision Statement		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MH 20 VISION STATEMENT

Chestnut will be a leader in the development and delivery of superior health and human services.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Mission and History		
Policy Name and Number:	MH 30 Chestnut's Values		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MH 30 CHESTNUT'S VALUES

Our clients, patients, and employees

Integrated care

Quality and safety

Health equity and fairness

Strength through diversity and inclusion

Communication and transparency

Innovation and strategic growth

Collaboration

Continuous Learning

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Mission and History		
Policy Name and Number:	MH 35 Chestnut's Recovery Values		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MH 35 CHESTNUT'S RECOVERY VALUES

Chestnut believes that recovery is possible for everyone and is a process strengthened through these essential values: Hope, Empowerment, Health and Wellness, Respect, and Spirituality and Connectedness.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Mission and History		
Policy Name and Number:	MH 40 Historical Overview		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MH 40 HISTORICAL OVERVIEW

Chestnut is a multidisciplinary health and human services agency and research institute with five service lines:

- Substance use disorder prevention and treatment
- Mental health treatment
- Primary care
- Housing and supportive services
- Applied research, training, and consultation

Chestnut is a private, not-for-profit corporation whose governing body is a volunteer Board of Directors. Chestnut was founded in 1973 by concerned citizens from McLean and Livingston Counties in Illinois. Functioning as a "drop-off" center (i.e. an alternative to incarceration for chronic substance users) Chestnut got its start in a small rented house on Chestnut Street in Bloomington, Illinois. The house was remodeled and maintained through the efforts and contributions of volunteers and benefactors who cared about individuals and families suffering from the destructive impacts of substance use. Clients dubbed the building as "Lighthouse."

Since its creation, Chestnut has remained dedicated to providing evidence-based substance use treatment to all in need regardless of race, color, religion, creed, gender identity, national origin, age, disabilities, marital or veteran's status, sexual orientation, the ability to pay or any other legally protected status.

Chestnut's substance use treatment has evolved from that "drop-off" center for those living with chronic alcohol and drug use to one of the finest comprehensive substance use disorder, mental health, and primary care treatment providers in a non-hospital setting in Illinois. Chestnut has grown into a diversified dynamic leader in the field of health and human services and the development of human potential. The following is an overview of Chestnut's evolution.

1973 Chestnut began in a small, rented, Victorian house and was known as McLean County Alcohol and Drug Assistance Unit, Inc. (MCADAU) and came to be called "Lighthouse."

1975 Lighthouse was accredited by the Joint Commission on Accreditation of Hospitals under the original Alcoholism Program Standards.

1978 Lighthouse moved to a single-story ranch-style facility at 702 West Chestnut Street in Bloomington, IL, with four detoxification beds and 16 rehabilitation beds.

1980 Employee Development Associates was created as a division of Lighthouse to offer employee assistance services to Central Illinois employers.

1985 Chestnut built a second facility at 702 West Chestnut to house 20 adolescent beds as well as outpatient client and administrative services.

1986 Lighthouse Institute ("LI") was founded to support training, research, and publication.

1988 Family Counseling Center of McLean County merged with Chestnut, expanding Chestnut's behavioral health treatment offerings into the field of outpatient client mental health services. Chestnut added a third building at 720 W. Chestnut Street.

1990 Chestnut built a 20-bed adolescent treatment center in Maryville, Illinois.

1992 A new 39,000 square foot corporate office and treatment facility with a capacity of 60 beds was built at 1003 Martin Luther King Jr. Drive in Bloomington. It housed adult treatment, including four social setting detoxification beds, 32 rehabilitation beds, and 14 extended care beds.

Bloomington adolescent services added the 16 beds vacated by the adult program to double its capacity.

Lighthouse Institute opened an office in Chicago to manage research projects in the greater metropolitan area.

1993 An addition to the Maryville treatment facility created a 20,000 square foot, 40-bed youth facility.

1994 Chestnut, in collaboration with Fayette Companies of Peoria, created a joint venture Limited Liability Company, Advantage Behavioral Health, to provide employee assistance and managed behavioral care products to public and private clients.

1996 Chestnut acquired PIASA Health Care, established in 1971 as the Madison County Council on Alcoholism and Drug Abuse. PIASA was an outpatient client chemical dependency treatment agency with offices in Alton, Collinsville, Wood River, and Granite City, Illinois. PIASA offered prevention, adolescent and adult outpatient and intensive outpatient services, and women's treatment.

Chestnut acquired the MetroCentre for Life Management in Madison County. MetroCentre for Life Management began in a small office in Granite City, Illinois in 1960. It offered individual, group and family counseling services, mental health services, prevention, day treatment, crisis intervention, supported living, case management, and psychosocial rehabilitation programs.

The Bloomington mental health component (Family Counseling Center of McLean County) changed its name to Counseling, Psychiatric and Family Services (CPFS), and moved to newly remodeled leased space in the east side of Normal to accommodate additional growth.
Chestnut opened an office in Decatur, Illinois, to provide outpatient chemical dependency and mental health services including employee assistance services.

Chestnut, in collaboration with Center Point and Prairie Health Systems of Champaign, created a joint venture Limited Liability Company, Employee Assistance Services (EAS).

Chestnut, in collaboration with Mental Health Centers of Central Illinois, an affiliate of Springfield Memorial Hospital, created a joint venture Limited Liability Company, Memorial Employee Assistance Services.

Employee Development Associates moved to a leased building at 719 West Chestnut Street. The Maryville facility was expanded to include outpatient mental health and psychiatric services.

The Granite City Northgate facility expanded, allowing consolidation of Chemical Dependency services at the facility and the sale of the former PIASA property in Alton, Illinois.

2000 Youth services moved to 1003 Martin Luther King Jr. Drive and adult services moved to 702 West Chestnut, both in Bloomington.

Chestnut began a crisis intervention program through funding by the Illinois Office of Mental Health. The program provided a 24-hour emergency phone line, walk-in crisis services, outreach, short-term counseling, psychiatric consultations, and referrals.

Chestnut's workplace services division began offering international employee assistance programs.

2001 A 10,000 square-foot outpatient services and activity center, including a gymnasium, wasbuilt at the King Drive campus.

In Granite City, Illinois, Chestnut began offering the only medically managed detox program integrated with a psychiatric crisis stabilization program in the state.

Chestnut Housing Solutions, Inc. and Chestnut Mainstay, L.P., were formed to establish additional housing in the southern region for persons living with mental illness.

2002 Chestnut constructed a 39,000-square-foot addition to King Drive campus for counseling and family services, workplace services, and administrative offices. The building enabled Chestnut to discontinue leasing three locations in Bloomington-Normal.

The state Office of Mental Health and the Mental Health Board of St. Clair County asked Chestnut to take over services for persons with chronic and persistent mental illness from Mid-America Behavioral Health. Chestnut began offering services to St. Clair County residents on July 1, from leased space in Belleville.

The detox program in Granite City switched from medically-managed to clinically-managed.

Chestnut opened a 12-unit housing facility in Granite City for persons living with mental illness. The U.S. Department of Housing and Urban Development (HUD) provided partial funding.

2003 Chestnut purchased and remodeled a building in Belleville to relocate mental health services from rented space.

Lighthouse Institute's GAIN Coordinating Center (GCC) was created.

2005 The program formerly known as Employee Assistance and Workplace Services became a wholly owned subsidiary of Chestnut Health Systems and was re-named Chestnut Global Partners, LLC.

Chestnut Madison Recovery, LP, was created as a subsidiary of Chestnut Housing Solutions, Inc. to establish additional housing in the southern region for persons living with mental illness.

Chestnut Global Partners, LLC, formed an equity joint venture, Psychcn-Chestnut Global Partners, Inc., in Beijing, China with Psychcn Technology Development Co., Ltd. and Xinyueyinhe Culture Development Co., Ltd.

Chestnut added a 16-bed, 24-hour supervised housing program in Fairview Heights, Illinois.

Chestnut was awarded funds from HUD for the Families in Safe Recovery Program in the southern region to provide housing and supportive services to 10 dually-diagnosed homeless/disabled women and their children.

Chestnut secured HUD Shelter Plus Care housing vouchers for 16 persons living with mental illness in St. Clair County.

Chestnut Global Partners, LLC, formed a Brazilian limited liability company known as Chestnut Global Partners do Brasil, LLC.

Chestnut Health Systems created Chestnut Resolutions, Inc., a not-for-profit corporation to accept HUD 811 funding for additional housing for persons living with mental illness in the southern region.

Chestnut relocated the Lighthouse Institute staff from leased space on North Wells Street to leased space at 221 Walton Street in Chicago.

2007 Chestnut Global Partners, LLC, purchased interest in Solutions Latin America, a Brazilian Limitada, in Sao Paulo, Brazil.

Chestnut's central prevention office received a three year grant as administrative body for the Bloomington-Normal Community Campus Committee (BNCCC).

Lighthouse Institute was awarded a five year technical assistance contract from the Center for Substance Abuse (CSAT)/DHHS to support 17 grant programs across the country, funded under the Assertive Adolescent and Family Treatment (AAFT) grant program.

Lighthouse Institute was awarded a five year grant from the National Institute on Drug Abuse (NIDA) to test the effectiveness of a re-entry model that provides quarterly recovery management checkups.

2008 Chestnut, with representatives of the Samaritano Hospital, the Sao Paulo Secretary of Health, and Vila Serena (Brazil Treatment Center), created a consortium to deliver substance use treatment services to youth in Sao Paulo, Brazil. Renovation of a facility to serve 30 adolescent males was completed in late 2008 at Recanto Maria Theresa, a partner hospital.

A family center opened in Wood River, Illinois for participants in Chestnut's Families in Safe Recovery and Women's Recovery Housing programs.

The Health Ministry of Quebec recognized the Global Assessment of Individual Needs (GAIN), developed by Lighthouse Institute, as an evidenced-based practice and negotiated with Chestnut to translate the GAIN into French.

Chestnut's Road Home program was awarded six sponsor-based Shelter Plus Care rental assistance vouchers through a five year grant from the U.S. Department of Housing and Urban Development (HUD). The program also provides rental assistance to individuals who are chronically homeless and have a mental illness.

Chestnut celebrated its 35th anniversary.

Chestnut Global Partners, LLC, joined with Dr. Alexander David Shtoulman, Baron Konstantin von Vietinghoff-Scheel and Harris, Rothenberg International, LLC to form Corporate Health, LLC in Moscow, Russia.

2010 Chestnut Global Partners, LLC, formed Employee Assistance Solutions, Inc., forming CGP Employee Assistance Solutions of India Private Limited in New Delhi, India.

Metroeast Behavioral Health (MBH) was established in Belleville, Illinois. Services include psychiatric evaluation, counseling and therapy, and medication assisted treatment (MAT) for persons with an opiate addiction.

2011 Chestnut Global Partners, LLC, and Solutions Latin America, SA, merge to form Mind Solutions S.A. in Rio de Janeiro, Brazil.

Chestnut opened an adolescent recovery home for males ages 13-20 in the central region at the King Drive campus.

2012 Chestnut was awarded a federal grant and designation as a federally qualified health center (FQHC) and opened Chestnut Family Health Center ("CFHC") at 720 W. Chestnut St. CFHC delivers medical services to medically-underserved residents of McLean County.

Expansion and renovation of the Northgate facility in Granite City was completed.

2013 Chestnut celebrated its 40th anniversary.

Chestnut Global Partners, LLC, opened a branch office in Brussels, Belgium.

Chestnut Global Partners, LLC, formed Chestnut Global Partners of Mexico, S.A. de C.V., in Mexico City, Mexico.

Chestnut, together with six other Illinois providers, formed Illinois Behavioral Health Home Coalition, LLC, a behavioral health home care coordination model that provides behavioral health and social services to persons who are disabled.

2014 Chestnut Global Partners, LLC, became a 50 percent owner in CGP Central Europe Korlátolt Felelősségű Társaság, located in Budapest, Hungary.

CGP Employee Assistance Solutions of India Private Limited in New Delhi, India, admitted as a partner Nobby Nazareth Associates Pvt. Ltd.

2015 Chestnut Family Health Center, with 23 other federally qualified health centers, formed CHC Access Partnership, LLC.

Chestnut opened a 14-bed crisis stabilization unit and medically monitored detox center on its King Drive campus.

Chestnut received a federal grant for a second FQHC site in Granite City, Illinois.

2016 Chestnut Global Partners China opened its second office in Shanghai, China.

2017 Chestnut relocated its adolescent substance use treatment program from Bloomington, Illinois, to consolidate all adolescent SUD treatment in Maryville, Illinois.

Chestnut sold Chestnut Global Partners, LLC, including Chestnut Global Partners, LLC's equity interests in all international and domestic joint venture companies but one, to Morneau Shepell Limited, the U.S. subsidiary of Toronto-based Morneau Shepell. Chestnut maintained ownership of Chestnut Global Partners of Mexico, S.A. de C.V.

Chestnut Mainstay Center, LP was terminated and all Mainstay assets were assumed by Chestnut.

2018 Chestnut, with 29 other Illinois behavioral health organizations, purchased an equity interest in ProviderCo, LLC.

2019 Chestnut combined, renovated and expanded both of its buildings located at 702 W. Chestnut St. in Bloomington to create a state-of-the-art 32,000 square foot facility. CFHC relocated to this facility from its 6,000 square foot space at 720 W. Chestnut St. in Bloomington.

2020 Chestnut was awarded a federal grant to become a Certified Community Behavioral Health Center (CCBHC) in the Southern Region.

2022 Chestnut discontinues Chestnut Credit Counseling Services.

2023 Chestnut was awarded a federal grant to become a Certified Community Behavioral Health Center (CCBHC) in the Central Region.

2023 – Maryville facility reopens as an adult residential treatment facility, 24-hour crisis and detox services, and family health services.

2023 – Chestnut celebrates its 50th anniversary with celebrations across the regions.

2024 – Added dental services at 702 W. Chestnut

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Mission and History		
Policy Name and Number:	MH 50 The Chestnut Health Systems Treatment Philosophy		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

MH 50 THE CHESTNUT HEALTH SYSTEMS TREATMENT PHILOSOPHY

Chestnut is committed to strategic initiatives that create a comprehensive delivery system integrating behavioral health care, primary health care, and wellness.

Chestnut's treatment philosophy is based on the premise that alcoholism, substance use, and mental illness, often correlated with physical health issues, are treatable health problems and that recovery is possible for everyone. Further, it is Chestnut's intention that the client be treated in the least restrictive environment, as determined by professional staff, for the client to have a reasonable likelihood of success. It is also Chestnut's belief that the needs of youth and adult clients, and those with a variety of concerns, frequently differ. Consequently, services for these different populations are best provided in appropriate facilities staffed by professionals with appropriate training and interests.

Chestnut's clinical services have their theoretical foundation in a combination of learning theory concepts, counseling theory concepts, and effective interpersonal counseling methods. The major counseling theories drawn upon are Rogerian, Cognitive Modification, Behavioral, Rational Emotive, Family Systems, Reality, Brief/Solution-focused, Community Reinforcement Approach, and Motivational Interviewing. In addition, psychopharmacologic interventions are utilized for those clients assessed as appropriate. Along with these concepts and methods, an understanding of, and participation in, established self-help groups and support groups is encouraged.

Chestnut's mental health programs are committed to providing accessible effective prevention and intervention services regardless of a person's ability to pay. Through the provision of a broad range of behavioral health services, Chestnut strives to promote mental health and improve the quality of life for citizens and for the community at large.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Mission and History		
Policy Name and Number:	MH 60 Corporate Relationships		
Revision Date:	06/25/2014		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Corporate Relationships Chart		

MH 60 CORPORATE RELATIONSHIPS

Chestnut values collaborations and its relationships with other organizations. The Corporate Relationships chart provides an overview.

Chestnut Health Systems
Personnel Policies

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CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 20 Disclaimer		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CSB 640 – Board Approval of Policy Handbook CSB 650 – Board Approval Procedures		
Citation(s):			

PP 20 DISCLAIMER

The Personnel Policies contained herein were adopted by the Board of Directors of Chestnut Health Systems, Inc. ("Chestnut") on August 25, 2021, and supersede previous policies. They are reviewed, in part or as a whole, to insure that they continue to reflect current thinking in the field of human resource management and are consistent with current trends and legislative requirements. The policies contained herein are intended as a guide for benefits and general information to assist employees during employment. Nothing in the Policy Handbook or any Personnel policy is intended to create a contract between Chestnut and any employee, or otherwise change the at will nature of the employment relationship. These policies are subject to change at the discretion of the Board of Directors of Chestnut.

At the sole discretion of Chestnut's leadership team, from time to time there may be a need to make temporary adjustments to existing Personnel Policies, or to create new temporary policies. Such an occurrence would most likely be in response to an emergency event that impacts Chestnut's daily operations.

Temporary Personnel Policies should expire between 30 and 90 days from the effective date and will be reviewed periodically for possible extensions or changes.

Temporary personnel policies will be adopted by Chestnut in accordance with its normal practices. The Board of Directors has the authority to adopt policies. Alternatively, consistent with CSB 640 and CSB 650 and in accordance with the Bylaws of the Corporation, the Chief Executive Officer or his/her designee may authorize the inclusion of specific policy or procedure statements in the policy manual.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 30 Purpose of Personnel Policies		
Revision Date:	08/25/2021		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 30 PURPOSE OF PERSONNEL POLICIES

The Personnel Policies and related practices shall apply to Chestnut's workforce, including without limitation individuals employed by Chestnut and those volunteers, contractors, interns, externs and other persons working under the supervision of individuals employed by Chestnut. The Personnel Policies do not apply to Board members. The purpose of the Personnel Policies is to provide structure and consistency to best serve the interests of Chestnut.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 40 Equal Employment		
Revision Date:	06/28/2023		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Ill. Admin. Code title 44 § 1120.2570		

PP 40 EQUAL EMPLOYMENT

Chestnut is an equal opportunity employer and does not discriminate on the basis of race, color, religion, creed, sex, gender identity, gender expression, national origin, age, sexual identity, marital status, ability or disability, including mental illness or substance use disorders, military or veteran status or other factors prohibited by law in any of its educational programs, activities, admissions or employment policies. Chestnut also does not discriminate against its employees on the basis of sex or gender by paying wages to a similarly qualified employee at a rate less than the rate at which the employer pays wages to another employee of a different sex or gender for the same or substantially similar work. Chestnut recruits personnel by normally accepted methods, including Internet-based media, digital advertisements, employment databases, and referrals by present and past employees, as well as friends of the corporation. Concerns regarding this policy should be referred to the Director of Human Resources,

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 50 At Will Relationship		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 50 AT WILL RELATIONSHIP

The relationship between Chestnut and its employees is “at will” as defined by Illinois applicable state law. This means that employment is for no specific timeframe and may, regardless of the time and manner of payment of wages and/or salary, be terminated at any time by the employee or Chestnut. Termination may be for any reason or no reason, with or without cause or notice. Any representation about the employment relationship and/or any provision of the Policy Handbook that is different from the above is invalid unless specifically agreed to in writing by the employee and Chestnut’s Chief Executive Officer or Chief Operating Officer. No Chestnut representative may change the “at will” relationship through oral or written promises. Nothing in the Policy Handbook or any Personnel Policy is intended to constitute or create a contract, expressed or implied, between Chestnut and any employee.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 60 Revision and Review of Personnel Policies		
Revision Date:	06/28/2023		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 60 REVISION AND REVIEW OF PERSONNEL POLICIES

Personnel Policies shall be reviewed at least annually by the Director of Human Resources, the Executive Leadership Council and the Personnel Committee of the Board, with any changes being approved by the Board. Should policies require revision based on a change in an agency program or a change in local, state or federal law or regulation, the Personnel Policies shall be reviewed immediately with revision recommendations being made to the Board of Directors.

Chestnut policies and procedures, including Personnel Policies, will be communicated to all new employees. It is expected that all new employees will receive such orientation on or before the first day of employment. Should circumstances prevent such orientation from taking place on or before the first day of employment, then such orientation shall be provided to the new employee before he/she has completed five working days. Although Chestnut is not required to provide each employee with a copy of the Chestnut Policy Handbook, it will be posted on the Chestnut Intranet and at least one copy of the Policy Handbook shall be placed where it is readily accessible to all Chestnut employees.

Chestnut reserves the right to make policy changes in content or application as it deems appropriate. Chestnut will make a good faith effort to communicate changes to these Personnel Policies by posting all changes on the Intranet in a timely manner. Policy changes are effective at the time of posting. All Chestnut staff have responsibility to keep informed of all current applicable Chestnut policies and procedures. Employees may contact the Human Resources Department for a copy of the most current policies or download a copy from the Intranet. These policies do not create a contract, expressed or implied, and should not be considered all-inclusive.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 70 Adherence to the Personnel Policies and Disciplinary Action		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 820 – Electronic Communications PP 950 – Corrective Action		
Citation(s):			

PP 70 ADHERENCE TO THE PERSONNEL POLICIES AND DISCIPLINARY ACTION

It is the independent responsibility of all staff members to read, understand or seek understanding, and stay informed on all Personnel Policies and procedures and to strictly follow such Policies and procedures in the performance of their job duties and responsibilities.

The primary method used to communicate Personnel Policy information and updates to Chestnut staff members is the internal e-mail system and internal Chestnut Intranet. Consistent with PP 820, all Chestnut staff members are required to check their individual company email and calendar a minimum of once per week during normal work hours. Part-time and PRN staff are required to keep current with company email by regularly and consistently checking email as shift scheduling allows.
Each staff member has responsibility to take positive action to inform his/her reporting supervisor if there are areas of concern within the Personnel Policies and to make recommendations regarding changes if he/she feels that these are warranted or needed.

Violations of the Personnel Policies or procedures, or failure to follow any of them, may be grounds for disciplinary action. The degree of disciplinary action will depend on the type of violation, the seriousness of the infraction, and the frequency of violation. Disciplinary action may result in any one or more of the following actions (although this is not an all-inclusive list of options). These disciplinary actions are not progressive discipline steps, nor do such actions need to be taken in any sequence.

- Termination of employment
- Demotion
- Restitution
- Suspension without pay
- Suspension with pay
- Training
- Referral to the Employee Assistance Program (“EAP”)
- Transfer to a more suitable position
- Verbal warning
- Written warning via Performance Deficiency Report
- Referral for possible criminal prosecution/civil action
- Supervision meetings / coaching and
- Performance Improvement Plan

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 80 Grievance Procedures		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 80 GRIEVANCE PROCEDURES

There may be times when an employee has an issue or concern that needs to be addressed. It is always the intent of Chestnut to resolve issues in a timely manner. Therefore, whenever possible, the issue should be handled on an informal basis with an employee's immediate supervisor during routine supervision meetings. If the concern cannot be resolved during routine supervision, the employee and/or supervisor should bring the matter to the next level of management in the chain of command to assist in resolving the matter. If the concern still cannot be resolved, a formal, written grievance can be presented to the applicable Human Resources Manager. It is important that the employee makes a clear distinction between a routine concern and a grievance.

A grievance is a claim by an employee that he/she is adversely affected by the violation, misinterpretation, or misapplication of a written company policy. To address grievances, Chestnut follows a grievance procedure as a means of internal dispute resolution regarding a review of the policy interpretation or application. A grievance must be filed within 30 days of the most recent attempted informal resolution with the supervisor or second level of management to be considered under this policy. The grievance shall document 1) how the employee has been adversely impacted, 2) the specific policies involved and 3) the informal attempts to resolve the issue. The formal, written grievance shall be presented to the Human Resources Manager via company e-mail, interoffice mail or the Ethics Point reporting system. If the written grievance does not meet the criteria of a grievance, Human Resources Manager will decline further consideration of the grievance and return it to the employee.

If the grievance is accepted, the Human Resources Manager or designee, will refer the written grievance to the appropriate Program Director/Manager. The Program Director/Manager shall provide a written response to the employee as well as provide a copy to the Human Resources Manager, within a reasonable period of time as monitored by the Human Resources Manager. The total time used to resolve such a grievance is not intended to exceed 30 days following the original submission of the grievance document.

If resolution is still not achieved and the employee desires additional consideration, the employee shall re-submit the grievance to the Director of Human Resources with an updated explanation as to why he/she feels that the matter is unresolved. The Director of Human Resources will work in conjunction with the appropriate Executive Leadership Council ("ELC") member. If the Director of Human Resources is unable to find a resolution, the employee may then re-submit the updated grievance to the Chief Executive Officer ("CEO"). If the grievance requires the consideration of the Director of Human Resources and CEO, the

total time used to resolve such a grievance is not intended to exceed a total of 75 days following the original submission of the grievance document. The decision of the CEO will be final and binding.

If the grievance directly involves the CEO, the employee may submit his/her grievance to the Executive Committee of the Board of Directors. The employee may present his/her grievance along with supporting information. The Executive Committee may investigate further if the members deem it necessary and may utilize Chestnut staff to assist if no conflict of interest is present. The Executive Committee will respond within 45 calendar days. The Executive Committee will present its recommendation to the Board of Directors at the next regularly scheduled Board meeting. The Board of Directors' decision will be final.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 100 Purpose		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 100 PURPOSE

This Code of Conduct and Ethics ("Code") of Chestnut is designed to provide a set of high standards for employees, volunteers, interns, and agents of Chestnut (collectively referred to herein as "staff") to conduct themselves in a manner that will enhance Chestnut's ability to achieve its mission and reinforce its organizational values. The Code is a critical component of Chestnut's Quality Improvement Program and the Corporate Compliance Program, to insure that Chestnut provides quality services, meets its ethical standards, and complies with applicable laws and regulations. Chestnut considers its staff to be its most valuable asset. This Code is designed to reinforce and encourage ethical conduct, diligence, professionalism and excellence of staff. This Code does not apply to Board members. The Board members shall abide by the Board of Directors' Code of Ethics.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 110 Principle One: Client Care and Rights		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 110 PRINCIPLE ONE: CLIENT CARE AND RIGHTS

Chestnut is dedicated to making a difference: improving the quality of life through excellence in service as an integrated behavioral health care provider delivering high quality, cost effective services to diverse populations. Chestnut staff treats all clients with respect and dignity and provides care that is both necessary and appropriate.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 120 Client Rights		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 120 CLIENT RIGHTS

Upon admission, each client is provided with a written statement of his/her rights. This statement includes the right of the client to make decisions regarding his/her care. It also emphasizes the dignity, individuality, privacy and high quality of care that is to be afforded each client/family. The written statement conforms to all applicable state and Federal laws.

Chestnut staff shall not verbally or physically abuse clients or the client's family members and all client reports of verbal, physical, or sexual abuse shall be immediately communicated to supervisory staff.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 130 Mandated Child Abuse Reporting		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 130 MANDATED CHILD ABUSE REPORTING

All Chestnut staff identified as mandated reporters in Chestnut's Child Abuse and Neglect Reporting Policy and Procedures must comply with the rules and regulations for reporting child abuse and neglect as outlined in the most current version of the Illinois Department of Children & Family Services ("DCFS") Manual for Mandated Reporters and Missouri Guidelines for Mandatory Reporters. All staff identified as mandated reporters must read and sign the "Acknowledgment of Mandated Reporter Status" form and a copy of this form will be maintained in the staff member's Personnel record.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 200 Principle Two: Confidentiality		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 200 PRINCIPLE TWO: CONFIDENTIALITY

Chestnut staff must maintain the confidentiality of client and other confidential information in accordance with applicable legal and ethical standards.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 210 Client Information		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 210 CLIENT INFORMATION

Staff of Chestnut might have access to clients' medical and treatment records and/or financial and personal information. Staff must maintain the confidentiality of client information in accordance with state and federal statutes and regulations. Staff must also be aware of mandated reporting requirements with regard to child abuse and elder abuse, as well as mandated reporting requirements with regard to allegations of abuse, neglect and death in community agencies serving persons with mental illness. It is the responsibility of all Personnel associated with the organization to take action to become familiar with these statutes and regulations. Any unauthorized or inappropriate disclosure or accessing of information whether verbal, written or electronic, about a client may result in disciplinary action up to and including termination of employment.

Certain Chestnut staff might have access to client information on various computerized systems. None of the information contained in the client record or computer files is to be disclosed or used for any purposes other than those included in the staff's assigned duties. Staff should discuss the situation with his/her supervisor whenever there is doubt regarding the appropriate use or disclosure of such information.

Employees, family members of an employee, and individuals having a personal relationship with an employee who access services at Chestnut or Chestnut Family Health Center ("CFHC") acknowledge that their health information may be accessible to other Chestnut employees in the course of their duties and that it will be treated the same as other health information received by Chestnut or CFHC.

When a Chestnut employee is also a Chestnut client, his/her immediate co-workers shall not be involved in the treatment or staffing of that individual; and in any case of a pre-existing relationship, the staff involved in the pre-existing relationship shall not be involved in the treatment or staffing; unless there is imminent risk or danger. See policy PP 330 regarding staff pre-existing relationships with a client.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 220 Proprietary Information		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 220 PROPRIETARY INFORMATION

Staff must not reveal any trade secret or proprietary or confidential information of Chestnut, either during or after employment. Some positions may require the staff member to sign a confidentiality agreement. Trade secret, proprietary or confidential information includes without limitation all business and financial documents and information of Chestnut, information relating to proposed and existing relationships with other organizations, information relating to organizational structures, company policies, procedures and protocols, business methods, business plans, pricing and rate structures, corporate systems, staff information, training materials and any other information of a business nature. Such information need not be marked as confidential to be considered trade secret, confidential or proprietary. Staff may disclose a trade secret, proprietary or confidential information if such disclosure is necessary for the staff person to perform his/her job duties and only if the employee receives written approval from a member of the Chestnut Executive Leadership Council prior to the disclosure. Staff should exercise care to insure that proprietary materials developed by Chestnut, including copyrights and software, are carefully maintained and managed to preserve and protect its value.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 230 Personnel Information		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 230 PERSONNEL INFORMATION

Personnel files and records are the property of Chestnut. Salary, benefit and other personal information relating to staff must be treated as confidential. Personnel files, payroll information, disciplinary matters and similar information must be maintained in a manner designed to preserve confidentiality in accordance with applicable laws. Staff must exercise due care to prevent the release or sharing of information beyond those persons who may need such information to fulfill their job function. The candidacy of job applicants as well their personal information contained in job applications, resumes and other submitted records must also be treated as confidential.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 300 Principle Three: Professional Behavior		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 300 PRINCIPLE THREE: PROFESSIONAL BEHAVIOR

Chestnut staff should conduct themselves in a professional manner at all times. Chestnut staff should provide services in a manner consistent with the mission of the organization and the philosophy of the programs.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 301 Customer Service		
Revision Date:	06/27/208		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 301 CUSTOMER SERVICE

All Chestnut employees will promote Chestnut's culture of customer service excellence through adherence to the seven behavioral standards for customer service. These standards, which are the subject of mandatory employee training made available to all employees, are focused on the following and apply to both internal and external interactions:

1. Greeting, welcome, and appreciation
2. Professional telephone behavior
3. Confidentiality and privacy
4. Communication
5. Respect
6. Responsiveness
7. Environment

All Chestnut employees will report violations of this policy or inappropriate employee conduct to their immediate supervisors; if the situation is unresolved and any violations persist, employees will make a report to our Corporate Compliance Program.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section: Personnel Policies

Policy Name and Number: PP 310 Definition of Client

Revision Date:

Applies To:	☒Employees	☐Clinical Staff Only	☐Interns
	☐Contractors	☐Administrative Staff Only	☐Board Members
	☐Volunteers		
Type of Policy:	☒Administrative	☐Clinical	

Policy Cross Reference(s):

Citation(s):

PP 310 DEFINITION OF CLIENT

Chestnut recognizes that alcohol and substance abuse and mental illness are often long-term disorders and that many clients will go through varying periods of recovery and relapse. Given that clients who have completed treatment at one point may at a later point in time seek further services, all references to "client" in this Code shall include both currently active and former clients. A former client is someone who has received services within 2 years. In the case of an adolescent client, a former client is someone who has received services and is less than 20 years old. The terms "patient", "client" and "consumer" are to be used synonymously. In this context, the term "client" applies to individuals who are currently receiving or have formerly received therapeutic or counseling services from Chestnut. The term "client" excludes "clients" who are recipients primarily of educational or prevention services, organizations, employers, government agencies, or other customers that have agreements with Chestnut. The standards apply when Chestnut staff have firsthand knowledge that an individual is or has been a "client" of a clinical intervention or treatment program at Chestnut.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 320 Dual Relationships/Conflicts (Applies to All Staff)		
Revision Date:	07/27/2022		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 310 Definition of Client PP 1605 – Transportation Via Staff's Personal Vehicle		
Citation(s):	Missouri Department of Mental Health, Personnel, 9 CSR 10-7.110(3)		

PP 320 DUAL RELATIONSHIPS/CONFLICTS (APPLIES TO ALL STAFF)

The decisions, recommendations, and professional actions of Chestnut employees, officers, and agents ("Chestnut Staff") may have a profound impact on the lives of others. Chestnut Staff shall adhere to corporate and applicable professional standards of behavior in their relationships with clients and must avoid relationships or commitments that conflict with the interests of clients or which might affect professional judgment or increase the risk of client exploitation. A dual relationship occurs when a staff person relates to a client in more than one relationship, whether professional, social, legal or business.

Chestnut Staff should not use the perceived status, power, or authority of their position to exploit clients nor the client's family members through the development of personal relationships that could jeopardize the ability of Chestnut to provide effective services to that client and his/her family, at the present time or in the future.

Chestnut Staff must not engage in romantic relationships, sexual relationships or sexual acts of any kind with known Chestnut clients as defined in PP 310 Definition of Client or with a client's family members when such acts: violate the law; exploit relationships through the services the staff member offers; constitute harassment; conflict with a staff member's professional role; or occur at a time or place at which the staff member is acting in his/her professional role.

Chestnut Staff must maintain professional boundaries with clients at all times. Chestnut Staff may not initiate a personal friendship or romantic relationship with a client or former client, subject to the requirements of this policy. Dual relationships, or conflicts of interest, also include relationships between Chestnut Staff who are also Chestnut consumers and their relationships with other consumers and staff that predate their transition to Chestnut employment.

Chestnut Staff should not provide counseling or therapeutic services to current or previous family members. If there is a question concerning whether a client or potential client falls within a degree of kinship that is prohibited, staff should immediately consult his/her supervisor to determine the degree of staff involvement in the client's treatment.

Chestnut Staff should provide services to family members of staff, or individuals with whom they have a pre-existing relationship, only when the services the person needs are not available in other agencies in the community or when the Regional Manager or Clinical Director determines there are other compelling reasons. When persons are seen at Chestnut under these circumstances, the staff person affiliated with the client must

not participate, supervise, or be professionally involved in therapy or counseling services. The staff member may provide services other than therapy or counseling with the approval of the Program Director.

In addition, when a known Chestnut consumer is employed at Chestnut, he/she will not work in the same program in which he/she is receiving his/her services. This same program prohibition will not apply to Chestnut employees hired prior to March 1, 2008. When clinically approved, these employees will be encouraged to transfer their services to the Employee Assistance Program, another agency, or to comparable Chestnut services offered in another county or area.

If a staff member is receiving services through Chestnut, his/her primary provider shall not be a co-worker from the program in which the staff member is working. If a Chestnut employee is also a Chestnut consumer, all policies related to consumers still apply. Similarly, consumer employees will be held to the standard in these Personnel Policies. To the extent of any inconsistencies between the consumer policies, the Personnel Policies will govern.

Chestnut Staff must not enter into any kind of financial transaction with a current or former client or client's family member which could be viewed by the client or the client's family members or others as a type of financial exploitation.

Chestnut recovering staff must avoid serving as temporary or permanent sponsors for current clients or their families as a part of self-help participation.

Clinical objectivity of staff should never be compromised by dual relationships, blurring of boundaries, or family kinship. While staff self-disclosure can be used effectively as a relationship-building tool, it may defocus the attention of the intervention from the client to the staff and may represent an over-involvement with the client to meet the needs of the staff. Although appropriate self-disclosures are not prohibited, staff should determine whether the needs of the client are being met through the use of self-disclosure and seek clinical supervision regarding the content and timing.

Chestnut Staff must not enter into any kind of financial transaction with a current or former client or client's family member in which the staff member receives special considerations based on the prior treatment relationship, or which could be viewed by the client or the client's family members or others as a type of financial exploitation.

Chestnut recovering staff must avoid serving as temporary or permanent sponsors for current clients or their families as a part of self-help participation.

Clinical objectivity of staff should never be compromised by dual relationships, blurring of boundaries, or family kinship. While staff self-disclosure can be used effectively as a relationship-building tool, it may defocus the attention of the intervention from the client to the staff and may represent an over-involvement with the client to meet the needs of the staff. Although appropriate self-disclosures are not prohibited, staff should determine whether the needs of the client are being met through the use of self-disclosure and seek clinical supervision regarding the content and timing.

Staff must comply with applicable labor and related laws that regulate employment such as wage and hour requirements, OSHA and workplace safety requirements as well as other applicable employment laws.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 321 Dual Relationships/Conflicts (Applies to All Clinical and Treatment Staff)		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 321 DUAL RELATIONSHIPS/CONFLICTS (APPLIES TO ALL CLINICAL AND TREATMENT STAFF)

For the purposes of determining dual relationships or conflicts of interest, family members generally include mother, father, wife, husband, brother, sister, son, daughter, mother-in-law, father-in-law, daughter-in-law, son-in-law, niece, nephew, aunt, uncle, cousin, grandmother, grandfather, grandchildren, brother-in-law and sister-in-law. Dual relationships, or conflicts of interest, also include relationships between Chestnut staff who are also Chestnut consumers and their relationships with other consumers and staff that predate their transition to Chestnut employment.

Chestnut staff should not provide counseling or therapeutic services to current or previous family members. If there is a question concerning whether a client or potential client falls within a degree of kinship that is prohibited, staff should immediately consult his/her supervisor to determine the degree of staff involvement in the client's treatment.

Chestnut staff should provide services to family members of staff, or individuals with whom they have a pre-existing relationship, only when the services the person needs are not available in other agencies in the community or when the Regional Manager or Clinical Director determines there are other compelling reasons. When persons are seen at Chestnut under these circumstances, the staff person affiliated with the client must not participate, supervise, or be professionally involved in therapy or counseling services. The staff member may provide services other than therapy or counseling with the approval of the Program Director.

In addition, when a known Chestnut consumer is employed at Chestnut, he/she will not work in the same program in which he/she is receiving his/her services. This same program prohibition will not apply to Chestnut employees hired prior to March 1, 2008. When clinically approved, these employees will be encouraged to transfer their services to the Employee Assistance Program, another agency, or to comparable Chestnut services offered in another county or area.

If a staff member is receiving services through Chestnut, his/her primary provider shall not be a co-worker from the program in which the staff member is working. If a Chestnut employee is also a Chestnut consumer, all policies related to consumers still apply. Similarly, consumer employees will be held to the standard in these Personnel Policies. To the extent of any inconsistencies between the consumer policies, the Personnel Policies will govern.

Chestnut staff must not enter into any kind of financial transaction with a current or former client or client's family member which could be viewed by the client or the client's family members or others as a type of financial exploitation.

Chestnut recovering staff must avoid serving as temporary or permanent sponsors for current clients or their families as a part of self-help participation.

Clinical objectivity of staff should never be compromised by dual relationships, blurring of boundaries, or family kinship. While staff self-disclosure can be used effectively as a relationship-building tool, it may defocus the attention of the intervention from the client to the staff and may represent an over-involvement with the client to meet the needs of the staff. Although appropriate self-disclosures are not prohibited, staff should determine whether the needs of the client are being met through the use of self-disclosure and seek clinical supervision regarding the content and timing.

Chestnut staff must not enter into any kind of financial transaction with a current or former client or client's family member in which the staff member receives special considerations based on the prior treatment relationship, or which could be viewed by the client or the client's family members or others as a type of financial exploitation.

Chestnut recovering staff must avoid serving as temporary or permanent sponsors for current clients or their families as a part of self-help participation.

Clinical objectivity of staff should never be compromised by dual relationships, blurring of boundaries, or family kinship. While staff self-disclosure can be used effectively as a relationship-building tool, it may defocus the attention of the intervention from the client to the staff and may represent an over-involvement with the client to meet the needs of the staff. Although appropriate self-disclosures are not prohibited, staff should determine whether the needs of the client are being met through the use of self-disclosure and seek clinical supervision regarding the content and timing.

Staff must comply with applicable labor and related laws that regulate employment such as wage and hour requirements, OSHA and workplace safety requirements as well as other applicable employment laws.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 322 Dual Relationships/Conflicts (Applies to All Research, Consulting, Training and Publishing Staff)		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 322 DUAL RELATIONSHIPS/CONFLICTS (APPLIES TO ALL RESEARCH, CONSULTING, TRAINING AND PUBLISHING STAFF)

Chestnut staff must avoid using the perceived status, power or authority of their position to emotionally, sexually or financially exploit study participants, trainees or representatives of organization clients.

A Chestnut staff member must notify his or her supervisor immediately:

- When any dual relationship (pre-existing or current non-professional relationship) exists with a study participant, that could compromise the participant's comfort or the ability to elicit accurate information.
- When conflicts exist because of data relating to individuals that he or she knows outside his or her professional role.
- When any potential conflicts of interest arise that could influence one's objectivity as an author, editor or reviewer.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 323 Dual Relationships/Conflicts (Applies to All Clinical and Medical Staff Working at Chestnut Family Health Center)		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 330 – Staff Rights Regarding Client Care		
Citation(s):			

PP 323 DUAL RELATIONSHIPS/CONFLICTS (APPLIES TO ALL CLINICAL AND MEDICAL STAFF WORKING AT CHESTNUT FAMILY HEALTH CENTER)

A tenet of CFHC's operations is that Chestnut staff, family members and, in particular, members of the Board of Directors, are encouraged to obtain services from CFHC. As a result, there may exist situations in which CFHC staff treat other CFHC or Chestnut staff, family members, Chestnut Board members, or individuals with whom they have a pre-existing relationship. In such situations, a prohibited dual relationship or conflict of interest shall not be deemed to exist. However, unless approved by an ELC member, a conflict of interest will be deemed to exist when, in the case where the individual seeking services is a CFHC or Chestnut staff member, such individual is directly supervised or works under the direction or delegation of the treating provider. Nevertheless, staff are still required to comply with PP 330, Staff Rights Regarding Client Care, in treating co-workers and clients with which they have a personal relationship.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 327 Dual Relationships/Conflicts Regarding Prevention Service Recipients		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 327 DUAL RELATIONSHIPS/CONFLICTS REGARDING PREVENTION SERVICE RECIPIENTS

Unlike clinical services, prevention services are usually:

- "Universal" or "Selective" (as defined in the Institute of Medicine classification system) rather than "Indicated". Accordingly, participants are either the general population or a group selected according to some "risk" attribute, but without any individual indication of substance use or other problem behavior.
- Devoid of intimate personal confidences.

Examples of prevention service recipients include, but are not limited to, youth in classroom groups, youth participating in youth leadership activities, parents from the general population participating in parent education programs, teachers and other professionals receiving training services, and community members involved in community mobilization efforts.

To some extent, the broad community context of prevention makes avoidance of interaction with friends and family on the job impractical, and the nature of prevention work makes such "dual relationships" unproblematic. However, certain policies used by the clinical staff are also appropriate for prevention service staff:

1. Chestnut staff must avoid relationships or commitments that conflict with the interests of prevention service recipients or that compromise the integrity of a prevention program.
2. A Chestnut staff member must not enter into any kind of financial relationship with a current or former prevention service recipient in which the staff member receives special considerations based on the professional relationship or which could be viewed as a type of financial exploitation. Prevention staff working on site at a school or other organization that has a service contract with Chestnut should not attempt to offer private prevention services to schools they serve on behalf of Chestnut.
3. Chestnut staff must not engage in romantic relationships, sexual relationships or sexual acts of any kind with prevention service recipients when such acts: violate the law; exploit relationships through the services the staff member offers; constitute harassment; conflict with a staff member's professional role; or occur at a time or place at which the staff member is acting in his/her professional role.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 330 Staff Rights Regarding Client Care		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 330 STAFF RIGHTS REGARDING CLIENT CARE

Upon hire or discovery, Chestnut staff must immediately notify their direct supervisor of any pre-existing relationship with a client.

Chestnut staff must identify and report to their supervisor any areas of bias or conflict that would preclude effective work with an assigned client. Each member of the staff who provides direct services to clients reserves the right to, at any time, request not to participate in the care or treatment of any particular client or group of clients that constitutes a conflict. The objecting staff member must make such a request in writing to his/her supervisor stating in full the reasons for the conflict.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 340 Professional Interaction Among Colleagues		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 340 PROFESSIONAL INTERACTION AMONG COLLEAGUES

Relationships among Chestnut staff and with other professionals in the community should be characterized by mutual respect and an appreciation for the wide variation in professional and life experiences. The primary values in the relationships among staff should be the value of mutual consideration and respect and the value of direct communication.

Chestnut staff should work to support, not undermine, decisions made by or in collaboration with other staff. Chestnut staff shall display positive behavior and promote a supportive work environment.

Individuals should not be the direct or indirect supervisor of an immediate family member. Individuals may not supervise, either directly or indirectly, any staff member with whom they have a romantic relationship. If a situation develops in which a supervisor and a staff member become romantically involved, this relationship must be disclosed to the Program Director and the Human Resources Manager immediately. The circumstances of the situation will be evaluated further at that time.

Under this policy, an immediate family member includes spouse, parent, stepparent, mother/father-in-law, child, stepchild, daughter/son-in-law, sibling, sister/brother-in-law, aunt/uncle, grandparent, grandchild, or any member of the employee's household (including roommates or other personal relationships). Such relationships involving direct or indirect supervision must be disclosed in advance to the Program Director, applicable ELC member, and the Human Resources Manager. A decision will then be made by the applicable Executive Leadership Council member after consulting with the Program Director and HR Director.

Indirect supervision includes those individuals working in the same reporting chain of the same department or program.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 350 No Workplace Harassment		
Revision Date:			
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 350 NO WORKPLACE HARASSMENT

Chestnut staff must respect the rights of co-workers to work in a psychologically safe environment, free from sexual, political, and other forms of harassment. Staff shall refer to Chestnut's Anti-Harassment policies for specific expectations, policy definition and procedures. A supervisor who provides constructive criticism or coaching to an employee who has engaged in substandard performance does not constitute harassment.

Chestnut strives to maintain a working atmosphere that insures adequate protection for all staff, contractors, and the public. Chestnut expects its staff to avoid any behavior that creates or contributes to an intimidating, hostile or offensive working environment for any fellow workers. Violence, aggression, or intimidation, including the explicit or implied threat of physical violence, will not be tolerated, especially whenever:

- The act, behavior or communication is abusive and could cause another person physical or psychological harm; or
- The act, behavior or communication damages company or staff property or disrupts the work task of an individual or group of people within Chestnut's workforce.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 355 No Weapons		
Revision Date:			
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1600 – Staff Transportation in Chestnut Owned Vehicles		
Citation(s):			

PP 355 NO WEAPONS

For the safety of Chestnut clients, guests, and staff, Chestnut prohibits the use or possession of firearms and/or other weapons of any type by staff while on Chestnut premises or while carrying out company business, except as specifically provided below. Weapons include firearms, explosives, knives and other dangerous items that could cause harm to individuals. Staff must ensure that weapons or objects that could be used as weapons will be safeguarded and kept reasonably inaccessible from clients. A license to carry a weapon does not supersede this policy.

Chestnut's premises are defined as all Chestnut-owned or Chestnut-leased buildings and their surrounding areas such as sidewalks, walkways, grassy areas, and driveways under Chestnut's ownership or control. This policy also applies to all Chestnut-owned or Chestnut-leased vehicles, see PP 1600.

This prohibition on the use or possession of weapons shall also apply in all Chestnut parking lots, except that an individual may store a firearm (including, without limitation, a handgun, shotgun, or rifle) and/or ammunition in a vehicle in the parking lot: (1) in a case within a locked vehicle, or (2) in a locked container out of plain view within the vehicle. The individual may only carry such firearm outside the vehicle for the purpose of storing it in the trunk of the vehicle and may only carry it outside of the vehicle if it is first unloaded.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 360 Professional Competencies/Licensure		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 360 PROFESSIONAL COMPETENCIES/LICENSURE

Treatment techniques utilized by staff members must be appropriate and within limits of the job description, expertise, occupational licensure or certification of the person providing care. Continuously improving professional competency is required by participating in continuing education and maintaining appropriate certification and/or licensure. Licensed and certified staff must also comply with applicable ethics codes of such licensing and certifying bodies. To the extent of any inconsistencies between this Code and other ethics codes, the more stringent will govern.

Chestnut staff must accurately represent their competency, education, training, and experience. A copy of all diplomas, licenses, certifications, and training records or other pertinent documentation must be provided by all staff for inclusion in his/her personnel file. Failure of clinical and nursing staff to maintain or renew a license or certification and provide copies of all current licenses and certifications to the Human Resources Department on or before the expiration date may result in removal from the work schedule and/or disciplinary action.

Chestnut staff must request approval from the Regional Program Director or Clinical Director of their program prior to utilizing new or experimental clinical methods and techniques that are not standard, acceptable, clinical practice.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 370 Drug and Alcohol Free Work Place		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1145 Employee Assistance Program (EAP)		
Citation(s):			

PP 370 DRUG AND ALCOHOL FREE WORK PLACE

"Work place" is defined as the environment where a staff person works while performing her or his job duties whether on or off Chestnut premises and receiving a wage from Chestnut.

Chestnut is committed to maintaining a work environment that is safe for clients and patients as well as staff and is conducive to attaining high work standards in the behavioral health care industry. Chestnut maintains a drug and alcohol free work place that allows safety, quality of care and productivity to be maximized. This standard applies to all staff of Chestnut regardless of rank or position.

The use, possession, sale, manufacturing or distribution of alcohol or illegal drugs as well as unauthorized controlled substances is strictly prohibited in the work place. The use of cannabis, or any product containing cannabis or THC in the work place is also prohibited. Chestnut staff have a responsibility to themselves, the organization, clients, patients, and the community to provide a positive role model regarding the use of mood altering substances. Chestnut staff must not misuse alcohol and other legal drugs and must not possess, use, or sell/distribute illicit drugs under any circumstances.

Chestnut staff must not drink alcoholic beverages during working hours or have alcohol in their system when reporting to work. However, staff may consume alcohol in the evenings while attending conferences, seminars and other business-related social functions that are not located on Chestnut property. Staff who choose to consume alcohol in these circumstances should exercise appropriate and professional behavior including being mindful of safety, driving restrictions and applicable DUI laws and of the reputation of Chestnut. Staff who work back-up and on-call must not drink alcoholic beverages during the time period they are scheduled for on-call duty.

Staff are subject to drug and alcohol testing upon the reasonable suspicion of an administrator or supervisor. If reasonable suspicion exists, the staff member's supervisor will contact the Human Resources Manager to arrange for appropriate testing with an independent agency.

Reasonable suspicion may be based on a variety of factors, including:

1. Observance of possible intoxication, including the appearance of physical or behavioral symptoms that suggest being under the influence of alcohol or substances that impair one's ability to work safely and effectively, while on Chestnut premises or during work hours. Alternatively, reasonable suspicion may also be based on observance of actual alcohol use or possession on Chestnut

premises or during work hours (barring certain exceptions stated above), or observance of any use of illegal substances, whether on or off Chestnut premises or during or after work hours;
2. A pattern of abnormal conduct or erratic behavior;
3. Arrest or conviction for a drug-related offense, or the identification of an employee as the focus of a criminal investigation concerning illegal drug use;
4. Information related to the use, sale, or distribution of illegal substances provided either by reliable or credible sources or independently corroborated; or
5. Newly discovered evidence that an employee has tampered with a previous drug test.
6. Medication management issues discovered at a Chestnut facility or with medications belonging to a specific Chestnut client or patient including, but not limited to, the inability to reconcile medication, possible diversion, etc.

A staff person's refusal to consent to a drug or alcohol test under the provisions of this policy is likely to result in termination, even for a first refusal. Staff who test positive for alcohol or other drugs will be referred to the Employee Assistance Program and encouraged to seek treatment. See PP1145 Employee Assistance Program (EAP). Seeking treatment, however, in and of itself, will not preclude disciplinary action, up to and including termination for policy violations or performance issues. After successful completion of treatment Chestnut will evaluate the individual's circumstances and determine in its sole discretion whether the person can perform the essential functions of the job and fulfill Chestnut's mission to provide a safe environment that is conducive to recovery for clients and patients.

In accordance with applicable state and federal drug free workplace statutes, any staff person convicted of any criminal drug statute violation must notify the Human Resources Department within five (5) days of the conviction. Appropriate disciplinary action will follow. The Human Resources Department shall notify the General Counsel of such conviction. The General Counsel will then notify applicable contracting agencies within ten (10) days of the notice of the conviction.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 375 Arrest Reporting		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1610 – Traffic Violations PP 370 – Drug and Alcohol Free Workplace		
Citation(s):			

PP 375 ARREST REPORTING

Due to the sensitive nature of services that Chestnut provides to its clients and patients and the involvement of governmental agencies and/or the legal system in those services, it is essential that staff members comply with the requirements of this policy in order to protect Chestnut and its clients and patients from risks that may arise when an employee is arrested and charged with a crime.

Chestnut does not request or use information concerning arrests to affect the terms and conditions of a staff member's employment, except as allowed by law. Incidents for which a staff member is arrested but not convicted may, however, be considered if Chestnut has information concerning the incident that is not based solely on the fact of the arrest and if the incident is job-related or otherwise relevant to the staff member's employment.

Chestnut considers certain types of crimes to be particularly significant for a staff member of Chestnut in general and especially for staff members who are directly involved in client and patient care. These crimes include, but are not limited to 1) crimes involving either threats or violence; 2) crimes involving sexual misconduct; 3) crimes involving use, possession, sale, intent to sell or other offenses concerning alcohol, illegal drugs or other mood altering substances (including but not limited to DUIs); 4) crimes involving dishonesty, theft, fraud, forgery, deception or bribery; 5) crimes involving firearms or other weapons; and 6) crimes involving minors.

Any current staff member who is arrested for any crime must report the arrest to the Human Resources Department and/or the immediate supervisor prior to the start of his or her next work shift. The supervisor shall notify the Human Resources Department within 24 hours of being notified. Delay in reporting, failing to report, or misrepresentation by a staff member concerning the reporting of an arrest will result in disciplinary action, up to and including termination.

If the arrest relates directly to the staff member's employment Chestnut reserves the right to alter the terms and conditions of a staff member's employment and to take disciplinary action, up to and including termination, based on the nature of, and the facts surrounding, the offense(s) for which the staff member was arrested. Continued employment with Chestnut is contingent upon a resolution of the arrest that is acceptable to Chestnut.

The requirements of this policy are in addition to a staff member's reporting obligations for traffic violations as required by PP 1610 Traffic Violations and drug related convictions as required by PP 370 Drug and Alcohol Free Workplace.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 380 Impaired Professionals/Staff		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 380 IMPAIRED PROFESSIONALS/STAFF

Chestnut expects staff to report to work in a condition fit to perform their duties. Staff with unresolved or untreated physical, mental health or substance abuse problems can adversely affect the safety and productivity of the work environment. Chestnut stands ready to assist staff who are willing to voluntarily seek help before their work performance deteriorates or the safety of the work environment is threatened or compromised. Chestnut actively supports treatment and rehabilitation efforts, when applicable and appropriate, through group health benefits, disability policies, and the availability of a free and confidential Employee Assistance Program (EAP). Participation in a treatment program or Chestnut's EAP will not protect a staff person from disciplinary action for policy violations, poor job performance, or misconduct.

Staff who report to work in an impaired condition may be required to undergo a medical evaluation and/or drug alcohol test if a supervisor reasonably suspects that the staff person may not be able to safely or properly initiate or continue normal work duties due to some type of impairment. The suspected impairment may be due to a medical or psychiatric illness or the influence of alcohol or drugs. If reasonable suspicion exists, the staff member's supervisor will contact the Human Resources Manager to arrange for appropriate testing with an independent agency. Employee refusals to accept and comply with requested medical evaluations and/or drug or alcohol tests will result in disciplinary action, including termination.

Employees who test positive for an illegal drug or for alcohol will be relieved of duty and referred to Chestnut's EAP for a professional assessment. If the EAP recommends treatment, failure to promptly enter treatment will result in termination of employment. Seeking treatment, however, in and of itself, will not preclude disciplinary action, up to and including termination for policy violations or performance issues. Employees who test positive while on duty, cooperate with the EAP's recommendations, and are permitted by Chestnut to return to duty will be expected to cooperate with any and all requests from the Human Resources Department for subsequent unannounced drug and alcohol tests, irrespective of cause or circumstances, for up to two years. An additional confirmed positive test may result in termination without opportunity for additional treatment, regardless of whether the substance was ingested on or off the job.

Staff are expected to report to the start of their shift on time, rested and refreshed and capable of performing their job duties. Sleeping during paid work hours is strictly forbidden and will result in staff being relieved of their duties and sent home. Supervisors will then consult with Human Resources to take appropriate next steps which may include fitness for duty assessments or disciplinary action. If a supervisor has reasonable suspicion that an employee sleeping on the job involves drug or alcohol impairment, the supervisor will pursue immediate drug and alcohol testing in consult with Human Resources.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 390 Professional Appearance and Grooming		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 390 PROFESSIONAL APPEARANCE AND GROOMING

Chestnut values the individuality of its employees. To preserve the safety and wellbeing of Chestnut's clients, patients, visitors and other staff, Chestnut employees are expected to maintain standards of dress and appearance that are professional and appropriate for their department and/or job responsibilities. Employees who report to work in violation of this policy may be sent home and may be subject to discipline up to and including termination. Absence from work that results from being sent home for a violation of this policy is not considered work time; therefore, this absence would be unpaid. Employees will be allowed to use personal or vacation time,

The following are guidelines for appropriate/inappropriate dress for regular workdays as well as for designated casual days. This is not intended to be an all-inclusive list, and Chestnut management reserves the right to determine appropriateness. Specific programs may have more formal standards than what is listed. When planning for the workday, employees should always be mindful of the population they are serving, individuals with whom they are meeting, and the type of work they will be performing when deciding appropriateness for the workplace.

Appropriate dress for regular workdays:

- Clothes that are clean, neat, and not frayed
- Dress pants
- Skirts and dresses
- Blouses, dress shirts, casual dress shirts, Chestnut logo shirts, polos, golf shirts, sweaters, and turtlenecks
- Head coverings worn for religious observance
- Business suits with pants or skirts
- Business shoes (heels, flats, loafers, boots, dress sandals, etc.)

Inappropriate dress for regular workdays:

- Denim pants or skirts (unless approved by program director and relevant to the function of the position)
- Tennis shoes or sneakers (unless approved by program director and relevant to the function of the position)
- Sweatshirts/sweat suits or overly baggy clothing
- Cargo pocket pants, beachwear pants

Appropriate Grooming:

- Good personal hygiene is required
- Hair should be clean and neat
- When wearing perfume, cologne, or lotions, be conservative. Fellow co-workers and clients may be medically sensitive or have allergic reactions to various fragrant products

In addition, the following is a guideline for appropriate dress on designated Casual Days:

- Denim (not torn, frayed, or wrinkled)
- T-shirts and sweatshirts
- Athletic shoes, tennis shoes, or sandals
- Casual pants (clean, neat, and not frayed)

The following are never appropriate in the workplace:

- Shorts (appropriate for employee picnic days only)
- Garments that reveal abdomen, back, or chest.
- Sheer clothing or visible undergarments
- Flip-flops and beach sandals
- Clothing with tears
- Clothing or accessories, including personal protective equipment with political or offensive slogans or logos
- Offensive tattoos
- Piercings or jewelry that pose a safety risk to employees or patients
- Hats, caps, or visors worn for fashion
- Sweatpants

These guidelines also apply to employees participating in meetings or other gatherings via video technology, to the extent the employee can be seen by other participants. Employee questions regarding appropriate clothing in the workplace should be referred to supervisors or the Human Resources Department.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section: Personnel Policies

Policy Name and Number: PP 395 Personal Phone Calls/Cell Phones

Revision Date:

Applies To:
☐Employees ☐Clinical Staff Only ☐Interns
☐Contractors ☐Administrative Staff Only ☐Board Members
☐Volunteers

Type of Policy: ☐Administrative ☐Clinical

Policy Cross Reference(s):

Citation(s):

PP 395 PERSONAL PHONE CALLS/CELL PHONES

Chestnut recognizes that employees must sometimes place or receive personal calls on company phones; however, the telephone system is intended to serve the needs of Chestnut. If employees have personal calls to make, they are encouraged to use a personal phone card or personal cellular phone and limit the number of personal calls made during working hours. Excessive personal use will be addressed.

Use of cell phone cameras or other image or voice capturing devices is prohibited without authorization from the applicable Executive Leadership Council member.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 400 Principle Four: Legal Compliance		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 400 PRINCIPLE FOUR: LEGAL COMPLIANCE

Chestnut will strive to insure all activity by or on behalf of the organization is in compliance with applicable laws.

The following standards are intended to provide guidance to staff to assist them in their obligation to comply with applicable laws. These standards are neither exclusive nor complete. Staff are required to comply with all applicable laws, whether or not specifically addressed in these policies. If questions regarding the existence or interpretation of, or application of any law arise, they should be directed to Chestnut's Corporate Compliance Officer or General Counsel.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 410 Records Documentation and Retention		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 410 RECORDS DOCUMENTATION AND RETENTION

Every Chestnut staff person is responsible for the integrity and accuracy of Chestnut's documents and records, not only to comply with all applicable legal and regulatory requirements, but also to insure that records are available to defend any of Chestnut's business practices or other actions. No staff person may falsify information on any record or document. No staff person may destroy any records or documents except in accordance with Chestnut's record retention policy.

The client and business records of Chestnut are retained in accordance with applicable law and the Chestnut record retention policy. Client records and business documents include paper documents such as letters and memos, computer-based information such as e-mail or computer files on disk or tape, and any other medium that contains information about Chestnut or its business activities. Staff must retain and destroy records appropriately according to Chestnut's policy. Staff must not tamper with records, nor remove or destroy them prior to the specified date.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 420 Fraud and Abuse		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CC 50 False Claims Reporting/Whistleblower Protection		
Citation(s):			

PP 420 FRAUD AND ABUSE

Chestnut expects its staff to refrain from conduct that may violate the fraud and abuse laws. The laws prohibit:

- Direct, indirect or disguised payments in exchange for the referral of clients;
- The submission of false, fraudulent or misleading claims to any government entity or third-party payer, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which otherwise do not comply with applicable program or contractual requirements (see also Chestnut's Policy Handbook, policy CC 50 False Claims Reporting/Whistleblower Protection for additional examples of prohibited conduct); and
- Making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 430 Licenses and Certifications		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 430 LICENSES AND CERTIFICATIONS

Chestnut operates its business within the constraints of all applicable licensure and certification requirements. Chestnut and its staff must obtain and maintain all appropriate licenses and certifications and comply with all licensure and certification requirements governing its program operations. Chestnut and its staff must file all licensure and certification information in a manner consistent with applicable laws.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 440 Funding Contract Requirements/Certifications		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 440 FUNDING CONTRACT REQUIREMENTS/CERTIFICATIONS

Chestnut has a legal and ethical obligation to act in compliance with funding contract requirements and certifications.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 450 Labor Laws		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	OSHA		

PP 450 LABOR LAWS

Staff must comply with applicable labor and related laws that regulate employment such as wage and hour requirements, OSHA and workplace safety requirements as well as other applicable employment laws.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 460 Discrimination		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1030 – Internal Reporting of Harassment Complaint		
Citation(s):			

PP 460 DISCRIMINATION

Chestnut believes that the fair and equitable treatment of staff, clients and other persons is critical to fulfilling its vision and goals.

Chestnut will not tolerate any form of harassment or discrimination on the basis of sex, race, color, religion, national origin, age, gender identity, gender expression, sexual identity, marital status, unfavorable military discharge, ability or disability, and all other classifications as stated in federal and state employment laws. Each allegation of harassment or discrimination will be promptly investigated in accordance with PP1030 below.

Upon an employee's disclosure to a supervisor of the need for a reasonable accommodation of an essential job duty under the Americans with Disabilities Act ("ADA"), Chestnut will engage in an interactive process among the employee, the employee's health care provider, supervisor, Program Director and Human Resources department. The result of the interactive process will be documented in writing to the employee. The specifics of any related medical information will receive full privacy and will only be shared with those with a need to know to make job performance decisions.

If an employee is pregnant, is recovering from childbirth, or has a condition related to pregnancy, she has the right to ask for a reasonable accommodation. This includes bathroom breaks, assistance with heavy lifting, a private space for expressing milk, or time off to recover from your pregnancy. For more information regarding your rights on Pregnancy in the Workplace, download the Illinois Department of Human Rights fact sheet at www.illinois.gov/dhr, or refer to the posted "Pregnancy Rights Notice".

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 465 Animals in the Workplace		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Americans with Disabilities Act (ADA)		

PP 465 ANIMALS IN THE WORKPLACE

In order to maintain the safety, health and well-being of our clients and employees, Chestnut prohibits employees from bringing a pet (defined as a domestic animal kept for pleasure or companionship) into the workplace or having a pet in Chestnut controlled buildings and premises. However, Chestnut will allow "service animals", as defined in the Americans with Disabilities Act (ADA), into the workplace as a reasonable accommodation for individuals with qualifying disabilities. The prohibition of pets in the workplace also applies to "therapy animals" and "emotional support animals" which are not covered under the ADA.

Requests for employee accommodations involving a service animal or a purported service animal must be made in writing for the review and approval of the applicable Program Director/ELC member and the Human Resources Manager. If approved, the employee will receive a document from Human Resources outlining the criteria for having a service animal in the workplace which will be acknowledged and co-signed by the employee and the supervisor.

On a case-by-case basis, "pet therapy" companies or groups will be permitted to bring animals on Chestnut premises in an organized way for the therapeutic benefit of clients, subject to the prior approval of and within constraints established by Chestnut's General Counsel in each instance.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 470 Tax-Exemption		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 470 TAX-EXEMPTION

As a not-for-profit entity, Chestnut has a legal and ethical obligation to act in compliance with applicable laws; to engage in activities in furtherance of its charitable purpose; and to insure that its resources are used in a manner which furthers the public good rather than the private or personal interests of any individual. Chestnut's staff must avoid financial arrangements incurred on behalf of Chestnut in excess of fair market value. Chestnut staff must also accurately report Chestnut payments to appropriate taxing authorities and must file all Chestnut tax and information returns in a manner consistent with applicable laws.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 480 Antitrust		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 480 ANTITRUST

All staff must comply with applicable antitrust and similar laws which regulate competition. Examples of conduct prohibited by the laws include (1) agreements to fix prices, bid rigging, collusion (including price sharing) with competitors; (2) boycotts, certain exclusive dealing and price discrimination agreements; and (3) unfair trade practices including bribery, misappropriation of trade secrets, deception, intimidation and similar unfair practices. Staff should seek advice from Chestnut's Compliance Officer when confronted with business decisions involving the risk of violation of the antitrust laws.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 490 Legal Compliance Training and Consultation		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 490 LEGAL COMPLIANCE TRAINING AND CONSULTATION

Chestnut Health Systems employees will maintain the highest ethical standards in the conduct of company affairs. The intent of this policy is that each employee will conduct the organization's business with integrity and comply with all applicable laws in a manner that excludes consideration of personal advantage or gain.

Except as noted in the "Acceptable Courtesies" section below, Chestnut employees shall not seek or accept, for themselves or for others, any gifts, favors, entertainment, personal loans (other than conventional loans at market rates from lending institutions) or other payments from any persons or business organizations that do or seek to do business with Chestnut without a legitimate Chestnut business purpose for doing so.

Acceptable Courtesies:

Employees may accept for themselves and members of their families common courtesies associated with customary legitimate business practices.

Following are some examples of courtesies that employees are permitted to accept on an infrequent basis if offered to the employee:

- Lunch and/or dinner with vendors, including spouses
- Gifts of nominal value (a retail value less than $20) such as pens, calendars, notepads, etc.
- Tickets to events (sports, arts, etc.) but only if the Chief Financial Officer or General Counsel or either of his/her designees approves attending the event
- Day outings such as golf, fishing, etc. but only if the Chief Financial Officer or General Counsel or either of his/her designees approves attending the outing
- Overnight outings but only if the Chief Financial Officer or General Counsel or either of his/her designees approves attending the overnight outing
- Any prize received in a raffle, competition or other game of chance or skill
- Gifts of perishable items usually given during the holidays such as cookies, candy and nuts, although the receipt of alcoholic beverages is strongly discouraged.

Prohibitions:

- Employees are not permitted to solicit any gifts or favors from anyone.
- Employees may never accept for themselves and members of their families the following types of gifts:
- Gifts of cash or a cash equivalent such as stocks or other forms of marketable securities
- Gifts greater than nominal value including real estate, jewelry, electronics or other tangible personal property
- Gifts, services or entertainment that contain explicit or implicit sexual references or would otherwise be deemed as offensive or violate Chestnut's anti-harassment policies
- Use of vendor facilities (such as vacation homes, houseboats, etc.) unless the vendor is reimbursed for the value of the use of the facility. The Chief Financial Officer or General Counsel or either of his/her designees must be informed of any such arrangements in advance of such use.

Supervisors should not accept gifts from subordinates or those under their supervision of more than nominal value.

Gifts Given to or Received by Clients:

- Staff should not accept gifts or extra remuneration (tips) from clients or their families, with the exception of nominal non-monetary gifts.
- Staff should not give gifts and/or money to clients or their families, with the exception of nominal non-monetary gifts paid for with the staff member's personal funds.
- Staff must not accept personal liability for outstanding client fees.
- Each staff member should consult with his/her supervisor prior to giving or receiving gifts from clients who are also co-workers.
- Fellow co-workers may accept from other co-workers (even if a client) nominal money on an infrequent basis for a non-alcoholic drink or snack.

Employees are expected to comply with all IRS rules and guidelines for reporting gifts as income.

If any questions arise regarding this policy, staff should consult with his/her supervisor prior to accepting or offering any gift.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 500 Principle Five: Business Ethics		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 500 PRINCIPLE FIVE: BUSINESS ETHICS

Staff must accurately and honestly represent Chestnut in all business dealings and must not engage in any activity or scheme to defraud anyone of money, property or honest services.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 510 Marketing and Billing Practices		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 510 MARKETING AND BILLING PRACTICES

Chestnut accurately, honestly and professionally markets and advertises only those services that are deliverable within the professional, technical, and licensure limits and capabilities of the organization.

Chestnut staff must provide accurate and timely information to payer sources.

Billing must be accurate and done in a timely and professional fashion in accordance with commonly acceptable account receivable standards.

Conflicts regarding client billing must be resolved without real or perceived harassment.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section: Personnel Policies

Policy Name and Number: PP 520 Honest Communications

Revision Date:

Applies To:	☒Employees	☐Clinical Staff Only	☐Interns
	☐Contractors	☐Administrative Staff Only	☐Board Members
	☐Volunteers		
Type of Policy:	☒Administrative	☐Clinical	

Policy Cross Reference(s):

Citation(s):

PP 520 HONEST COMMUNICATIONS

Chestnut staff must deal honestly and fairly with clients, customers, vendors, competitors, payers, and financial partners.

All communications and disclosure of information must be clear, accurate, and sufficiently complete to prevent misleading communications.

All financial and operational reports must be truthful and accurate.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 530 Admission, Transfer or Discharge		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 530 ADMISSION, TRANSFER OR DISCHARGE

The decision to admit, transfer, and discharge clients by authorized staff must be based upon a variety of factors including consideration of licensing standards, accreditation standards, contract requirements, and most importantly the best interest of the client in order to insure treatment that is appropriate to the client's needs and therapeutic goals.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 540 Misappropriation of Proprietary Information		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 540 MISAPPROPRIATION OF PROPRIETARY INFORMATION

Chestnut staff must not misappropriate confidential or proprietary information belonging to another person or entity or utilize any publication, document, computer program, information or product in violation of a third party's interest in such product. All Chestnut staff are responsible to insure that they do not improperly copy for their own use documents or computer programs in violation of applicable copyright laws or licensing agreements. Staff must not utilize confidential business information obtained from competitors, including customer lists, price lists, contracts, or other information in violation of a covenant not to compete, prior employment agreements, or in any other manner likely to provide an illegal competitive advantage to Chestnut.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 550 Misappropriation of Company Property and Theft		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 550 MISAPPROPRIATION OF COMPANY PROPERTY AND THEFT

Chestnut staff must not steal, commit theft, embezzle funds or misappropriate, willfully damage or misuse any Chestnut property or property of Chestnut staff, clients or visitors.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 560 Gifts and Gratuities		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 560 GIFTS AND GRATUITIES

Chestnut Health Systems employees will maintain the highest ethical standards in the conduct of company affairs. The intent of this policy is that each employee will conduct the organization's business with integrity and comply with all applicable laws in a manner that excludes consideration of personal advantage or gain.

Except as noted in the "Acceptable Courtesies" section below, Chestnut employees shall not seek or accept, for themselves or for others, any gifts, favors, entertainment, personal loans (other than conventional loans at market rates from lending institutions) or other payments from any persons or business organizations that do or seek to do business with Chestnut without a legitimate Chestnut business purpose for doing so.

Acceptable Courtesies:

Employees may accept for themselves and members of their families common courtesies associated with customary legitimate business practices.

Following are some examples of courtesies that employees are permitted to accept on an infrequent basis if offered to the employee:

- Lunch and/or dinner with vendors, including spouses
- Gifts of nominal value (a retail value less than $20) such as pens, calendars, notepads, etc.
- Tickets to events (sports, arts, etc.) but only if approved by the Chief Financial Officer or General Counsel or either of his/her designees
- Day outings such as golf, fishing, etc. but only if the Chief Financial Officer or General Counsel or either of his/her designees approves attending the outing
- Overnight outings but only if the Chief Financial Officer or General Counsel or either of his/her designees approves attending the overnight outing
- Any prize received in a raffle, competition or other game of chance or skill
- Gifts of perishable items usually given during the holidays such as cookies, candy and nuts, although the receipt of alcoholic beverages is strongly discouraged

Prohibitions:

Employees are not permitted to solicit any gifts or favors from anyone.

Employees may never accept for themselves and members of their families the following types of gifts:

- Gifts of cash or a cash equivalent such as stocks or other forms of marketable securities
- Gifts greater than nominal value including real estate, jewelry, electronics or other tangible personal property
- Gifts, services or entertainment that contain explicit or implicit sexual references or would otherwise be deemed as offensive or violate Chestnut's anti-harassment policies
- Use of vendor facilities (such as vacation homes, houseboats, etc.) unless the vendor is reimbursed for the value of the use of the facility. The Chief Financial Officer or General Counsel or either of his/her designees must be informed of any such arrangements in advance of such use.

Supervisors should not accept gifts from subordinates or those under their supervision of more than nominal value.

Gifts Given to or Received by Clients:

- Staff should not accept gifts or extra remuneration (tips) from clients or their families, with the exception of nominal non-monetary gifts.
- Staff should not give gifts and/or money to clients or their families, with the exception of nominal non-monetary gifts paid for with the staff member's personal funds.
- Staff must not accept personal liability for outstanding client fees.
- Each staff member should consult with his/her supervisor prior to giving or receiving gifts from clients who are also co-workers.
- Fellow co-workers may accept from other co-workers (even if a client) nominal money on an infrequent basis for a non-alcoholic drink or snack.

Employees are expected to comply with all IRS rules and guidelines for reporting gifts as income.

If any questions arise regarding this policy, staff should consult with his/her supervisor prior to accepting or offering any gift.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 600 Principle Six: Conflicts of Interest		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 600 PRINCIPLE SIX: CONFLICTS OF INTEREST

Chestnut staff will maintain the highest ethical standards in the conduct of the organization's affairs. Each employee is expected to conduct the organization's business with integrity and comply with all applicable laws in a manner that excludes consideration of personal advantage or gain.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 610 Relationships Outside Chestnut		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 610 RELATIONSHIPS OUTSIDE CHESTNUT

A conflict of interest may occur if an employee's outside activities or personal interests influence or appear to influence the employee's ability to make objective decisions in the course of his or her job responsibilities. A conflict of interest may also exist if the demand of any outside activities hinder or distract the staff from the performance of his or her job or cause the use of Chestnut's resources for other than Chestnut's purposes. Staff must insure that they remain free of conflicts of interest in the performance of their responsibilities at Chestnut. Chestnut reserves the right to require all employees to complete an annual conflict of interest disclosure statement and update the disclosure statement as necessary. Additionally, all employees shall make prompt and full disclosure, in writing, to their supervisor, of any potential situation that may involve a conflict of interest or possible violation of Chestnut's conflict of interest policy.

Such conflicts include:

1. Ownership by employee, or member of an employee's family, of a significant interest in any outside enterprise that does or seeks to do business with Chestnut or with a competitor of Chestnut, provided the employee has first-hand knowledge that such entity is a competitor or has an existing or potential business relationship with Chestnut.

2. Serving as a director, officer, partner, consultant, or in a managerial or consultative capacity with an outside enterprise that does or seeks to do business with Chestnut or with a competitor of Chestnut, provided the employee has first-hand knowledge that such entity is a competitor or has an existing or potential business relationship with Chestnut. The Chief Executive Officer can approve exceptions to this provision.

3. Any other arrangements or circumstances, including family or other personal relationships, which might dissuade the employee from acting in the best interest of Chestnut.

Upon review of this disclosure, Chestnut reserves the right to determine in its sole discretion whether a conflict exists. Chestnut will notify the employee of its determination including whether the conflict affects continued employment at Chestnut.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 615 Secondary Employment		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 615 SECONDARY EMPLOYMENT

Chestnut staff must abide by strict conflict of interest requirements as a result of its status as a state and federal contractor. A conflict of interest may occur

- if an employee's outside activities (i.e., secondary employment) influence or appear to influence the employee's ability to make objective decisions concerning his or her job responsibilities,
- if the demand of outside activities hinders or distracts an employee in the performance of his or her job responsibilities,
- if the outside activity is contrary to the mission, vision and values of Chestnut, or if the outside activity presents a financial conflict of interest.

Employees may not accept any additional employment or begin any other occupation in exchange for which he/she will receive compensation without Chestnut's written approval. An employee must submit a letter stating the conditions of the second position or occupation to his or her supervisor and route it to the applicable Executive Leadership Council member and the Human Resources Manager. Once notification is made, and if approvals are received from all required parties, the letter will be retained in the employee's personnel file with a copy being returned to the employee. If approval is not given, the employee will be notified by the supervisor.

An employee must receive approval before accepting or commencing work in the second position or occupation. Employees may not have a private practice or work for a competing agency, unless approved in writing by the applicable Executive Leadership Council member. Failure to comply with this policy will result in disciplinary action up to and including termination.

Even if approved, outside employment or another occupation will not be considered an excuse for poor performance, absenteeism, tardiness, or refusal to work extended hours due to emergencies. Employees may not solicit or conduct any outside business during paid work time. Should the outside employment cause or contribute to any of these situations, it must be discontinued.

There could be occasional situations in which secondary positions may be of mutual benefit to both the employee and to Chestnut. All internal secondary employment arrangements must be carried out with the full knowledge and advance authorization of the primary position supervisor and the Human Resources department. Internal secondary positions must comply with the following:

- Full-time, hourly employees must have Program Director and ELC member approval before

working in a secondary position.

- Part-time, hourly employees can work in a secondary position only if the total combined hours worked for Chestnut each week is less than 40 hours. It is the responsibility of the immediate supervisors to coordinate schedules and monitor hours.
- Multiple part-time positions cannot be combined to create a full-time employee with benefits without the advance approval of the primary Program Director, Chief Financial Officer and Director of Human Resources.
- Full-time, salaried employees can work in a secondary part-time hourly position only if –
    - The secondary position is in a program/department that is different from the primary position, along with a different line of supervision.
    - The secondary position has unique job duties and responsibilities from the primary position.

The following is an exception to this prohibition on secondary employment. Any employee working in the field of nursing (i.e., Medical Assistants, Licensed Practical Nurses, and Registered Nurses) may hold secondary positions within different programs or departments of Chestnut, so long as such secondary employment is also in the field of nursing. All such arrangements must be approved in writing by the impacted program supervisors (both primary and secondary).

The employee's secondary supervisor must submit a "Change of Status" document to the Human Resources Department prior to start of the employee's secondary employment.

All internal secondary positions must be in compliance with all Federal and State employment laws. All provisions of this policy (including conflicts of interest, prioritization, performance, scheduling conflicts, etc.) also apply to internal secondary positions. The supervisor of the primary position is the supervisor of record and is responsible for all administrative details. Any circumstances that impact the employment status of the employee in one position may also impact his/her other position(s).

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 620 Utilization Review Conflicts		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 620 UTILIZATION REVIEW CONFLICTS

Staff conducting utilization review activities must not review their own medical records as a function of a formal utilization review or quality assurance process. In situations where it is necessary to perform a utilization review on the chart of an individual who is both a client and an employee, the review shall be performed by the clinical supervisor, or the Program Director of the primary clinician assigned to the case.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 700 Principle Seven: Research, Consultation, Training and Publishing		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 700 PRINCIPLE SEVEN: RESEARCH, CONSULTATION, TRAINING AND PUBLISHING

Chestnut employees, contractors, and others (e.g. students) who conduct research with clients of Chestnut or other organizations must insure that these endeavors are designed, conducted, and reported in accordance with recognized standards of scientific competence and ethical research. All employees, contractors and others shall maintain the highest standards of professionalism in their research, consultation, education/training and publishing activities.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 710 Compliance with Laws and Standards		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 710 COMPLIANCE WITH LAWS AND STANDARDS

Chestnut staff and others who have business relationships with Chestnut and conduct research with clients of Chestnut or other organizations must plan and conduct research in a manner consistent with federal and state laws and regulations, as well as professional standards governing the conduct of research, and particularly those standards governing research with human participants.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 720 Planning Research		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 720 PLANNING RESEARCH

Chestnut staff are responsible for planning research studies that minimize the possibility that results will be misleading.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 730 Institutional Approval		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 730 INSTITUTIONAL APPROVAL

As one means of ensuring the protection of human subjects, all human subjects research conducted by Chestnut researchers or on Chestnut clients, including student projects, must be approved by the Chestnut Institutional Review Board. Chestnut will maintain a Federal-Wide Assurance with the federal Office for Human Research Protection.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 740 Informed Consent		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 740 INFORMED CONSENT

Chestnut staff and others who have business relationships with Chestnut and conduct research with clients of Chestnut or other organizations must comply with all informed consent requirements and procedures established within each study and as specified in federal and state regulations.

Locator information shall only be used to contact research participants regarding their involvement in the research study and for no other purposes.

Written consent must be obtained before recording training sessions that involve activities or elicitation of comments from participants.

Staff should immediately report to his or her supervisor threats by a research participant to harm themselves or others.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 745 Competency of Staff		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 745 COMPETENCY OF STAFF

Chestnut staff must avoid responding to clients (e.g. offering advice) regarding problems or issues that are beyond their role responsibilities or boundaries of competence. A staff member must accurately represent the scope and limitations of his or her education, training and experience.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 750 Research Integrity		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RE 50 – Research Integrity		
Citation(s):			

PP 750 RESEARCH INTEGRITY

Chestnut maintains a Research Integrity Policy and a Research Integrity Committee designed to prevent unethical behavior in research, and to monitor and deal effectively with instances in which unethical research behavior is suspected. See Chestnut's policy RE 50 Research Integrity for specific provisions or consult with a member of Chestnut's Research Integrity Committee.

All research will be conducted within the framework of the policies established by Chestnut's Research Integrity Committee and Institutional Review Board.

Established study procedures (e.g. a pyramid refusal system-referring clients who want to drop out of a study first to the research supervisor and then the Principal Investigator (PI), or a referral system-switching the participant to another research assistant) will be used to assure that every ethical strategy has been exhausted to sustain study participation and to assure that the participant's rights to terminate participation has not been unduly compromised.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 760 Misconduct, Reporting and Whistleblower Retaliation		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 760 MISCONDUCT, REPORTING AND WHISTLEBLOWER RETALIATION

Chestnut maintains a policy to encourage staff to report instances of research misconduct without the threat of retaliation. Chestnut takes seriously any alleged or actual retaliation and has developed measures to encourage ethical conduct in research while discouraging retaliation for the reporting of unethical research conduct. Chestnut staff should report any research misconduct to the Research Integrity Committee Chairperson.

If the potential misconduct involved the chairperson or members of the Research Integrity Committee, the staff member should simultaneously report the misconduct to the Chairperson of the Chestnut Institutional Review Board and to Chestnut's Chief Executive Officer.

Chestnut staff must comply with state and federal law and professional codes of ethics in reporting breaches of professional conduct or professional impairment that are revealed within the training environment.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 765 Lighthouse Institute Consulting and GAIN Coordinating Center (GCC)		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 765 LIGHTHOUSE INSTITUTE CONSULTING AND GAIN COORDINATING CENTER (GCC)

Each staff member of Lighthouse Institute and the Gain Coordinating Center shall:

- Remain clear about his or her service, monitoring, and audit reporting accountabilities to the individual clinician, the clinical supervisor, the treatment organization, and the state or federal agency when working with organizational clients.
- Report to his or her supervisor all acts of incompetence or breaches of professional conduct committed by any individual whose work Chestnut, Lighthouse Institute and GCC is monitoring that could do harm to an individual recipient or the recipient's family and that are identified via the quality assurance monitoring.
- Remain cognizant of the boundaries of his/her competence and authority and remain out of local programmatic/personality conflicts involving issues that do not specifically relate to quality assurance monitoring.
- Remain aware of the potential misuse of data. Data should inform researchers and clinical staff but not replace clinical judgment.
- Honestly represent time expended on particular projects when such time is used as the basis for billing organizational clients.
- Accurately represent and practice within the boundaries of his/her knowledge and level of decision-making authority.
- Ensure that public data sets are de-identified and reported in formats that would not disclose personal health information of a particular individual.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 770 Publishing		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 770 PUBLISHING

Each Chestnut staff member shall:

- Use copyrighted material only with permission or within legally permissible limits.
- Honestly and accurately describe the methods by which published data was obtained.
- Avoid withholding data or altering the presentation of data in a way that distorts its scientific value.
- Refrain from 1) plagiarism (e.g., representing the words and text of others as one's own), 2) self-plagiarism (e.g., inserting one's own previously published text into a new article, chapter, or book without citing the original source), 3) redundant publishing (e.g., publishing the same study data two or more times without acknowledging the earlier sources to the respective editors) and 4) divided/repeated publishing (e.g., representing or splitting data from a single study that is best presented as a whole into multiple articles/chapters).
- Read and accurately synthesize all sources cited in publications.
- Honestly represent the scope of previously completed research by citing all relevant studies, including those not supporting the author's hypothesis, accurately representing the nature or importance of others' work.
- Honestly represent authorship by attributing co-authorship to all individuals who made a major contribution to a publication and not granting co-authorship to those who did not make such a contribution.
- Immediately report potential misconduct related to the publishing activities of a staff member or consultant to Chestnut's Corporate Compliance Officer.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 775 Training		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 775 TRAINING

Each Chestnut staff member shall:

- Train only on topics that are within the boundaries of his/her education training and experience.
- Avoid injecting his/her own political or religious philosophies into the training environment except where the staff member has been invited as an advocate to represent a particular school of thought.
- Present and interpret material in a manner that demonstrates sensitivity and competence related to developmental age, gender identity, gender expression, sexual identity and ethnic/cultural diversity.
- Accurately represent the training content and methods in materials used to promote training events.
- Not use the training environment for the explicit purpose of marketing (e.g., to promote proprietary products, services and institutions in which the trainer has a vested interest). When Chestnut staff may be asked to present on a particular approach, the focus should be on the transmission of objective knowledge and skills and not the sale of products and services.
- Work to protect and preserve the physical and psychological safety and comfort of participants within the training environment.
- Carefully separate presentation of the state of scientific knowledge from the presentation of one's own opinions.
- Present clinical case studies only with the permission of the clients or with all potentially identifying information removed from the case presentation.
- Fully acknowledge the work and contributions of others and not claim or imply personal or institutional ownership of ideas or the work of others.
- Avoid duplicating copyrighted material for use as handouts unless the permission for such use has been obtained.

- Accurately and completely report training evaluation data to training sponsors.
- Maintain respectful, collegial relationships with co-trainers.
- Maintain confidences shared in the training environment, except where maintaining such confidence would lead to injury to self or others.
- Refrain from using agency resources for the development or presentation of training not delivered through Chestnut.
- Respect the principle that training products developed while performing work for Chestnut belong to Chestnut. These products may not be used by the individual employee for work not associated with Chestnut unless permission has been granted by the applicable Executive Leadership Council member.
- Immediately report potential misconduct of other staff members or trainers to Chestnut's Corporate Compliance Officer.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 800 Principle Eight: Management of Information		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 800 PRINCIPLE EIGHT: MANAGEMENT OF INFORMATION

Chestnut Health Systems views maintaining the security and proper use of its business and client information with the utmost importance. It is the responsibility of each staff person to ensure that computer and electronic systems technologies are used for proper business purposes; in a manner that does not compromise the confidentiality or security of clinical, proprietary, or other sensitive information; and in accordance with established ethical and professional standards. All Chestnut staff must recognize that maintaining legal and ethical standards in relation to use of technology, including for ensuring confidentiality and security, is everyone's responsibility.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 801 Staff Appropriate Use		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	ISS 1101 – Chestnut-Owned Devices		
Citation(s):	HIPAA		

PP 801 STAFF APPROPRIATE USE

Chestnut Health Systems policies and procedures for appropriate use of electronic / computing systems are designed and maintained with standards set by HIPAA, and its accrediting bodies, such as The Joint Commission, as their basis, and other applicable laws. Their purpose is to ensure the proper use of Chestnut's information systems and make staff members aware of what the organization deems as acceptable and unacceptable use of such systems while conducting Chestnut business. These policies were written to complement other Chestnut policies on professional and ethical conduct, confidentiality, privacy, and other IT policies.

These appropriate use policies cover all users of all Chestnut Health Systems computer and electronic systems, which include without limitation Chestnut-owned mobile devices, personal mobile devices that are used (in whole or in part) for Chestnut purposes, systems hosted in-house, and systems hosted externally "in the cloud" outside of Chestnut's network. The terms "staff", "staff members", and "employees" refer to all Chestnut workforce members, including but not limited to employees, volunteers, interns, contractors, consultants, and any individual granted access to company computing and communication systems.

The Director of IT and other department managers and staff will create and distribute support documentation as needed to provide staff members with details on proper procedures.

All employees with Chestnut-owned devices must be aware of and comply with all local, state and federal laws regarding usage, including those related to safe driving. Employees are required to exercise reasonable care regarding securing and concealing Chestnut equipment and minimizing risk of theft, damage, and data breach away from the office. Chestnut equipment of all kinds should not be left unattended whenever possible; staff are advised not to leave laptops, cell phones, and other devices exposed in vehicles overnight or in high-risk locations.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 802 User IDs and Passwords		
Revision Date:			
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 802 USER IDS AND PASSWORDS

All staff members who are granted access to the organization's information system(s) will be assigned a unique user ID and password for general access to corporate systems. Additional user IDs and passwords for other systems are assigned as necessary for each staff person's role. Each person is responsible for securing their accounts and keeping the passwords secure and confidential, changing them according to Chestnut policies and procedures, and using safeguards to prevent misappropriation of passwords and systems access permissions. This policy also applies to all electronic signature and codes that uniquely identify system users for legal or compliance reasons.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 803 Protection of Confidential Information		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 803 PROTECTION OF CONFIDENTIAL INFORMATION

Improper exposure or transmission of sensitive data, including client or patient personal health information, is strictly prohibited. All electronic communications must be consistent with Chestnut's policies and associated procedures regarding confidentiality, including those concerning Chestnut confidential information and client or patient personal health information. Employees must also take appropriate measures to prevent inadvertent exposure of all confidential information. These measures include but are not limited to those identified in HR 104 of the Privacy Manual.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 804 Inappropriate Systems Use		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 812 – Inappropriate Internet Use PP 824 – Inappropriate Use of Electronic Communications PP 830 – Personal Equipment		
Citation(s):			

PP 804 INAPPROPRIATE SYSTEMS USE

Chestnut staff members are prohibited from inappropriate use of corporate electronic and computing systems and of personal devices, to the extent personal devices are used for Chestnut purposes. Such inappropriate use includes, but is not limited to the following activities:

1. Engaging in any illegal activity as defined by local, state, or federal law.
2. Intentional or reckless abuse or misuse of any Chestnut computing equipment, network, or system.
3. Sharing Chestnut computer accounts or access with any other individual.
4. Copying or transferring protected or sensitive data via unapproved and/or insecure means.
5. Attempting to disable or compromise the security of information contained on Chestnut computers and systems.
6. Bypassing file/folder or data systems permissions on internal systems or failing to notify IT or department managers of incorrect access.
7. Disguising use or impersonating others, except where anonymous access is explicitly authorized.
8. Disabling, bypassing, or functionally modifying any security measures without the consent of the Director of IT.
9. Downloading, distributing, or using pirated software or data, or otherwise violating copyright, trade secret, patent, or other intellectual property rights.
10. Initiating any form of network sniffing, monitoring, port scanning, or similar activity, unless under the direction of the Director of IT.
11. Uploading unapproved electronic files, programs, etc., of any kind to Chestnut computing systems.
12. Using technology in a manner that is contrary to applicable professional or ethical standards or guidelines.

Refer also to PP 812 Inappropriate Internet Use, PP 824 Inappropriate Use of Electronic Communications, and PP 830 Personal Equipment.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 805 Encryption		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 805 ENCRYPTION

Staff members will use data encryption in ways consistent with Chestnut Health Systems policy, best practices, IT or departmental procedures, or authorization granted by the Security Officer.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 810 Internet Use		
Revision Date:			
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 810 INTERNET USE

Chestnut views the Internet as an important business tool to be provided to staff as necessary. Chestnut networks, including its connection to the Internet, are intended primarily for business related purposes. These policies define the parameters for using this resource.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 811 Monitoring Systems and Internet Use		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 811 MONITORING SYSTEMS AND INTERNET USE

Chestnut Health Systems reserves the right to monitor system activity and data accessing of all kinds on all corporate computing systems at its discretion. No staff member should have any expectation of privacy as to his or her internal systems or Internet usage. Logs of system usage and activity may be reviewed and analyzed at any time deemed appropriate by the Director of IT, Director of Human Resources, General Counsel, Director of Corporate Compliance, Security Officer or designee, and/or senior management.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 812 Inappropriate Internet Use		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 812 INAPPROPRIATE INTERNET USE

Any unauthorized and/or inappropriate use of Chestnut's Internet access is strictly prohibited, including but not limited to these activities:

1. Connecting to, posting, or downloading pornographic material.
2. Engaging in computer "hacking" and other illegal or unethical activity.
3. Non-business use of audio or video streaming sites and services.
4. Unauthorized playing of computer or Internet games.
5. Attempting to disable, compromise, or overload any computer system or network, or to circumvent any system intended to protect the privacy or security of company data or networks.
6. Unless prior approval by the Director of IT or designee has been obtained, staff shall not establish connectivity or capability by any means that could allow unauthorized access to Chestnut systems and information. Examples of such prohibited activities include:
   - bypassing web-filtering systems, such as by proxy avoidance,
   - allowing external access to internal networks not related to usual IT systems procedures,
   - the unapproved establishment of internal hosts or web pages with external access,
   - unapproved use of VPN (Virtual Private Network) or other remote access solutions
   - unapproved use of FTP (File transfer protocol), or other similar technologies,
   - peer-to-peer networks of any kind,
   - unapproved use of web or "cloud" based services to store or route corporate data.
7. Excessive use of Chestnut's computers, networks, and Internet access for personal use.

"Inappropriate" use also refers to such activities whenever conducted on Chestnut property and/or while conducting Chestnut business, whether or not Chestnut owned equipment is involved.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 813 Downloading from the Internet		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 813 DOWNLOADING FROM THE INTERNET

When downloading documents or other informational files from the Internet, employees assume responsibility a) to comply with any applicable copyright laws or licensing restrictions, b) to ensure that the file(s) are scanned for viruses and c) for any negative PC performance/reliability consequences such downloads may create. Employees may not download any software, images, or videos, or other files for non-business use. Employees must also consult with IT staff before installing any shareware or freeware software. Failure to comply with these terms may result in termination of Internet privileges or other sanctions.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 814 Uploading to the Internet		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 814 UPLOADING TO THE INTERNET

Chestnut employees with Internet access may not upload any data owned or licensed by Chestnut Health Systems to any external network or system without explicit authorization from the Director of IT and/or Security Officer, Privacy Officer(s), and appropriate departmental managers.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 815 Cloud-Based Data Systems		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 815 CLOUD-BASED DATA SYSTEMS

All policies defining appropriate or inappropriate use of Chestnut data and computing systems also apply to the use of externally-hosted data and third party systems which also store or process Chestnut data. The Director of IT or designee(s), and departmental managers with responsibilities for managing such external systems, must approve corporate and/or departmental policies and procedures related to administration of these cloud-based (aka “software-as-a-service”) systems.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 816 VPN and Remote Access		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 816 VPN AND REMOTE ACCESS

Remote VPN access by staff from non-Chestnut equipment is highly restricted and requires approval of the Security Officer and applicable ELC or LC member. Where staff members are granted secure (VPN) remote access to Chestnut networks and systems, staff members are responsible a) for preventing unauthorized individuals from inappropriately viewing company data, and b) ensuring that home networking equipment is properly configured and updated with security software and patches to minimize security risk. Such staff members must consult with IT and abide by all relevant procedures for maintaining secure remote access to Chestnut networks and systems.

All policies defining appropriate or inappropriate use of Chestnut data and computing systems also apply to all means of remote access to Chestnut networks, such as VPN, Webmail, or other systems or methods that may be approved. Staff members or others who have been granted remote access are responsible for maintaining secure and private access. Non-Chestnut persons are not permitted use of Chestnut equipment nor allowed remote access to Chestnut systems without explicit approval from the Security Officer and appropriate management.

Personally-owned equipment may not be used to connect remotely to Chestnut systems, via VPN, without approval from the Security Officer. Webmail access from personally-owned computing equipment is permitted for approved staff members. Two-factor authentication is required for access and must be used as directed by IT. Email access via smartphone is only permitted on an individual basis and requires use of IT-authorized app only.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 820 Electronic Communications		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 820 ELECTRONIC COMMUNICATIONS

Chestnut Health Systems views electronic communications, including email and text (IM) messaging, as important business tools. Staff use of email and IM is intended primarily for business related purposes. Similarly, staff use of text messaging on Chestnut-owned devices is also intended primarily for business related purposes. These policies apply to e-mail, instant messages, text messages, chat and other electronic communications where relevant. As with personal phone calls and Internet use, personal email sent by staff must be kept to a minimum and not disrupt daily business. These policies define the parameters for using these resources. The primary method used to communicate important information to Chestnut staff members is the internal e-mail system. All Chestnut staff members are required to check their individual company email and calendar a minimum of once per week during normal work hours. Part-time and PRN staff are required to keep current with company email by regularly and consistently checking email as shift scheduling allows.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 821 Ownership of Electronic Communications		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 821 OWNERSHIP OF ELECTRONIC COMMUNICATIONS

As with all corporate data and information systems, email, email systems, IM / text messages, and similar communications technologies used by Chestnut staff and routed through Chestnut computer systems or Chestnut-owned devices is the property of Chestnut Health Systems. Employee email communications are not considered private despite any such designation either by the sender or the recipient. Similarly, text messages sent or received on Chestnut-owned devices are not considered private. Chestnut reserves the right to monitor its electronic communications systems, including an employee's mailbox or inbox, at its discretion.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 822 Confidentiality of Electronic Communications		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 822 CONFIDENTIALITY OF ELECTRONIC COMMUNICATIONS

Staff should treat all e-mail messages and their attachments and text messages on Chestnut-owned devices as potentially vulnerable to breach of security and confidentiality. Staff shall follow the safeguarding practices as described in Privacy Policy HR 104, Safeguards to Limit Incidental Uses and Disclosures, when electronic communications, including e-mail and text messaging, involves client information.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 823 Chestnut E-Mail Standards		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 823 CHESTNUT E-MAIL STANDARDS

Because email and other postings placed on the internet may display Chestnut Health Systems name and address or may otherwise be associated with Chestnut, staff members are responsible for first determining that the information is consistent with all Chestnut standards and policies before posting or sending such information to the internet.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 824 Inappropriate Use of Electronic Communications		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 824 INAPPROPRIATE USE OF ELECTRONIC COMMUNICATIONS

Any unauthorized and/or inappropriate use of Chestnut's email, IM / text messaging on Chestnut-owned devices, or related communications systems is strictly prohibited, including but not limited to these activities:

1. Offensive, demeaning, disruptive, libelous, or obscene messages or other postings are prohibited. This includes, but is not limited to, messages that are inconsistent with Chestnut Health Systems' policies concerning "Equal Employment Opportunity" and "Sexual Harassment and Other Unlawful Harassment".
2. Electronic communications shall not be used for any non-Chestnut solicitations unless expressly permitted by the General Counsel.
3. No employee shall misrepresent himself or herself by sending electronic communications in the name of any other person.
4. Employees shall not provide email or IM access to an unauthorized user, nor access another user's email mailbox, without authorization from the Director of IT and other designated senior management.
5. Use of any non-Chestnut third-party email account for conducting company business or transmitting company data, without authorization from the Director of IT and/or Security Officer and Privacy Officer(s).
6. Sending unsolicited "spam" messages or contributing to its distribution.
7. Excessive use of email for personal use.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 825 Retention of Electronic Communications and Limitations		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 825 RETENTION OF ELECTRONIC COMMUNICATIONS AND LIMITATIONS

E-mail systems and IM / text messages are not considered a permanent record for storing regulated information. Some pertinent data categories requiring retention by means other than e-mail or text message storage include clinical, financial and personnel information. Staff must print, copy to an appropriate electronic data system, or otherwise permanently store per established corporate departmental, or clinical/medical records procedures, any electronic communication or attachment that is governed by applicable retention requirements.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 830 Personal Equipment		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 830 PERSONAL EQUIPMENT

Chestnut policy defines the appropriate personal and business use of computing and related communication devices not owned by the organization. These devices include but are not limited to smart phones, cell phones, MP3 players, tablets, laptops / notebooks, and e-book readers. Chestnut management may modify the terms of this policy at any time.

Personal Devices – In general, staff-owned personal computers and laptops are not permitted for Chestnut business use. Staff members are permitted to bring their own smartphones or similar devices to Chestnut premises for their own use, provided that these guidelines specifying limitations and appropriate use of personally-owned devices are acknowledged and followed:

- Connectivity to Internal Systems – Use of personal equipment to connect to Chestnut systems is highly restricted. Staff members are ONLY permitted to connect to Chestnut computing or communication systems using procedures and devices approved by the Director of IT or designee(s), and ONLY after explicit approval of the Director of IT and the applicable ELC member.
- Denial of Use – Personal use of such devices (either by device type or by individual staff member) may be denied by the Director of IT and/or Security Officer in situations where personally-owned equipment a) creates a security or operational risk to the company, its data, or its systems, b) fails to conform to all security, safety, and regulatory guidelines, or c) the staff person owning the equipment fails to properly follow all policies pertaining to its use. The Director of IT and/or Security Officer shall have authority and responsibility for enforcing limitations to this policy, as well as for defining terms and conditions and for administering oversight procedures for such devices.
- Appropriate Use –Chestnut policy governing appropriate computing use also applies to the use of personally-owned devices a) while conducting company business and/or b) while present on company property, regardless of whether devices are connected to Chestnut systems. Refer to PP 395 (Personal Phone Calls / Cell Phones) for more details on acceptable use.
- Email Access – Staff members may be granted access to his/her individual Chestnut email account via Webmail from web browsers on remote or home computers. Such access requires use of two-factor authentication. Email access via personal smartphone or tablet app is restricted and requires approval by the Director of IT and the applicable ELC member. Upon separation from Chestnut employment, staff members with Chestnut email access via personal smartphone/tablet app agree to allow his/her device to be remotely wiped of Chestnut corporate data (such as email)..The employee assumes responsibility for personal data that may not be recoverable as a result.

- Camera & Video chat / similar functions – Staff use of device features such as cameras or video communications (Skype, Facebook Live, Apple FaceTime, etc.), is prohibited where such use may put patient privacy or safety at risk or where use is otherwise prohibited by Chestnut policy.
- Programmatic Guidelines – In consultation with Human Resources, ELC members and program directors have discretion to establish additional usage guidelines and limitations for their programs which do not involve connectivity to Chestnut computing and communication systems.
- Staff must consult with IT prior to attempting any new, non-standard, or previously unidentified connectivity or data sharing method.

Personal storage devices (USB/Flash drives, Micro Disk, optical disc, media players & recorders, etc.) – Use of personally-owned storage devices to store, access, or transport confidential, sensitive, or proprietary Chestnut data is strictly prohibited except in compliance with PP 803, PP 804, PP 805, and other applicable Chestnut policies. Any exception to this rule requires the approval of the Security Officer and applicable ELC member. This policy applies to personal smart phones that access Chestnut data or email systems, as well as other storage media formats, including but not limited to USB/Flash drives, CD/DVD disks, Micro Disk, and all other storage technologies not explicitly listed. Use of any storage device, process, or technology not mentioned by this policy is not permitted until a security review has been undertaken by IT and approval has been granted by the Security Officer and applicable ELC member.

Working in excess of forty hours in one work week requires advance authorization of the non-exempt employee's supervisor or Program Director. This would include time spent accessing, monitoring, reading and/or responding to electronic communications or phone calls and messages through a mobile device or computer, whether or not owned by Chestnut. Failure to receive written e-mail authorization prior to working overtime hours will be grounds for disciplinary action.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 840 Social Media Policy		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 90-970 – Chestnut Code of Conduct and Ethics PP 220 – Proprietary Information PP 210 – Client Information		
Citation(s):			

PP 840 SOCIAL MEDIA POLICY

Purpose

The purpose of this policy is to outline the appropriate business use of social media.

Policy

The use of social media presents both risks and rewards. It also carries with it certain responsibilities. To assist employees, interns, contractors, and volunteers with making responsible decisions about the use of social media, Chestnut Health Systems ("Chestnut") has established these guidelines for appropriate use of social media. This policy applies to all Chestnut employees, interns, contractors, and volunteers (sometimes collectively referred to herein as "employee" or "employees").

Social media may not be accessed through Chestnut computers without appropriate management authorization, unless such activity is part of an employee's job duties.

Conduct that adversely affects job performance, the performance of fellow employees or otherwise adversely affects patients, practitioners, or people who work on behalf of Chestnut or Chestnut's legitimate business interests may result in disciplinary action up to and including termination.

Definitions

As used in this policy, "Social Media" includes all means of communicating or posting information or content of any sort on the Internet, including to your own or someone else's web log or blog, journal or diary, personal web site, social networking or affinity web site, web bulletin board or chat room, whether or not associated or affiliated with Chestnut, as well as any other form of electronic communication. Forms of social media include, but are not limited to, written text, audio recording, photography, and video recording.

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Do's and Do Not's for Use of Social Media

Do:

- Understand that all data and information that is entered, received, stored, or transmitted via Chestnut's electronic resources is the property of Chestnut and employees should have no expectation of privacy with respect to such data and information.

- Exercise good judgment. Chestnut does not wish to interfere with the personal lives of its employees, but employees should be aware that their personal online life may be perceived as linked to their professional life. Employees are at all times expected to follow the Chestnut Code of Conduct and Ethics (*see* PP 90-970).

- Be fair and courteous to fellow employees, vendors, or people who work on behalf of Chestnut.

- Keep in mind that you are more likely to resolve work related complaints by speaking directly with your co-workers than by posting complaints or criticism to a Social Media outlet. This includes statements, photographs, video or audio that could be viewed as malicious, obscene, threatening, or intimidating, that disparage employees or vendors, or that might constitute harassment or bullying.

- Always make sure you are honest and accurate when posting information. If you make a mistake, correct it quickly. Be open about any previous posts you have altered. Remember that the Internet archives almost everything; therefore, even deleted postings can be searched. Never post any information or rumors that you know to be false about Chestnut, fellow employees, vendors or people working on behalf of Chestnut.

- Express only your personal opinions. Unless you are officially and explicitly permitted to speak on Chestnut's behalf, never represent yourself as a spokesperson for Chestnut and refrain from attributing views that you express to Chestnut, fellow employees, vendors or people working on behalf of Chestnut. If you become aware of a post that may require an official response from Chestnut or could otherwise become an issue for the organization, contact and inform your supervisor and the Human Resources and Marketing Departments for proper handling.

- Be particular about your "friends" and associations and check the privacy and security settings on your accounts.

- Access Social Media only on your personal devices and/or cell phones and only during lunch/break times, unless such activity is part of your job duties.

Do Not:

- Use offensive language or engage in harassment or intimidation. Inappropriate postings that may include discriminatory remarks, harassment, and threats of violence or similar inappropriate or unlawful conduct will not be tolerated and may subject you to disciplinary action up to and including termination. It is a violation of this policy to electronically communicate in a manner that is obscene, harassing, abusive, or threatens an individual's safety, in accordance with Chestnut's policies on harassment.

- Exchange or disclose information that is proprietary or confidential to Chestnut. This may include information regarding the development of systems, processes, products, know-how and technology. Do not post internal reports, policies, procedures or other internal business-related confidential communications. Employees are at all times expected to comply with Chestnut's policy

on Proprietary Information (*see* PP 220).

- Exchange or disclose client information. Employees are at all times expected to comply with Chestnut's policy on Client Information (*see* PP 210).

- Create or maintain a Social Media outlet branded by Chestnut or any of its wholly-owned subsidiaries unless specifically authorized to do so by the Marketing Department. When authorized to operate a Social Media outlet branded by Chestnut or one of its wholly-owned subsidiaries, you must follow and work within the confines of current written guidelines developed and maintained by the Marketing Department. The foregoing requirement shall not apply to Social Media outlets branded by any of Chestnut's joint venture companies, which shall be operated by the partners of such joint venture companies. All employees are expected to notify their supervisors and the Marketing Department if they suspect the existence of an unauthorized Social Media outlet purported to be branded by Chestnut or one of its joint ventures or subsidiaries.

Management may not request passwords or other account information for staff members' personal accounts on social networking websites that have privacy settings. Violation of this policy may lead to discipline up to and including termination of employment.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 900 Principle Nine: Corporate Compliance Program		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 900 PRINCIPLE NINE: CORPORATE COMPLANCE PROGRAM

Chestnut is committed as an organization to meet its ethical standards and compliance with all applicable laws and regulations, whether federal, state, or local. It is Chestnut's expectation that staff will know and understand the rules affecting their respective areas of operation.

CHESTNUT
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Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 910 Corporate Compliance Program Structure		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 910 CORPORATE COMPLIANCE PROGRAM STRUCTURE

The Corporate Compliance Program is intended to demonstrate in the clearest possible terms the absolute commitment of Chestnut to the highest standards of ethics and compliance. Although staff must comply with all applicable laws that regulate Chestnut's business, the following areas of law have been identified as risk areas to be covered by the Corporate Compliance Program: tax-exemption; antitrust; confidentiality of client records; licenses and certification requirements; funding contract requirements/certifications; records documentation and retention; and clinical services documentation and billing (fraud & abuse).

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 920 Resources for Guidance and Reporting Violations		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 920 RESOURCES FOR GUIDANCE AND REPORTING VIOLATIONS

Staff who have a question regarding this Code or Chestnut's Compliance Program, or who observe practices that appear to violate this Code, the law, or contractual obligations, should contact:

* Their supervisor; or
* Chestnut's Corporate Compliance Officer.

Chestnut encourages the resolution of issues by encouraging each staff member to initially contact his or her immediate supervisor. If a staff person perceives his or her immediate supervisor or supervisory staff as having a conflict of interest or does not receive a satisfactory response, then she or he may contact the Compliance Officer in writing or by phone. Subject to certain limitations, anonymous reporting is permitted (please see Chestnut's "Employee Reporting Policy" for further details).

Chestnut will make every effort to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports possible misconduct. There will be no retribution or discipline for anyone who reports a possible violation in good faith. There will also be no retribution or discipline for anyone cooperating with an investigation who is not a subject of the report or investigation. Any staff person who deliberately makes a false accusation against another employee will be subject to discipline.

All Chestnut staff are encouraged to utilize Chestnut's established procedures for dealing with suspected illegal, unethical behavior or unsafe conditions, including utilizing the Corporate Compliance reporting procedures. If any staff member believes Chestnut has not responded appropriately to his or her report and believes that Chestnut continues to perform in illegal, unethical or unsafe ways, the staff member may report those concerns directly to:

The Joint Commission

One Renaissance Blvd.

Oakbrook Terrace, Illinois 60181

630/792-5000

No retaliation will be tolerated against any employee who has filed a report based on a good faith belief that an employee or agent of Chestnut Health Systems has violated this Code of Conduct and Ethics or the Compliance Program.

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Policy Handbook Section: Personnel Policies

Policy Name and Number: PP 930 Personal Obligation to Report

Revision Date:

Applies To:	☒Employees	☐Clinical Staff Only	☐Interns
	☐Contractors	☐Administrative Staff Only	☐Board Members
	☐Volunteers		
Type of Policy:	☒Administrative	☐Clinical	

Policy Cross Reference(s):

Citation(s):

PP 930 PERSONAL OBLIGATION TO REPORT

Chestnut is committed to ethical and legal conduct that is compliant with all relevant laws and regulations and to correcting wrongdoing wherever it may occur in the organization. Each staff person has an individual responsibility for reporting any activity by any colleague, practitioner, subcontractor, or vendor that appears to violate applicable laws, rules, regulations, or this Code of Conduct and Ethics. Each staff person also has an individual responsibility to bring to the attention of supervisory staff any conditions that threaten the safety of clients, family members, visitors or staff.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 940 Internal Investigations of Reports		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 940 INTERNAL INVESTIGATIONS OF REPORTS

Chestnut is committed to inquire about or investigate all reported concerns promptly and confidentially to the extent possible. The Compliance Officer will coordinate any findings from the investigations and immediately recommend corrective action or changes that need to be made. All staff must cooperate with inquiries or investigation efforts.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 945 Whistleblower Protection		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CC 50 – False Claims Reporting / Whistleblower Protection		
Citation(s):			

PP 945 WHISTLEBLOWER PROTECTION

Chestnut shall not take any action to prevent any staff member from disclosing information to the proper authorities (including a government or law enforcement agency) if the staff member has reasonable cause to believe that the information discloses a violation of a state or federal law, rule or regulation or other unlawful act. This includes a staff member who reports to Chestnut any misconduct that violates a clear mandate of public policy as articulated in a constitutional provision, statute, or regulation promulgated under statute. Chestnut shall not retaliate against any staff member for either taking such action or for refusing to participate in any activity that would result in a violation of a state or federal law, rule or regulation. Chestnut shall also comply with the False Claims Reporting and Whistleblower Protections found in Chestnut's Policy Handbook, policy CC 50 False Claims Reporting/Whistleblower Protection.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 950 Corrective Action		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 70 – Adherence to the Personnel Policies & Disciplinary Action		
Citation(s):			

PP 950 CORRECTIVE ACTION

When an internal investigation substantiates a reported violation, it is the policy of Chestnut to initiate corrective action, including, as appropriate, making restitution of any overpayment amounts when indicated, notifying the appropriate governmental agency, instituting whatever disciplinary action is necessary, and implementing systemic changes to prevent a similar violation from recurring in the future.

All violators of the Code of Conduct and Ethics will be subject to appropriate action. The precise corrective action utilized will depend on the nature, severity, and frequency of the violation. The corrective actions listed below are not progressive discipline steps, nor do such actions need to be taken in any sequence. The corrective action may result in any one or combination of the following actions; however, this is not an all-inclusive list of options:

- Termination of employment
- Demotion
- Restitution
- Suspension without pay
- Suspension with pay
- Training
- Referral to the Employee Assistance Program (“EAP”)
- Transfer to a more suitable position
- Verbal warning
- Written warning via Performance Deficiency Report
- Referral for possible criminal prosecution/civil action
- Supervision meetings or coaching
- Performance Improvement Plan

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 960 Internal Audit and Other Monitoring		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 960 INTERNAL AUDIT AND OTHER MONITORING

Chestnut is committed to the aggressive monitoring of compliance with its policies. Much of this monitoring effort is provided by the Quality Improvement Program and Chestnut's internal auditor, which routinely conducts internal audits of issues that have regulatory or compliance implications. Chestnut also routinely seeks other means of ensuring and demonstrating compliance with laws, regulations and Chestnut policy.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 970 Compliance Training		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 970 COMPLIANCE TRAINING

Chestnut requires all staff to sign an acknowledgment confirming they have received the Code of Conduct and Ethics and have received corporate compliance training, including false claims act and whistleblower training. Staff whose jobs with Chestnut require them to have more detailed knowledge of specific areas of law covered by the Corporate Compliance Program must attend specialized Chestnut educational programs. New staff will be required to sign an acknowledgment as a condition of employment.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1000 Principle Ten – Workplace Civility		
Revision Date:			
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1000 – WORKPLACE CIVILITY

It is the policy of Chestnut to promote and maintain a civil workplace where all of its employees will treat each other with professionalism, maturity, dignity and respect. Chestnut will not tolerate any personal conduct (whether intentional or unintentional) which negatively affects the workplace or interferes with an individual's work performance or sense of security at work.

Examples of employee conduct that are prohibited include, but are not limited to:

- Harassment
- Bullying
- Intimidation
- Discrimination
- Exclusion (a pattern of socially or physically excluding or disregarding another employee in work-related activities)

Employee behavior in violation of this policy, whether directly experienced or witnessed, should be promptly reported confidentially to a member of management, to the Human Resources department or by using the corporate compliance on-line reporting tool. Employees found to have violated this policy will have their conduct addressed using Chestnut's established disciplinary actions.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section: Personnel Policies

Policy Name and Number: PP 1010 No Harassment Tolerated

Revision Date:

Applies To: ☒Employees ☐Clinical Staff Only ☐Interns ☐Contractors ☐Administrative Staff Only ☐Board Members ☐Volunteers

Type of Policy: ☒Administrative ☐Clinical

Policy Cross Reference(s):

Citation(s):

PP 1010 NO HARASSMENT TOLERATED

Chestnut will not tolerate any form of harassment including, but not limited to, harassing conduct that affects any condition or privilege of employment, that interferes with an individual's work performance, or that creates an intimidating, hostile or offensive work environment. It is the policy of Chestnut to provide and maintain a workplace that is free from all forms of illegal discrimination, including harassment.

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Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1015 Definitions of Harassment and Bullying		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1015 DEFINITIONS OF HARASSMENT AND BULLYING

Harassment violates the law and Chestnut's policies if it involves discriminatory treatment based on race, color, sex (with or without sexual conduct), gender identity, gender expression, religion, national origin, age, ability or disability, sexual identity, marital status, unfavorable discharge from the military, or because the employee opposed job discrimination or participated in an investigation or complaint proceeding under the Equal Employment Opportunity (EEO) statutes.

While bullying may not always rise to the level of the legal definition of harassment, it is nonetheless unacceptable behavior in the Chestnut workplace. Chestnut defines bullying as repeated, unwelcome behavior that takes place over a period of time and is meant to harm or influence someone who feels powerless to respond. Bullying behavior may be direct or indirect. Bullying may be evident in verbal, physical, or written actions.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1020 Sexual Harassment		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1020 SEXUAL HARASSMENT

Sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when one or more of the following apply:

1. Submission to such conduct is made an explicit or implicit term or condition of an employee's employment;
2. Submission to or rejection of such conduct by an employee is used as a basis for employment decisions affecting the employee; or
3. Such conduct unreasonably interferes with an employee's work performance or creates an intimidating hostile or offensive working environment.

"Verbal or physical conduct" includes but is not limited to sexually-related comments; sexually suggestive pictures, notes or signs; unseemly gestures or sounds; touching; use of demeaning or inappropriate terms or names; crude or offensive language; discussing sexual activity about or around others.

All Chestnut employees are required to participate in sexual harassment training 1) at the time of hire and 2) each year at their employment anniversary date.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1030 Internal Reporting of Harassment Complaint		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☒Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Mo. Rev. Stat. §213.010		

PP 1030 INTERNAL REPORTING OF HARASSMENTOR BULLYING

Reporting a Complaint: Any employee who believes that he or she has been subjected to workplace harassment or bullying, is encouraged to inform the person that has participated in the harassment or bullying that he or she objects to the treatment. Any concerns involving workplace harassment or bullying shall be reported directly to

- A member of Chestnut management
- The Director of Human Resources / Human Resources Manager or
- Chestnut's on-line corporate compliance reporting website

Description of Misconduct/Time Frame for Reporting Complaint: Complainants are strongly encouraged to provide a written report of the incident(s) as indicated above. This written report will allow for an accurate record of objectionable behavior or misconduct, which is needed to assist in resolving a complaint of harassment or bullying. Reports should be made immediately. However, due to the sensitivity of these problems and because of the emotional toll such misconduct may have on an employee; no specific time frame is instituted for reporting harassment complaints. Late reporting of complaints will not in and of itself preclude Chestnut from taking remedial action.

Protection against Retaliation: Chestnut prohibits any form of retaliation against any employee who in good faith believes that he or she has been the subject of unlawful harassment or of workplace bullying, or because he or she had made a charge of discrimination, filed a complaint, testified, assisted or participated in an investigation, proceeding or hearing under the Civil Rights Act or the Illinois Human Rights Act, or applicable state or federal law. Any employee found to have retaliated against another for reporting harassment or bullying will be subject to the same disciplinary action as any offenders.

Confidentiality: Any allegation of workplace harassment or bullying brought to the attention of Chestnut will be promptly investigated in a confidential manner so as to protect the privacy of persons involved. Confidentiality will be maintained throughout the investigation process to the extent practical and appropriate under the circumstances.

If an investigation results in a finding that the complainant falsely accused another of harassment or bullying knowingly or in a malicious manner, the complainant will be subject to appropriate sanctions, including the possibility of termination.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1040 Pursuit of Harassment Complaint with Outside Agency		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1040 PURSUIT OF HARASSMENT COMPLAINT WITH OUTSIDE AGENCY

If the employee believes that his or her complaint has not been resolved to his or her satisfaction through the internal complaint procedures, he or she may file a charge of harassment with the United States Equal Employment Opportunity Commission ("EEOC") or the applicable state agency, such as the Illinois Department of Human Rights ("IDHR") or the Missouri Commission on Human Rights ("MCHR").

A charge with the EEOC must be filed within 300 days of the incident of harassment; a charge with IDHR must be filed within 180 days of the incident of harassment.

EEOC can be contacted as follows:

Phone: 1-800-669-4000
TDD: 1-800-800-3302
https://publicportal.eeoc.gov/portal/

IDHR can be contacted as follows:

Chicago Phone: 312-814-6200
Chicago TDD: 312-263-1579
Springfield Phone: 217-785-5100
Springfield TDD: 217-785-5125
Email: IDHR.ReportSH@illinois.gov

MCHR can be contacted as follows:

Phone: 573-751-3325
TDD:1-800-735-2966
mchr@labor.mo.gov

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1100-1170 Benefits		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 820		
Citation(s):			

PP 1100-1170 BENEFITS

Chestnut maintains a diverse selection of employee benefits for its part-time and full-time regular employees. The primary method used to communicate important information about employee benefits to Chestnut staff members is the internal e-mail system. Consistent with PP 820, all Chestnut staff members are required to check their individual company email and calendar a minimum of once per week during normal work hours. Part-time and PRN staff are required to keep current with company email by regularly and consistently checking email as shift scheduling allows

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1110 Vacations		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1110 VACATIONS

Vacation time is earned by full-time employees during an employment year and can be taken following the completion of the employment year. Vacation time will not accrue while employees are on unpaid leave receiving disability benefits, workers' compensation lost time benefits, or are taking other unpaid time off. Vacation time must be scheduled in advance with the approval of the immediate supervisor. Vacation shall be taken within the established timeframes according to the following schedule:

Length of Service Completed in Years And/or Months	Vacation Days Granted	Accrual Rate hours per month
1 year	10 days	6.66 hours
2 years	10 days	6.66 hours
3 years	15 days	10 hours
4 years	15 days	10 hours
5 years	15 days	10 hours
6 years	16 days	10.66 hours
7 years	17 days	11.33 hours
8 years	18 days	12 hours
9 years	19 days	12.66 hours
10 + years	20 days	13.33 hours

If a full time employee has unused vacation time on his or her anniversary, up to 5 days (40 hours) will automatically carry over to be used in the first 90 calendar days of the next anniversary year. This roll over will not require supervisory approval; however, supervisors must approve the scheduling of vacation time. Upon separation from employment, full-time employees shall receive compensation for earned but unused vacation time in accordance with this policy. The earned days shall be pro-rated based on the employee's anniversary date.

Regularly scheduled holidays falling within the vacation period shall not be deducted from the vacation allowance.

Paid time off benefits do not accrue during unpaid leaves of absence. Newly accrued vacation may only be used after the employee's anniversary date, and only if the employee is actively working.

Hourly, non-exempt employees are paid only for hours worked. Full-time, non-exempt employees who do not work their full-time schedule during a work week (Monday thru Sunday) will have their available paid time off benefits automatically applied against the hours not worked.

Employees may access their time off balances at any time through the Accounting and Payroll page on the Chestnut Intranet or their ADP Dashboard. Visit https://workforcenow.adp.com, click on the Myself tab, and then Dashboard under the Workforce Management option.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1115 Retention Reward Days		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1110 – Vacations		
Citation(s):			

PP 1115 RETENTION REWARD DAYS

In an effort to improve staff retention, first year full-time employees who have successfully completed six (6) months of service at Chestnut shall be eligible to receive up to five (5) Retention Reward days (RR Days). These RR Days are not vacation days. Vacation days are accrued for new employees and may be taken after one year of service consistent with PP 1110 above. RR Days are days off with pay given to a first year employee reaching a six month anniversary and may be taken up to the date of the employee's first anniversary. To assure adequate staffing, these days must be scheduled in advance with the approval of the immediate supervisor. These RR Days may not be carried over into the next year, nor is the employee entitled to any compensation for unused RR Days as a result of separation of employment. Full-time employees who change positions within Chestnut are not eligible for RR Days upon assumption of a new position. RR Days are only applicable to new full-time employees of Chestnut Health Systems.

Hourly, non-exempt employees are paid only for hours worked. Full-time, non-exempt employees who do not work their full-time schedule during a work week (Monday thru Sunday) will have their available paid time off benefits automatically applied against the hours not worked.

Paid time off benefits do not accrue during unpaid leaves of absence. Newly earned RR Days may only be used after the employee's sixth month of service, and only if the employee is actively working.

Employees may access their time of balances at any time through the Accounting and Payroll page on the Chestnut Intranet or their ADP Dashboard. Visit https://workforcenow.adp.com, click on the Myself tab, and then Dashboard under the Workforce Management option.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1120 Holidays		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1121 Floating Holiday		
Citation(s):			

PP 1120 HOLIDAYS

The following paid holidays are observed:

New Year's Day
Martin Luther King, Jr. Day
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
Christmas Day
*Floating Holiday (See PP1121)

When the holiday falls on Saturday, the preceding Friday will be observed unless a specific exception is made and communicated to Chestnut staff. When the holiday falls on a Sunday, the following Monday will be observed.

When a holiday falls on a weekend and the observed holiday is moved to Friday or Monday, an employee is not eligible for holiday pay (or alternative time off) for both the actual holiday and the observed holiday, even if the employee works both days. Also, if an employee has a secondary position within Chestnut, the employee cannot be eligible for holiday pay for hours worked in both jobs on both the actual and observed holidays, only for total hours worked on one of those days.

All staff may be required to work holidays in accordance with a schedule established by the appropriate Program Director or designee. All staff required to work on a holiday will receive additional compensation in the form of holiday pay. Holiday pay will be equivalent to one time an employee's base rate of compensation.

Full-time staff who are required to work on a holiday will receive either holiday pay or alternative time off (as determined by their individual supervisor), in addition to their regular pay, for all hours worked on the holiday. If alternative time off is to be taken, the time off must be used before the employee's anniversary date. Full-time staff taking alternative time off would still receive their regular pay for all hours worked on the holiday. If full-time staff will be taking alternate time off, this time will be reflected on the employee's time off summary as a personal time credit. If the personal time credit is posted less than 30 days prior to the employee's anniversary date, then it will be permitted to carryover to the next anniversary year. Full-

time staff who are required to work and who are given the choice of holiday pay or alternate time off are required to inform their supervisor of their choice of holiday compensation *prior* to the holiday. Supervisors will then provide payroll with a complete list of the employees who will be working on the holiday and the option each employee has chosen.

Part-time staff who are required to work on a holiday will receive regular pay and holiday pay for all hours worked on the holiday.

Employees scheduled to work on a holiday, and who do not report to work, will not receive holiday pay. The absence will be treated like any other absence on a non-holiday.

Employees will not be eligible for holiday pay when they are inactive and/or on a leave of absence.

Holiday Pay Examples:

Part-time Staff

Example 1: A part-time staff employee is scheduled to work 4 hours on a holiday. This employee will receive 4 hours of straight-time pay for the holiday and an additional 4 hours of straight-time pay for the time actually worked. The employee will receive a total of 8 hours of straight time pay.

Example 2: A part-time staff employee is not scheduled to work on a holiday. This employee will not receive compensation for the holiday.

Full-time Staff

Example 1: A full-time staff employee who normally works 8 hours per day is scheduled to work only 4 hours on a holiday. This employee will receive 8 hours straight time pay and an additional 4 hours straight time pay for the time actually worked. The employee will receive a total of 12 hours of straight time pay. As an option, the employee may take alternative time off. Under this option, the employee will receive 4 hours of alternative time off rather than 4 hours of straight time pay.

Example 2: A full-time staff employee is not scheduled to work on a holiday but the holiday falls on a day that the employee would normally be scheduled to work 8 hours. The employee will receive a total of 8 hours straight time pay for the holiday.

All references to holidays in this section refer to the Chestnut designated holidays shown above.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1121 Floating Holiday		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1121 FLOATING HOLIDAY

All full-time regular employees will be eligible for one floating holiday to be used during their anniversary year, starting immediately at their hire date. This paid day off is in addition to the company recognized holidays and other paid time off benefits.

The floating holiday is intended as a way to provide flexible options to our diverse workforce. Examples of using a floating holiday include: days of societal significance, employee birthday, family event, religious observance, or extension of existing company holiday (Christmas Eve, New Year's Eve, Friday after Thanksgiving). However, it is not required that the requested paid day off have any specific significance.

Scheduling of the floating holiday is on a full paid day off basis and is not to be split into smaller time increments.

Eligible employees are required to request their floating holiday a minimum of 10 business days in advance, or a timeline consistent with existing program or department procedures and receive approval from their supervisor. Supervisors will make every effort to grant all floating holiday requests. However, there may be certain days of the year which result in many employee requests for time off. In such cases, supervisors will need to make priority staffing decisions.

Unused floating holidays expire at the end of the anniversary year and cannot be carried over to the next year. Floating holidays are not accrued and; therefore, they are not payable upon termination of employment.

Floating holidays may only be used if the employee is actively working.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1130 Personal Days		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1130 PERSONAL DAYS

Two personal days shall be granted to full-time employees at the date of hire. These two personal days, if unused, will only be paid out to exiting employees if they have had ninety (90) days of service or more.

At the completion of six months of service, an additional three personal days will be granted. Thereafter, five personal days shall be granted at each anniversary date with no carry over. Personal days must be scheduled in advance with the approval of the immediate supervisor. Upon separation from employment, employees shall receive compensation for earned but unused personal days.

Hourly, non-exempt employees are paid only for hours worked. Full-time, non-exempt employees who do not work their full-time schedule during a work week (Monday thru Sunday) will have their available paid time off benefits automatically applied against the hours not worked.

Paid time off benefits do not accrue during unpaid leaves of absence. Newly earned personal days may only be used after the employee's sixth month of service, and only if the employee is actively working.

Employees may access their time of balances at any time through the Accounting and Payroll page on the Chestnut Intranet or their ADP Dashboard. Visit https://workforcenow.adp.com, click on the Myself tab, and then Dashboard under the Workforce Management option.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1140 Medical, Dental, Life and Disability Benefits		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1370 Regular Full Time Employees		
Citation(s):			

PP 1140 MEDICAL, DENTAL, LIFE AND DISABILITY BENEFITS

A medical, dental, life and disability insurance plan is available for all regular full-time employees and for other employees as required by law. The plan is reviewed annually and updated to keep it current and competitive. Agency and employee premium co-payments for both individual and dependent coverage are also reviewed annually. Benefits are explained at the time of employment.

Employees on unpaid leave must make arrangements through Human Resources to continue paying for any portion of employee premium co-payments for which they are responsible under the terms of the insurance plan. Failure by the employee to pay his/her portion of any insurance premium within 30 calendar days of the established deadline will result in termination of coverage.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1142 Health Insurance Portability and Accountability Act (HIPAA) for the Health Plan		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1142 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) FOR THE HEALTH PLAN

The privacy of health information maintained by Chestnut's Health Plan is protected under the Health Insurance Portability and Accountability Act (HIPAA) and its corresponding regulations. The Health Plan as defined for HIPAA purposes includes the medical, dental, flexible spending account, health savings account and vision benefit plans. All employees participating in the Health Plan will receive a notice of privacy practices explaining the uses and disclosures of information as well as participant rights. HIPAA Health Plan questions should be directed to the Director of Human Resources.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1145 Employee Assistance Program (EAP)		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1145 EMPLOYEE ASSISTANCE PROGRAM (EAP)

Chestnut will provide free, confidential and voluntary professional assistance to all full and part-time employees and their dependent family members who may be faced with personal, family, or behavioral health problems that are affecting their well-being or job performance. Services are limited to those which are available through the EAP administrator's network of providers. Employees are encouraged to take advantage of this service before any personal difficulty has a negative impact on job performance or conduct.

Employees and family members can refer themselves to the EAP. The program is managed by an outside vendor and may be reached 24 hours a day on weekdays and weekends by calling a toll-free number. The vendor utilizes experienced and licensed professionals at the masters and doctorate level who have both daytime and evening appointments with office locations in or near communities where Chestnut has staff and operations. Contact your Supervisor or the Human Resources Department for a brochure or information on how to access the EAP plan.

EAP counselors are available to talk by telephone with employees or family members to assess a problem and develop a plan for resolution. The counselors may suggest a referral to an outside resource, such as a therapist, agency, physician, treatment facility, self-help group or other community resources that would be appropriate to assist in resolving the problem or situation. The counselor may also suggest short-term counseling within the EAP for problems that can be handled within one to six visits. Where an employee may be in need of information, a referral or suggestion may be made over the telephone. There is no charge for employees or their families to use the services of the EAP. For employees needing referrals beyond the EAP, counselors will make a good faith effort to coordinate referrals for ongoing treatment with the provisions of Chestnut's health insurance coverage as well as consider the employee's ability to pay. However, the employee is ultimately responsible for any fees for services incurred outside of any EAP assessment or counseling sessions.

Employees who need to visit the EAP during regular work hours, must use sick, vacation, or personal time. If illness is involved, sick, vacation and/or personal time may be used for treatment or rehabilitation on the same basis that it is granted for other health problems.

When an employee's job performance or attendance is unsatisfactory or there appears to be signs of personal problems interfering with work performance, the supervisor should coach the employee in consultation with the Human Resources Manager or designee. If the employee appears to be unable or

unwilling to correct the situation, he or she may be referred to the EAP to assist in the resolution of the problem. Depending on the situation, the employee may accept or refuse participation in the EAP. However, there may be situations where continued employment at Chestnut may be contingent upon the employee contacting the EAP for assistance and cooperating with EAP recommendations.

Participation in Chestnut's EAP does not jeopardize job security or promotional opportunities. However, it does not excuse the employee from following agency policies and procedures or meeting required standards for satisfactory job performance except where required by law.

All contact between an employee and the EAP is strictly confidential and Chestnut receives no identifying information from the EAP vendor or who uses the program. In cases where an employee's continued employment is contingent upon calling the EAP, the EAP counselor will only verify whether or not the employee has contacted the EAP and if he or she is cooperating with EAP recommendations.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section: Personnel Policies

Policy Name and Number: PP 1150 Employee Retirement Plan

Revision Date:

Applies To:	☒Employees	☐Clinical Staff Only	☐Interns
	☐Contractors	☐Administrative Staff Only	☐Board Members
	☐Volunteers		
Type of Policy:	☒Administrative	☐Clinical	

Policy Cross Reference(s):

Citation(s):

PP 1150 EMPLOYEE RETIREMENT PLAN

An employee retirement plan is available for all regular employees. Benefits are explained at the time of employment. A Retirement Plan Investment Committee, as authorized by the Board of Directors, monitors the Plan's fund performance and reviews and implements the Plan's investment policy.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1151 Plan Changes		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP1100-1150		
Citation(s):			

PP 1151 PLAN CHANGES

This handbook provides only general benefit descriptions for plans in sections PP1100-1150. Specific information about all offered benefits is available from the Human Resources Department or by referring to the respective Summary Plan Descriptions and Plan Documents. Chestnut reserves the right, in its sole discretion, to change, alter, amend, add to or delete any offered insurance coverage or benefit plan in whole or in part, or to completely eliminate any benefit plan or insurance coverage. The terms and conditions of all benefits offered by Chestnut are defined in the respective plan documents and policies providing benefits. The terms and conditions of plan documents govern and control any inconsistent terms regarding the applicable benefit that may appear in these policies or the Summary Plan Descriptions.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1160 Reimbursement for Professional Licenses		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1160 REIMBURSEMENT FOR PROFESSIONAL LICENSES

Chestnut employees may request reimbursement for the expenses involved in acquiring a job-related professional license or certificate by applying to the Human Resources department and applicable Lead Director. Expenses will be limited to application and testing fees, except where licensing in other states is required and involves additional fees. The application fee associated with renewal of an authorized license or certification will also be eligible for reimbursement.

Human Resources and Lead Director reserve the right to determine the procedures to be followed for this request. The process is outlined as follows:

1. Obtain the Reimbursement Application from the Chestnut intranet under the “Forms” section or by contacting the Human Resources Department.
2. Submit the License Reimbursement Application and supporting documentation to the Director/Lead Director for review.
3. Once approved, the Lead Director will forward the packet to the applicable Human Resources contact who will review and if acceptable, approve the request and submit application packet to Accounts Payable for reimbursement.

The following credentials listed will be considered for reimbursement (Other licenses/certifications will also be considered for reimbursement upon approval from the Executive Leadership Council. Decisions will be based on the appropriateness of the license/certification received relative to the employee's role within Chestnut):

Advanced Practice Registered Nurse (APRN)
American Association of Nurse Practitioners (AANP)
American Nurse Credentialing Center (ANCC)
Birth and Postpartum Doula Certification
Certified Alcohol and Other Drug Counselor (CADC)
Certified Associate Addictions Professional (CAAP)
Certified Diabetes Educator (CDE)
Certified Employee Assistance Professional (CEAP)
Certified Health Educator Specialist (CHES)
Certified Medical Assistant (CMA)

Certified Medical Office Assistant (CMOA)
Certified Nursing Assistant (CNA)
Certified Peer Recovery Specialist (CPRS)
Certified Reciprocal Alcohol and Other Drug Counselor (CRADC)
Certified Recovery Support Specialist (CRSS)
Community Health Worker
Dental Assistant
Dental Hygienist
Dental Sedation Permit
Dental Specialist
Dentist (DDS)
EMDR Certified Therapist
Health Fitness Specialist (HFS)
Illinois Controlled Substance
Illinois Problem & Compulsive Gambling Certification (PCGC)
Licensed Clinical Social Worker (LCSW)
Licensed Clinical Professional Counselor (LCPC)
Licensed Marriage and Family Therapist (LMFT)
Licensed Professional Counselor (LPC)
Licensed Psychologist
Licensed Social Worker (LSW)
Licensed Dietitian (LD)
Licensed Practical Nurse (LPN)
Master Certified Health Educator Specialist (MCHES)
Missouri Controlled Substance
National Certified Gambling Addiction Counselor (NCGAC)
Physician (MD or DO)
Physician Assistant (PA)
Public Health Dental Hygienist
Registered Dietician (RD)
Registered Nurse (RN)
U.S. Drug Enforcement Agency registration (DEA)

Eligible part-time staff with other employment as a licensed professional will only be eligible for a pro-rated reimbursement.

If an employee leaves within twelve months from issuance of license, then he or she agrees in writing to repay the pro-rated cost of the licensure process. Employees shall agree in writing to permit Chestnut to deduct the pro-rated cost of the licensure process from their final paychecks, if they leave within twelve months from the date of issuance of the license.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1165 Educational Assistance Program		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1165 EDUCATIONAL ASSISTANCE PROGRAM

Chestnut maintains as an employee benefit an Educational Assistance Program for qualified Chestnut employees who wish to pursue certain professional disciplines at Chestnut. In order to apply for the Educational Assistance Program, an employee must meet predetermined eligibility criteria and must have a desire to pursue a career in a prescribed field or fields of study. Employee and course eligibility criteria and procedures for the administration of the Educational Assistance Program are maintained by and are available from the Human Resources Department.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1170 Telecommuting		
Revision Date:	08/25/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1170 TELECOMMUTING

Telecommuting allows eligible employees to work from home or another remote location on a routine full- or part-time basis in order to meet the needs of Chestnut and the employee. The telecommuting program is not a formal employee benefit and participation in the program is not available to all employees in the organization. No employee is entitled to, or guaranteed the opportunity to, participate in the telecommuting program. Chestnut has the right to refuse telecommuting to any employee or to terminate existing telecommuting agreements, with or without cause, at its sole discretion.

Telecommuting would include:

- Employees in on-site positions who have voluntary pre-approved arrangements to work remotely on a routine full-time or part-time basis.
- Employees who are hired to work in specialized roles that do not require working on-site.

Telecommuting would not include:

- Employees in positions that require working on a part-time or full-time basis at the location of a client company or business partner.
- Employees who have a need to work remotely on an occasional, non-routine basis and have prior management approval.

Following the COVID-19 pandemic of 2020-2021, employees authorized to continue working remotely on an ongoing, full-time basis are telecommuters and will fall under this policy.

Eligibility to participate is limited to regular status employees only and may include, but not be limited to, factors such as:

• The nature of the job duties and responsibilities
• The location of the assigned job functions
• The availability of necessary equipment and technology
• The employee's length of service and performance levels
• Credentials to work independently
• Ability to supervise staff remotely

Job Responsibilities

The employee's core job responsibilities will not change solely as a result of telecommuting. The employee's job requirements are subject to change to the same extent as they would be if the employee was working in the office. The employee is responsible for completing and submitting all work assignments as if he or she was in the office.

Telecommuting employees must comply at all times with all applicable policies and procedures. The employee must view assigned trainings on Relias, attend teleconference meetings, and participate in other activities as directed by the employee's supervisor.

Work Schedule

The employee and his or her supervisor will determine, based on the nature of the employee's job responsibilities and the operational needs of Chestnut, the specific times and days of the week on which the employee will telecommute. No change in the employee's telecommuting schedule will take place without prior approval by the employee's supervisor.

The employee and his or her supervisor will determine the core work hours for the days when the employee is telecommuting. The employee must be reasonably available by telephone and/or e-mail during the designated work hours.

Work Hours

Telecommuting employees must work during the hours specified by their supervisor, and must submit normal documentation of the actual hours worked and/or time missed, or as otherwise directed by his or her supervisor. The employee shall be entitled to all authorized break periods while telecommuting.

Hourly, non-exempt employees should make every effort to avoid working overtime while telecommuting. Non-exempt employees will not perform any overtime work (as defined in Chestnut's Personnel Policies) without the express prior approval of the employee's supervisor.

Work Product

All work products developed by the employee while working on behalf of Chestnut are and shall remain the property of Chestnut, regardless of whether the employee performed the work on-site or off-site.

Absences

Telecommuting employees will follow the same policies and procedures as on-site employees regarding reporting of absences, use of paid time off benefits (for full-time employees) and leaves of absence.

Temporary policies regarding these topics will also apply to all employees, whether telecommuting or on-site.

Equipment

Chestnut may temporarily provide the necessary computer/laptop, modem, software, and other equipment needed for temporary telecommuting. All of these items remain the property of the Chestnut and must be returned to Chestnut upon request. The computer/laptop, modem, software, and any other equipment or supplies provided by Chestnut are provided for the use on work assignments. No other household members or other persons may use the equipment and software.

Workspace and Office Supplies

The employee shall designate a workspace within the employee's remote work location for placement and installation of equipment to be used while telecommuting. All company materials and client-related data must be kept in the designated work area at all times. Any company materials taken home should be kept in the designated work area at home and not be made accessible to others.

Office supplies will be provided by Chestnut as needed. Any out-of-pocket expenses for supplies will be reimbursed only with the prior approval of the employee's supervisor.

Security, Privacy and Confidentiality

Chestnut's MIS staff and the Security Officer have the authority to ensure that all computing equipment connecting to the company networks are secure, including confirming that critical patches, anti-virus software, firewall software, and other tools are properly installed and functional. Temporary telecommuters are responsible for following related MIS departmental directives for securing their equipment.

While working at the temporary remote site, the employee shall safeguard the privacy of patient health information and all other confidential or sensitive materials in the possession of the employee. The employee shall comply with all applicable federal and state laws and regulations, as well as all Chestnut policies and procedures pertaining to the privacy and security of patient information.

Maintenance and Technical Support

The relative responsibilities of the employee and of Chestnut with respect to maintenance of Chestnut equipment located in the employee's home, technical assistance, and related technical/MIS needs shall be determined on a case-by-case basis.

Eligibility to participate in telecommuting is limited to regular status employees only and may include, but not be limited to, factors such as:

- The nature of the job duties and responsibilities
- The location of the assigned job functions
- The availability of equipment and technology needed
- The employee's length of service and performance levels
- Credentials to work independently
- Ability to supervise staff remotely

Telecommuting arrangements require 1) a proposal plan, 2) management approval and 3) a Telecommuting Agreement. Additional policy information and procedures are available on the Chestnut intranet site.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policy		
Policy Name and Number:	PP 1175 Flexible Scheduling		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1100 – benefits eligibility and utilization PP 1200 & 1210 – attendance and absences PP 1350 - 1370 – exempt, non-exempt, and full-time status PP 1540-1560 – meal periods, pay periods, overtime		
Citation(s):			

PP 1175 FLEXIBLE SCHEDULING

Flexible work schedules are those that differ from the standard work week or standard work hours/days for a particular department/program or role, but that allow for an employee to still fulfill the responsibilities of a particular role and to work the number of hours per week required of the role. Flexible scheduling is not a formal employee benefit.

Certain, but not all, Chestnut employees are eligible to maintain flexible schedules, as determined by their supervisor and the needs of the department/program in which they work. No employee is entitled to or guaranteed the opportunity to maintain flexible work schedules. Chestnut, in its sole discretion, has the right to deny requests for flexible scheduling or to terminate existing flexible scheduling with or without cause. Only regular, full-time employees are eligible to maintain flexible schedules. The following is a non-exhaustive list of factors will be considered when determining whether to grant or deny a request for flexible schedules:

1. Nature of job duties and responsibilities
2. Patient/client needs
3. Location of the assigned job functions
4. Availability of other staff needed to support role
5. Availability of equipment and needed technology
6. Employee's length of service and performance levels
7. Credentials to work independently
8. Ability to supervise staff remotely

Flexible scheduling requires a plan that must be agreed upon by the employee and the employee's supervisor.

A flexible scheduling plan will also take into relevant policies regarding benefit eligibility, attendance, and Chestnut's pay practices. Examples include, but are not limited to:

- PP 1100 – benefits eligibility and utilization
- PP 1200 & 1210 – attendance and absences
- PP 1350 - 1370 – exempt, non-exempt, and full-time status
- PP 1540-1560 – meal periods, pay periods, overtime

Additional information and procedures are available through supervisors and the Human Resources Department.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1180 Get Well Gifts		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1180 GET WELL GIFTS

There are circumstances where Chestnut Health Systems may send a flower arrangement if an employee is hospitalized or is seriously ill or injured.

The initiating supervisor should contact the appropriate ELC member for authorization and coordinate with the Purchasing Department. for further details.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1181 Memorial Contributions		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1181 MEMORIAL CONTRIBUTIONS

When a Chestnut Health Systems employee or immediate family member passes away Chestnut will make a memorial contribution to a charity named by the employee or family member. If a charity is not named, the contribution will be made to a local charity designated by the Program Director or Department Head.

The initiating supervisor should contact the contact the appropriate ELC member for authorization and coordinate with the Marketing and Communication Department for further details.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1200 Attendance		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1200 ATTENDANCE

Regular attendance and punctuality by staff are important elements in Chestnut's efforts to maintain high levels of customer service and client satisfaction. Chestnut will be able to achieve its mission only when all members of the team are contributing positively. Chestnut considers each employee's contribution to be valuable in successfully accomplishing the organization's goals. Good attendance is important to the success of both the employee and the program the employee represents.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1210 Absences		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1210 ABSENCES

Chestnut recognizes that staff occasionally become ill, need to miss work or will be late. In such instances, it is the employee's responsibility to report all absences to his/her supervisor by telephone with as much notice as possible. The employee must report by phone directly to the supervisor prior to the beginning of the work shift for each work day missed.

If the reporting supervisor is not available, the absent employee shall leave a message for the supervisor with an expected return date.

If an employee is absent for three consecutive scheduled work days without notifying his/her immediate supervisor, it shall be assumed that the employee has voluntarily resigned his/her position. At that time, Chestnut will formally note the resignation and advise the employee of the action by regular mail to the employee’s last known address.

Time-off/absence from duty reports must be completed and approved in advance when possible or otherwise reports must be completed the day the employee returns to work.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1220 Sick Leave		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1220 SICK LEAVE

Chestnut Health Systems is committed to respecting, supporting, and promoting the health and wellness of its employees. Chestnut therefore offers as an employee benefit sick leave to all full-time employees in accordance with this policy.

Sick leave with pay is granted at the rate of 6 hours for each month of service. Paid sick leave accumulates throughout an employee's full-time service to a maximum of 480 hours. An employee may take sick leave for their own individual physical health, behavioral health, and/or injury or the physical health, behavioral health, and/or injury of a parent, child, sibling or spouse. Requests to use sick leave for illnesses and/or injuries of extended family members, or other members of the household, will be reviewed and approved/denied by the supervisor and the Director of Human Resources. An employee off work due to illness and/or injury will not accumulate sick leave credits.

When an employee is confronted with a serious issue related to physical or behavioral health or surgery or injury, it is appropriate to use accrued sick time. Ideally, sick time should be accumulated and used as a bank of time to build income security in times of need. Sick time is not to be used in lieu of vacation or personal time. If an employee consistently and regularly uses most or all of their accrued sick time as it becomes available, this pattern will be reviewed carefully by the employee's supervisor and could affect the employee's annual performance evaluation and annual salary increase. Excessive absences may also affect their employment status.

If an employee is absent due to an illness and/or injury for forty (40) or more consecutive work hours, a relevant healthcare provider's statement authorizing the employee to return to work is required. All employees returning to work may be subject to approval by a Chestnut appointed healthcare provider. All return to work medical statements should be submitted to the employee's supervisor. The supervisor should promptly forward these statements to the Human Resources Department.

Paid sick time benefits do not accrue during unpaid leaves of absence. New accrued sick time may only be used after the employee is actively working. Employees may access their Time Off Summary through the Accounting and Payroll page on the Chestnut Intranet. https://intranet.chestnut.org/accounting-and-payroll/

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1221 Medical Verification		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1221 MEDICAL VERIFICATION

Chestnut reserves the right at any time to require proof or medical verification of an employee's ability or inability to work. Such proof or verification may include periodic reports from, or in consultation with, the employee's physician or examination of the employee at Chestnut's expense by a physician selected by Chestnut. Chestnut may also require periodic reports during the leave concerning intent to return to work. Staff should consult the Human Resources Department for additional information including notice requirements, intermittent leave, return rights, benefits during leave and use of accrued paid time off.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1229 Leaves of Absence – General		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1229 LEAVES OF ABSENCE - GENERAL

Chestnut may grant employees leaves of absence under certain circumstances. Except as stated in the policies below and where state and federal law mandate otherwise, the following conditions will apply to any leave of absence: employee will be required to pay his/her own benefits premiums; paid time off benefits must be exhausted (unless specific leave policy designates otherwise) and will run concurrently with unpaid leave; and leaves approved under more than one policy will run concurrently.

Paid time off benefits do not accrue during unpaid leaves of absence. Newly accrued vacation may only be used after the employee's anniversary date, and only if the employee is actively working.

Employees on unpaid leave must make arrangements through Human Resources to continue paying for any portion of employee premium co-payments for which they are responsible under the terms of the insurance plan. Failure by the employee to pay his/her portion of any insurance premium within 30 calendar days of the established deadline will result in termination of coverage.

Any single cumulative leave period (consisting of Family, Medical, and/or Personal Leave approved at the sole discretion of Chestnut), which exceeds 180 continuous calendar days, may result in termination of the individual's employment with Chestnut, unless Federal or State law requires that longer leaves be granted.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1230 Family and Medical Leave of Absence		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1260 Personal Leave of Absence		
Citation(s):			

PP 1230 FAMILY AND MEDICAL LEAVE OF ABSENCE

Chestnut recognizes that employees may need extended time off from work for different reasons and provides unpaid leaves of absence consistent with its need to serve its business. Employees who have been employed for at least one year and have worked at least 1,250 hours in the past 12 months are eligible for leave in accordance with the Family and Medical Leave Act (FMLA). FMLA leave is approved solely by Chestnut beginning with the employee submitting an application to Human Resources with 30 days advance notice when foreseeable and practical. Chestnut requires eligible employees to use available paid time off benefits (sick leave, personal days and/or vacation days) for FMLA-qualifying leave. However, if the eligible employee is receiving short-term disability benefits, or is on leave related to a work-related injury or illness (receiving workers' compensation benefits) at the same time as FMLA leave is taken, the employee is not permitted to use paid time off benefits. In addition, leave granted under the FMLA may not qualify for paid sick leave benefits for cases that do not involve personal or family illness/injury (see PP1220). Paid time off benefits, as well as a leave related to short-term disability or workers compensation, will run concurrently for purposes of both the benefit plan and FMLA leave entitlement.

Paid time off benefits do not accrue during unpaid leaves of absence. Newly accrued vacation may only be used after the employee's anniversary date, and only if the employee is actively working.

An employee who meets the applicable length of service requirements may be granted FMLA leave for a period of up to 12 weeks during any rolling 12-month period for the following reasons:

- The birth of the employee's child and to care for that child.
- The placement of a child with the employee for adoption or foster care.
- To care for a spouse, child or parent who has a serious health condition.
- A serious health condition that prevents an employee from performing the functions of his/her job.
- A "qualifying issue" concerning a spouse, son, daughter or parent of the employee who is on covered active duty in the Armed Forces, National Guard or Reserves in support of a Federal call to duty or order to active duty, involving deployment to a foreign country (a call to service by a State does not qualify for FMLA leave).

  A "qualifying issue" entitling an employee to FMLA leave associated with a family member called to active duty as defined above includes the following **non-medical** issues:

  - A short-notice deployment of 7 or less calendar days prior to the day of deployment;
  - Military events and activities related to the deployment;
  - Childcare arrangement and school activities;

- Financial and legal arrangements;
- Counseling provided by someone other than a healthcare provider;
- To spend time with a family member on rest and recuperation leave (up to 15 days leave);
- To attend activities related to the end of the deployment, such as arrival ceremonies and debriefings;
- Deployment to a foreign country;
- Additional activities as agreed to by Chestnut and the employee and
- To provide care to a military member's parent who is incapable of self-care when necessitated by the military member's covered active duty.

Also, employees may take up to 26 weeks of FMLA leave to care for a family member with a serious injury or illness that 1) occurred in the line of duty while the family member was on active duty in the Armed Forces, or 2) that was pre-existing and was aggravated in the line of duty. In addition, employees may take up to 26 weeks of FMLA leave to care for a family member who is a veteran and who is undergoing medical treatment for a qualifying serious injury or illness and was a member of the Armed Forces during the 5 years preceding the beginning of treatment. For this leave only, a family member is defined as a spouse, son, daughter, parent or, if no spouse, parent or child exists, the nearest blood relative of that family member. This leave is not in addition to the 12 weeks of FMLA granted above. In other words, employees can receive no more than 26 weeks of FMLA leave during a single 12-month period.

An employee seeking to use FMLA leave is required to provide 30 day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practical. If such notice is not practical, the employee may need to provide further information to Chestnut on why such notice was not practical.

An employee taking a leave under this policy is required to provide a medical certification of the condition and the need for the leave from the health care provider. For leave related to a qualifying issue for a family member serving in the Armed Forces, an employee is required to provide certification of the qualifying issue triggering the need for the leave. Certification forms may be obtained from the Human Resources Department. A completed certification form must be returned to the Human Resources Department within fifteen days of the request. Once the certification is received, Chestnut will provide notice to the employee of any deficiencies found in the certification and the additional information needed. Employees will have seven days from the date of the notice to provide the additional information.

All employees have been provided with a notice concerning their rights and responsibilities under the FMLA as part of these personnel policies (see Appendix A). Additionally, an employee who requests FMLA leave will also be provided with a written rights and responsibilities notice form detailing the expectations and obligations of the employee under FMLA. Once Chestnut has received all necessary information to make an FMLA leave determination, Chestnut will notify the employee within five business days whether or not they are approved for FMLA leave.

An employee who has a serious health condition, or qualifying leave issue, and is unable to return to work after twelve weeks of family and medical leave may submit an application for a personal leave of absence in accordance with PP1260. Upon the employee's return from an FMLA leave the agency cannot guarantee that the employee will return to his/her former position. The employee will be given a position that is comparable and the rate of pay shall be no less than when the employee left. If the employee cannot or does not return to work at the end of the approved leave period, his/her employment may be terminated. While on approved FMLA leave, Chestnut will maintain group health, disability, life, vision and dental insurance coverage for an employee if the employee had the insurance coverage before leave was taken. The employee will be responsible for reimbursing Chestnut for his/her share of the insurance premium. The payment to continue coverage must be submitted to the Human Resources Department by the first of each month. Failure by the employee to pay the employee's share of any insurance premium within 30 calendar days of the established deadline will result in termination of the coverage.

Staff should consult the Human Resources Department for additional information including notice requirements, intermittent leave, return rights, benefits during leave, and use of paid time off.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section: Personnel Policies

Policy Name and Number: PP 1231 School Visitation Leave

Revision Date:

Applies To:	☒Employees	☐Clinical Staff Only	☐Interns
	☐Contractors	☐Administrative Staff Only	☐Board Members
	☐Volunteers		
Type of Policy:	☒Administrative	☐Clinical	

Policy Cross Reference(s):

Citation(s):

PP 1231 SCHOOL VISITATION LEAVE

In accordance with the School Visitation Rights Act, Chestnut will allow eligible employees who are parents or guardians time away from work to attend school conferences or classroom activities for their child(ren). Employees will be granted up to eight hours during a school year, of which no more than four hours can be used on a given day. This does not apply until after an employee has exhausted all accrued vacation, personal or other leave time other than sick or disability leave.

Employees who work on average at least 20 hours per week will be eligible.

Leave can be used for primary or secondary schools.

Employees must request the leave in writing at least seven days prior to the leave unless it is an emergency. All requests should be submitted to the Human Resources Department for approval.

When parents or guardians visit schools, schools must provide documentation. This documentation should be obtained by the employee and submitted to the Human Resources Department no later than two working days after the visit. Employees who do not provide this documentation will be subject to discipline.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1232 Leave for Domestic and Sexual Violence		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1232 LEAVE FOR DOMESTIC AND SEXUAL VIOLENCE

Chestnut provides leave for domestic or sexual violence in accordance with the Illinois Victims' Economic Security and Safety Act. An employee who is a victim of domestic or sexual violence or has a family or household member who is a victim of domestic or sexual violence (whose interests are not adverse to the employee as it relates to the domestic or sexual violence) will be granted unpaid leave from work for a period of up to twelve weeks during any rolling 12 month period to address the domestic or sexual violence. Employees should consult the Human Resources Department for additional information on how to exercise this right.

Paid time off benefits do not accrue during unpaid leaves of absence. Newly accrued vacation may only be used after the employee's anniversary date, and only if the employee is actively working.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1240 Weather-Related Absences		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1240 WEATHER-RELATED ABSENCES

During severe weather employees who are unable to report to work because of the weather will be required to use earned vacation or personal time. If severe weather appears to warrant closure of a Chestnut facility, the CEO or his/her designated executive leadership staff must approve any decisions related to closure. When a decision is made to close a Chestnut facility by the CEO or his/her designee, full-time employees will be paid for hours missed and will not be required to use vacation or personal time.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1250 Military Leave		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1230 – Family and Medical Leave of Absence		
Citation(s):			

PP 1250 MILITARY LEAVE

Chestnut provides leave for military duty in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA") and all other applicable State and Federal laws. Employees must notify Chestnut of the need to request leave for military duty as soon as possible. Leave taken for military duty is unpaid leave; however, service members are, at their request, permitted to use any vacation time that accrued before the beginning of their military service. Service members cannot be forced to use accrued vacation time during military service. No new vacation or sick time will accrue while the employee is on leave. See PP 1230 concerning leave provisions for employees who are caring for injured family members who serve in the military or are requesting leave for other qualifying issues related to employee family members who are in the National Guard or Reserves.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1260 Personal Leave of Absence		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1230 – Family and Medical Leave of Absence		
Citation(s):			

PP 1260 PERSONAL LEAVE OF ABSENCE

A personal leave of absence for up to 30 calendar days, including leave extensions associated with a disability in accordance with the Family and Medical Leave of Absence (PP1230), may be granted at management's discretion by submitting an application to the employee's supervisor with at least 1-week notice (or within 48 hours of an emergency event). The request is subject to approval of the Program Director and Human Resources.

Medical documentation will be required for those personal leaves associated with an employee or family member medical condition. If the personal leave is an extension of an approved Medical Leave or Family Leave under PP 1230, then updated documentation will be required. Documentation related to other reasons for a personal leave may be required at the joint discretion of the supervisor and Human Resources.

The agency cannot guarantee that the employee will return to his/her former position.
All personal leaves shall be without pay (with the exception of disability benefits or available paid time off benefits) Prior to entering an unpaid status, all applicable paid time off benefits must first be exhausted (i.e. sick, vacation, or personal days). If the employee does not return to work at the end of the approved leave of absence, the employee's employment may be terminated.

Paid time off benefits do not accrue during unpaid leaves of absence. Newly accrued vacation may only be used after the employee's anniversary date, and only if the employee is actively working.

Employees on unpaid leave must make arrangements through Human Resources to continue paying for any portion of employee premium co-payments for which they are responsible under the terms of the insurance plan. Failure by the employee to pay his/her portion of any insurance premium within 30 calendar days of the designated deadline will result in termination of coverage.

Extensions to a personal leave of absence may be granted in no more than 30 calendar day increments at management's discretion by submitting a new application and updated documentation to the employee's supervisor at least one week prior to the expiration of the previously approved personal leave. Extension of a personal leave is subject to approval of the Program Director and Human Resources. Documentation and approvals must be renewed every 30-calendar days for ongoing extended personal leaves.

Any single cumulative leave period (consisting of Family, Medical, and/or Personal Leave), approved at the sole discretion of Chestnut, which exceeds 180 continuous calendar days may result in termination of the individual's employment with Chestnut, unless Federal or State law requires that longer leaves be granted.

The criteria used to evaluate whether to approve discretionary personal leave may include, but not be limited to:

- Length of the requested leave
- Certainty of a return to work date
- Reason for the leave
- Seniority
- Performance history
- Attendance history
- Current workload or staffing issues
- Hardships on Chestnut
- Availability of interim staffing solutions
- Timeliness of responding to document requests

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1261 Administrative Leave		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CR 15 – Mandated Reporting		
Citation(s):			

PP 1261 ADMINISTRATIVE LEAVE

Administrative leave is an involuntary leave status that is implemented at the sole discretion of Chestnut management. In compliance with labor laws administrative leaves for salaried, exempt employees will be paid time. For hourly, non-exempt employees an administrative leave is unpaid time. The employee's pay status may change once the employee is moved from administrative leave to a different status.

The Program/Regional Director and the Human Resources Manager will jointly make decisions associated with the need for administrative leave. Depending on the nature of the matter and the results of any investigations, Chestnut management may re-evaluate the employee's status and, as determined by the Program/Regional Director and the HR Manager, this may include a transition to another form of leave of absence.

Examples of pending matters that might require an administrative leave include, but are not limited to:

- Internal or external investigation
- Documentation related to other leave of absence requests
- Legal concerns
- Fitness for duty assessment
- Disciplinary action documentation
- Miscellaneous employment-related documentation
- Lapse of licensure or certification

As per policy CR 15, following a mandated report against a Chestnut employee, the supervisor of the employee who is the subject of the report will immediately remove from the schedule and temporarily relieve the employee of assigned duties. The employee will be placed on administrative leave and remain unscheduled and relieved of duties until such time that the supervisor and/or Program Director has met with the Director of Human Resources or his/her designee and the Director of Quality Management or his/her designee to determine an appropriate course of administrative action regarding the involved employee. Administrative actions may include but are not limited to 1) continuation in present position, 2) reassignment, 3) suspension or 4) termination of employment. When there is credible evidence supporting an allegation of abuse, Chestnut will remove the staff from all direct client contact.

Administrative leave time will not count toward the 180-day cumulative leave limitation that applies to Family, Medical and Personal leaves. Employees placed on unpaid administrative leave will have an option of using paid vacation or personal days for the missed time (Unpaid suspensions due to disciplinary action

will not qualify for paid time off benefits.). When an employee is placed on an Administrative Leave, all building and computer access will be temporarily disabled.

Chestnut cannot guarantee that the employee will return to his/her former position following an administrative leave. If the employee chooses not to return to work at the end of the administrative leave, the employee's employment may be terminated.

Employees on unpaid leave must make arrangements through Human Resources to continue paying for any portion of employee premium co-payments for which they are responsible under the terms of the insurance plan. Failure by the employee to pay his/her portion of any insurance premium within 30 calendar days of the designated deadline will result in termination of coverage.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1270 Leave for Professional Study and Conferences		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1270 LEAVE FOR PROFESSIONAL STUDY AND CONFERENCES

Leave for professional study, training, schooling, or conferences should be submitted to the Program Director for approval. Registration fees, travel and other expenses in connection with attendance at conferences and meetings may be allowed if they are within budgetary limitations and approved by the Program Director.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1280 Jury Duty		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1280 JURY DUTY

A leave for jury duty shall be provided to regular full-time employees called to serve on juries. No loss of regular income and no loss of vacation time shall occur due to serving on a jury. Employees will submit a copy of any compensation received for jury duty as proof of attendance.

It is the responsibility of the employee, when excused from jury duty, to report to work.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1281 Voting Leave		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1281 VOTING LEAVE

Chestnut Health Systems believes that it is an important obligation of all citizens to vote in local, state and national elections. It is for this reason that if Chestnut employees are unable to vote due to unavoidable conflicts between scheduled work hours and polling place hours, Chestnut may grant up to 2 hours of paid time off to vote to Illinois employees and up to 3 hours of paid time off to vote to Missouri employees under certain specific guidelines.

In order to do this, an employee would need to provide advance written notice to his/her supervisor no later than one week prior to the Election Day. A supervisor may determine the actual time during which the employee can be absent from work to vote. An employee will be required to provide documentation of having voted during his/her absence.

A schedule conflict exists only if an employee has both (1) less than a 2 or 3-hour window before work and (2) less than a 2 or 3-hour window after work to vote (depending on the state of work). For example, if the polling place hours are scheduled to be 6:00 a.m. - 7:00 p.m., to use this benefit an Illinois employee would have to have been scheduled to start work before 8 a.m. and ending after 5 p.m.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1290 Bereavement Leave		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1290 BEREAVEMENT LEAVE

Absence due to the death of a member in the immediate family will be excused for three days with no deduction in pay.

Immediate family is defined as:

Spouse	Parent/Step-Parent	Child's spouse
Domestic Partner	Sibling	Child's Domestic Partner
Child/Step-Child/Foster-Child	Parent-in-law	

A domestic partner is defined as an unrelated and unmarried person who shares common living quarters with an employee and lives in a committed, intimate relationship that is not legally defined as marriage.

One day, without loss of pay, will be granted to attend the funeral for the following relatives who do not live in the household:

Sibling's Child	Grandparent	Grandchildren
Parent's Sibling		Siblings-in-law

For the second list of family members, who are living in the same household, three days without loss of pay will be granted, rather than one day.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1291 Workers Compensation		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1291 WORKERS COMPENSATION

Workers' compensation provides benefits for employees who suffer personal injury from accidents or illnesses arising out of and in the course of employment with Chestnut, whether on or off Chestnut property. Worker's Compensation benefits are initiated by the employee by giving prompt notice to Chestnut of an injury or occupational disease. The following procedures must be followed for any work-related injuries, even if the employee does not plan to seek medical attention. Failure of the injured employee to comply with established reporting requirements and time frames may result in disciplinary action up to and including termination.

- The injury must be immediately reported by the employee to the Human Resources Department and his/her supervisor, if available.
- An incident report must be completed by the employee immediately, or in no case later than 24 hours following the incident and submitted to their immediate supervisor with a copy to Human Resources Department.
- If the employee is not able to submit an incident report due to injury, the employee's supervisor must complete the report and submit it to the Human Resources Department.
- In cases where **immediate medical attention** is required, staff on duty should call 911 and notify the employee's supervisor.

An employee who is injured at work will be paid for the remainder of the scheduled shift on which the injury occurs if he/she is medically unable to return to work that day.

If the employee must miss pre-scheduled work hours to attend future medical appointments associated with the diagnosis or treatment of a work-related injury or illness, the employee will not be required to use paid time off benefits for such an absence (but may do so). The employee, with the involvement of the supervisor, will be provided the opportunity to adjust his/her work schedule to accommodate the appointment, or be allowed to make up the missed work time.

To receive such accommodation, the following must occur:

- The injury or illness must be associated with an authorized workers' compensation claim as determined by the insurance carrier

- The employee must provide medical documentation of the appointment.

- The employee needs to demonstrate that the appointment could not be scheduled around his/her scheduled work hours.

- The employee is not receiving other workers' compensation disability benefits.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1292 Workers Compensation – Return to Work		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1291 Workers' Compensation		
Citation(s):			

PP 1292 WORKERS COMPENSATION – RETURN TO WORK

Chestnut is committed to helping injured employees return to work quickly and safely. The priority is to ensure that employees injured at work receive proper medical care with the goal of returning to their jobs or to a form of temporary transitional work. It is expected that all injured employees will participate in the return to work process by cooperating with the guidance of their supervisor. Supervisors will collaborate with their management team, Human Resources staff, insurance carrier representatives and medical providers to evaluate the feasibility of transitional duty assignments, which may involve flexibility in workflow, job assignments, scheduling, etc.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1310 Classification of Personnel		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1310 CLASSIFICATION OF PERSONNEL

The position classifications utilized in the agency are designed to meet the needs of the agency and its clients. This system provides a structure for defining the necessary skills, expectations, and requirements for each job within the agency. Each job is important to the effectiveness of the total agency. If there is limited advancement possible within a particular job classification, individuals interested in long-term advancement are encouraged to continue their skill development, obtain necessary certification, and demonstrate excellent performance and job effectiveness.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1320 Job Descriptions		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Ill. Admin. Code title 77 § 2060.311		

PP 1320 JOB DESCRIPTIONS

Job descriptions include the minimum requirements (education, certification(s), experience) necessary for consideration and essential job functions. Additional expectations and reporting supervisor are also listed.

All job descriptions will be periodically reviewed and when the interest of the agency dictates, changes will be made. Chestnut requires a signed job description to be on file for every unique position. As part of onboarding, new staff will be oriented to their specific job duties.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1325 Primary Source Verification		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1325 PRIMARY SOURCE VERIFICATION

All employees are required to have an employment application on file citing professional references. New employees must provide copies of all degrees, credentials, certifications, licenses, references, etc. Chestnut requires original college transcripts for the highest completed degree within 30 days of the hire date. The issuing educational institution or clearinghouse is to send the transcripts directly to the Chestnut Human Resources department in order for the documents to be considered originals.

Current employees are required to keep this information updated and to provide copies of all recertification, re-licensing or any new degrees or certificates. Chestnut conducts primary source verification of previous employment, professional and personal references, degrees, licenses, and certification through the respective business, individual, educational institution or licensing/certification body. Primary source verifications of licenses and certifications are conducted at time of hire and prior to expiration dates. Any employee providing false information or credentials will be subject to disciplinary action up to and including termination.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1330 Background Checks		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1330 BACKGROUND CHECKS

Before a person is hired, the hiring supervisor will conduct a check of at least two professional references with knowledge of the candidate's work experience and competency in a manner and format as outlined by the Human Resources department. Where feasible, the supervisor will also check on-line for licensing credentials. All offers of employment are contingent upon satisfactory completion of background checks and primary source verification of credentials, as allowed by law and are to be completed before the new hire starts work.

Chestnut treats clients who are in an especially vulnerable position. Chestnut is committed to providing the best in client care and is also concerned about the safety and welfare of its staff and clients. Therefore, to protect clients and staff and to provide the best possible client care, Chestnut conducts background checks on all employees as allowed by law.

All current employees may be periodically subject to a criminal background check. Chestnut may require staff members to consent to a criminal background check through the applicable State Police, UCIA Criminal Records History check or other relevant authorities and to execute the documents necessary for such a check to be performed. A current staff member who is found to have felony or serious misdemeanor convictions which directly affects his/her qualifications or ability to perform the job may be subject to disciplinary action, up to and including termination, after consideration of the convictions and as allowed by law.

Any misrepresentation by a staff member concerning convictions or arrests will result in disciplinary action up to and including termination.

In addition to criminal background checks, Chestnut is required to check a variety of other relevant State and Federal databases. Some of these databases are reviewed at the time of hire, some are reviewed monthly or annually.

Further, Chestnut will conduct background checks, including child abuse and neglect screenings, by the Missouri Family Care Safety Registry pre-hire and annually on all employees and volunteers who provide direct services to children and youth in Missouri.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1335 State Licensing Requirements		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Missouri Department of Mental Health, Mo. Rev. Stat. Chapter §630, and 9 CSR §10-7.010-7.140		

PP 1335 STATE LICENSING REQUIREMENTS

Chestnut and its staff shall comply with all relevant licensing standards of the State of Illinois, Department of Human Services, Division of Alcoholism and Substance Abuse (DASA) Missouri Department of Mental Health, and all applicable federal and/or state statutes. All staff in the clinical programs must meet current applicable licensing and accreditation standards. All employees:

- Must be at least 18 years of age;
- Must not have been convicted of a felony or had a subsequent incarceration within two years prior to the date of employment; and
- Shall be subject to a background check conducted by the Department of Children and Family Services (DCFS) to determine that said employee has not been indicated in any child abuse or neglect investigations.
    - Shall be subject to a background check of the applicable Health Care Worker registry to determine that said employee has no substantiated finding of abuse or neglect.
- Engaged in providing DUI evaluation or risk education services shall not have a suspension or revocation of driving privileges for an alcohol or drug related driving offense for at least two years prior to the date of employment.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1340 Minimum Age		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1340 MINIMUM AGE

No employee under 18 years of age will be hired for a clinical service, intervention service or driving position. Persons who are at least 16 years of age may be hired for some limited positions with the authorization of the Program Director or Department Manager, as well as the Human Resources Director.

A very limited number of positions may require that any candidates for the position be at least 21 years of age. Supervisors of such positions will have this documented in the job description and have a documented justification for the requirement on file and approved by the Human Resources Director.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1350 Exempt Employees		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Fair Labor Standards Act		

PP 1350 EXEMPT EMPLOYEES

Exempt employees are paid on a salaried basis and not eligible for overtime. Typical exempt employees are managers, supervisors and some professional employees. Employees are classified by the standards set forth by the Fair Labor Standards Act.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1360 Non-Exempt Employees		
Revision Date:	6/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1360 NON-EXEMPT EMPLOYEES

Non-exempt employees are paid on an hourly basis for actual hours worked and are eligible for overtime, paid at time and one half the normal hourly rate for actual hours worked past forty hours in one work week (Monday thru Sunday). These employees are required to complete a time sheet to record all actual hours worked, as well as designating the mandatory unpaid meal period as applicable. Employees are classified by the standards set forth by the Fair Labor Standards Act.

Working in excess of forty hours in one work week requires advance authorization of the non-exempt employee's supervisor or Program Director. This would include time spent accessing, monitoring, reading and/or responding to electronic communications or phone calls and messages through a mobile device or computer, whether or not owned by Chestnut. Failure to receive written e-mail authorization prior to working overtime hours will be grounds for disciplinary action.

Hourly, non-exempt employees will not be scheduled to work, or be called in to work, at least one consecutive twenty-four-hour period out of every seven calendar days. This includes any non-exempt employees working in multiple positions within Chestnut.

Failure of non-exempt employees to accurately report and document their actual hours worked via their timesheet will be addressed through disciplinary action.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section: Personnel Policies

Policy Name and Number: PP 1370 Regular Full Time Employees

Revision Date:

Applies To: ☒Employees ☐Clinical Staff Only ☐Interns ☐Contractors ☐Administrative Staff Only ☐Board Members ☐Volunteers

Type of Policy: ☒Administrative ☐Clinical

Policy Cross Reference(s):

Citation(s):

PP 1370 REGULAR FULL TIME EMPLOYEES

Regular full-time employees are those employees hired to work a full normal workweek of 40 hours or full-time salaried employees of Chestnut whose positions require the employee to work a school calendar year rather than a twelve month period. This category will also include certain positions, with pre-approval by the Executive Leadership Council, who are in 24-hour residential programs who work 36 hour weekly schedules. Regular full-time employees may participate in all fringe benefits of the agency.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section: Personnel Policies

Policy Name and Number: PP 1380 Temporary Full Time Employees

Revision Date:

Applies To:	☒Employees	☐Clinical Staff Only	☐Interns
	☐Contractors	☐Administrative Staff Only	☐Board Members
	☐Volunteers		
Type of Policy:	☒Administrative	☐Clinical	

Policy Cross Reference(s):

Citation(s):

PP 1380 TEMPORARY FULL TIME EMPLOYEES

Temporary employees are those employees who are employed and paid by Chestnut to work for a limited or defined period of time of less than one year, and not those contracted or employed by a service agency.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1381 11-Month Employees		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1381 11-MONTH EMPLOYEES

11-month employees are those Chestnut Health Systems employees who are paid by Chestnut to work in a position for 11 consecutive months out of a defined 12-month period.

Eligibility: Only the positions listed below are eligible for 11-month employee status

- Clinician I, II, II, IV (YFSS)
- Clinician I, II, III, IV (School Based)
- Community Support Specialists I, II, III (MHJJ)
- YFSS Coordinator
- Prevention Specialist I, II, III
- Prevention Coordinator

Pay & Scheduling:

- The 1 month out of 12 that 11-month employees do not work must be the same for all 11-month employees. Such dates must span two full consecutive pay periods, determined in advance by Payroll.
- Hourly positions will only be paid for actual time worked. For clarity, hourly employees will not be paid for the designated pay periods.
- Salaried positions will be paid over 24 pay periods versus the standard 26, resulting in no pay for the designated pay periods.

Time Off Accrual:

- 11-month employees will not accrue vacation or sick time during the 1 month they are not actively working.

Benefit Premiums:

- For 11-month employees, catch-up employee benefit premium payments for the 1 month such employees do not work and for which such employees are not paid will be deducted from their first paycheck after returning to work.

Miscellaneous:

- Should any 11-month employee wish to return to a 12-month schedule, there must be a valid business reason (for example, caseload to support need for an additional month), as determined

and approved by the applicable Vice President of Integrated Care and the Director of Human Resources.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1390 Regular Part Time Employees		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1390 REGULAR PART TIME EMPLOYEES

Regular part time employees are those employees hired to work a set schedule for part of a normal workweek. Those employees are not entitled to any fringe benefits, except for the retirement savings plan and EAP benefits (if eligible under the terms of the plan) or any other benefits as required by applicable state or Federal law.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1391 Part Time As Needed Employees		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1390 – Regular Part Time Employees		
Citation(s):			

PP 1391 PART TIME AS NEEDED EMPLOYEES (“PRN”)

Part-time as-needed employees are those employees hired to work part-time on an as-needed, irregular basis and do not have a set work schedule. These employees are referred to as “PRN”. “PRN” employees and are not entitled to any fringe benefits, except for the retirement savings plan and EAP benefits if eligible under the terms of the plan.

A part-time as-needed employee, not on an approved leave of absence, who has not worked any hours during any 120 consecutive calendar day period will be terminated from employment with Chestnut after a quarterly review of employee work hours, and with final authorization by the applicable member of the Executive Leadership Council.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section: Personnel Policies

Policy Name and Number: PP 1392 Active Employee

Revision Date:

Applies To:	☒Employees	☐Clinical Staff Only	☐Interns
	☐Contractors	☐Administrative Staff Only	☐Board Members
	☐Volunteers		
Type of Policy:	☒Administrative	☐Clinical	

Policy Cross Reference(s):

Citation(s):

PP 1392 ACTIVE EMPLOYEE

An employee is considered active when the employee is regularly reporting to work and is not currently on leave from the employer other than for vacation, sick leave, scheduled holiday or paid FMLA leave. Active employees accrue benefits to which they would be entitled.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1393 Inactive Employee		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1393 INACTIVE EMPLOYEE

An employee is considered inactive when the employee is not regularly reporting to work as scheduled, is on approved unpaid leave from the employer, on leave due to an illness or injury and receiving either disability benefits or worker's compensation benefits and has not been terminated. Inactive employees do not accrue benefits.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1400 Student Interns		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1400 STUDENT INTERNS

Student interns are those students placed by a college or university, upon approval of appropriate Chestnut supervisory personnel, for the purpose of a supervised learning experience. The appropriate Chestnut staff assume supervisory and evaluation responsibility for the students. The students are expected to function in a professional manner at all times and uphold the professional policies and procedures of the agency. Student interns do not receive any employee benefits from the agency. Generally, students will be earning college/university credit in lieu of compensation, unless prior agreement is made between the intern and the Chestnut supervisor.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1410 Volunteers		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1410 VOLUNTEERS

Volunteers are community individuals who volunteer their time to the agency. Volunteers perform tasks assigned and supervised by an agency staff person. All volunteers are expected to respect confidentiality and adhere to the agency's policies and procedures relating to the program. All volunteers must sign a confidentiality statement. Volunteers do not receive any compensation nor employee benefits.

Volunteers are not to be used for responsibilities in lieu of regular full-time or part-time employees.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1430 Promotions		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1430 PROMOTIONS

Chestnut policy is to encourage staff development and self-improvement and to promote from within if at all possible. Promotions within the organization are made after senior area supervisors discuss performance of all qualified and eligible employees. All promoted employees must have the necessary training and experience.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1440 Internal Employment Application		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1440 INTERNAL EMPLOYMENT APPLICATION

In order to express interest in an internal job posting within Chestnut, an employee must submit an Internal Employment Application, accompanied by a current resume or other employment history document.

This on-line application will be submitted via Chestnut's on-line applicant tracking system. The application will be electronically routed to the employee's current supervisor for review, comment and approval. The internal application will then be electronically routed to Human Resources for review prior to submission to the Hiring Supervisor.

In order for an internal employment application to receive consideration:

- The employee must have been in his/her current position at least 6 months for hourly, non-exempt positions (1 year for salaried, exempt positions), unless waived in writing by the applicable current Program Director.
- Any performance deficiency reports on file for the employee within the 90-day period preceding the application and the most recent performance evaluation will be provided to the Hiring Supervisor.
- The employee should possess the minimum qualifications of the position.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1450 Access to Chestnut Facilities		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1450 ACCESS TO CHESTNUT FACILITIES

Former employees of Chestnut Health Systems are not permitted access to any Chestnut facilities without being an authorized visitor who is escorted at all times as approved by the Program Director.

Hourly, non-exempt employees who are not scheduled to work, and who have not been authorized to work overtime or have not been called in to work additional hours, are not to be on the premises of Chestnut Health Systems without being an authorized visitor as approved by the Program Director.

Salaried, exempt employees may be on the premises during hours outside of their regular work schedule if they are in the course of carrying out their authorized job responsibilities or are an authorized visitor as approved by the Program Director.

All employees on an authorized leave of absence (medical, family, personal or administrative), or on a suspension, are not to be on Chestnut premises without being an authorized visitor as approved by the Program Director. Employees on leave or suspension status should not be performing their job duties on Chestnut premises or remotely without the prior authorization of both the Program Director and the Human Resources Manager.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1530 Shift Differentials		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1530 SHIFT DIFFERENTIALS

Certain non-exempt positions in specified 24-hour clinical programs, as determined by the Executive Leadership Council, will be eligible for hourly shift differentials on top of the base hourly wage. Due to the variable hours that eligible positions could work, the differential will be paid for the entire shift based on where the majority of the actual hours worked fall.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1540 Meal Periods		
Revision Date:	10/26/2016		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1540 MEAL PERIODS

All non-exempt employees must take an unpaid meal period during all shifts that are 7.5 continuous hours or longer. A meal period must begin no later than 5 hours after the start of the shift. The length of meal periods will be determined by the supervisor, but must be at least 30 minutes in length. During a meal period, the employee must not perform any job duties. A meal period is unpaid time and is not considered as hours worked. Meal periods are mandatory for non-exempt employees and must be documented on their timesheets. Some positions or shifts may warrant supervisory decisions restricting the employee from leaving the premises during a meal period.

Non-exempt employees whose scheduled shift of less than 7.5 hours is later extended to be 7.5 continuous hours or longer will be expected to take an unpaid meal period when it is reasonably possible to do so with the guidance of the supervisor.

An exception to the mandatory unpaid meal period for non-exempt employees exists for those employees who monitor clients with developmental or mental illnesses or both, and who, in the course of their duties, are required to be on call during their entire shift. These employees will be allowed time to eat a meal while continuing to monitor these clients and need not be relieved of all work duties and responsibilities. Such meal periods will be paid time and be considered hours worked. Substance abuse and chemical dependency programs do not fall under this exception.

Failure of non-exempt employees to take their mandatory unpaid meal period with no work responsibilities and to record this time on their timesheet will be addressed through disciplinary action.

All exempt employees will be provided a 30-60 minute meal period during shifts in excess of 7.5 continuous hours but these meal periods are not mandatory.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1550 Pay Period		
Revision Date:	10/26/2016		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	FS 70 - Payroll		
Citation(s):			

PP 1550 PAY PERIOD

Pay periods shall be two weeks in duration, lasting from 12:00 a.m. Monday through 11:59 p.m. Sunday. Payroll shall be available for distribution on Wednesday, a week after the close of a pay period. A time sheet with employee and supervisory signatures, or electronic authorization, and indicating actual hours worked and the taking of the mandatory meal period, where applicable, will be required for all non-exempt employees. Consistent with fiscal policy FS70, deliberate misrepresentation of submitted timesheet data may be grounds for dismissal.

All employees shall have their checks directly deposited to an account designated by the employee except for those workers who were employed at Chestnut prior to the onset of direct deposit services through the accounting department or those who have rejected the opportunity to avail themselves of direct deposit services. The organization will not guarantee the delivery of payroll checks on the date due to those who do not avail themselves of the direct deposit option. If requested, special paychecks may be written in the event of management error that would leave an employee without a paycheck that is properly owed. In order to be paid on schedule, time sheets and time off forms must be signed by employees and supervisors, or be electronically authorized, and turned in for processing by Monday noon following the close of a two week pay period. Paychecks will not be issued in advance.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1560 Overtime		
Revision Date:	10/26/2016		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☐Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1270 – Leave for Professional Study or Conferences		
Citation(s):			

PP 1560 OVERTIME

Only non-exempt employees are eligible for overtime. Overtime will be paid for "actual hours worked" in excess of forty hours in a work week (Monday through Sunday). "Actual hours worked" for purposes of computing overtime does not include vacation, personal, sick, jury or any other paid time-off. Attendance at training or professional conferences in accordance with PP1270 will be included in "actual hours worked". All overtime must have prior approval of the immediate supervisor or Program Director.

Failure to receive authorization prior to working overtime hours, including time spent accessing, monitoring, reading and/or responding to electronic communications or phone calls and messages through a mobile device or computer, whether or not owned by Chestnut, will be grounds for disciplinary action.

Occasionally it becomes necessary to make adjustments to work schedules and/or to require overtime from Chestnut staff based on unforeseen circumstances. The management of each program or department has the discretion to plan and make adjustments to the schedule as they deem necessary. It is expected that management will schedule staff in advance, but it is also understood that adjustments and accommodations may need to be made during any scheduling cycle to ensure appropriate client care and safety.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1570 Record Maintenance		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1570 RECORD MAINTENANCE

The Human Resources Department shall be responsible for the maintenance of Chestnut employee personnel records.

It shall be the responsibility of each employee to report changes in name, address, telephone number, marital status, number of dependents, persons to notify in an emergency, and beneficiary changes to the staff member delegated the responsibility of maintaining personnel records. Basic guidelines for the maintenance of employee personnel records are as follows:

1. Collect and retain information about employees needed for business purposes.
2. Limit access of records to those persons who work directly with the information contained in the file.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1571 Employee Medical Records		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1571 EMPLOYEE MEDICAL RECORDS

Employees who have received a Hepatitis B Virus (HBV) vaccine or declined to have the vaccine will have copies of the HBV vaccine or the HBV vaccine declination form maintained in their employee records. Should exposure to potentially infectious blood products occur, copies of the employee's hepatitis vaccine status will be provided to their physician as stated in the post-exposure procedure in the Safety, Infection/Exposure Control and Risk Management manual.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1580 Access to Personnel Records		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1580 ACCESS TO PERSONNEL RECORDS

Chestnut is committed to insure the privacy of personal information maintained in its personnel records. Information about or from an employee or applicant will be gathered using ethical and lawful means. Also, the agency will follow the requirements of equal employment opportunity laws with regard to the collection of information concerning sex, race, color, religion, national origin, age, sexual orientation, marital status, disability or any other legally protected status.

Upon reasonable request, a person is entitled to inspect his/her personnel records in accordance with applicable state law. This privilege is available to all current employees, those on layoff or leave of absence having a right to return to work, and former employees who have terminated employment within the past twelve months. An individual who wishes to review his/her personnel records, or request copies of those records, should submit a written request using a request document available through Human Resources. Requests for copies of personnel records will require a per-page fee to cover expenses associated with providing the copies.

Personnel records will be made available only to the appropriate supervisory staff having a need for this information to perform their respective duties. Personnel records will also be disclosed to licensing, funding and other applicable government oversight agencies in accordance with statutory and regulatory requirements.

All salary information is considered confidential. Individual salary information is generally not disclosed by Chestnut to outside agencies or organizations unless a release is signed by the employee, as in the case of credit references.

Salaries will be released for wage/salary surveys, grant applications, research projects, benefit plan administration and for any reports deemed by the CEO to be necessary and in the best interest of Chestnut.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1590 Solicitations		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1590 SOLICITATIONS

Only merchandise being sold to benefit charitable organizations (such as the United Way, Girl Scouts, Little League, church and school fundraisers) may be sold on company property and such sale is limited to the lunchroom/break rooms and may not be done during working time. No solicitations may occur via e-mail. Solicitation of employees is not permitted during working time in working areas. Distribution of literature or other materials is not permitted in any work area. Literature may only be posted on bulletin boards designated by Executive Management. Any items to be posted shall be approved by the Human Resources Department prior to posting. Non-employees are not allowed to enter company property for the purposes of solicitation and are not allowed to solicit or distribute any materials or literature at any time on company property. This policy shall not prohibit displaying posters throughout facilities or soliciting voluntary employee donations for internal fundraising activities that support Chestnut programs or needy consumers/patients.

Chestnut prohibits all forms of gambling for monetary gains in the workplace. Soliciting co-workers using company resources and time to participate in events such as lotteries, raffles, office pools, and sports pools is prohibited.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1600 Staff Transportation of Clients in Chestnut Vehicles		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 355 – No Weapons		
Citation(s):	Missouri Concealed Carry Law, Mo. Rev. Stat. §571.101		

PP 1600 STAFF TRANSPORTATION OF CLIENTS IN CHESTNUT VEHICLES

Chestnut vehicles are to be treated with care and respect. Extreme caution is required in driving Chestnut vehicles, especially while transporting clients. Only staff who have been approved by Chestnut's automobile insurance carrier and who have a valid state issued drivers' license may transport clients. Any staff transporting a client shall do so with the prior approval of the Program Director or other designated administrative individual. Careless driving of Chestnut vehicles and/or abuse of Chestnut property by staff may result in disciplinary action and/or termination of employment.

Staff are required to use seat belts when driving and ensure that all passengers are wearing seat belts or are properly secured in age-appropriate car seats at all times.

Staff must report any accident, theft or damage involving a Chestnut vehicle to the Program Director and the Regional Facilities Manager regardless of the extent of the damage or level of severity of injuries. Such reports must be made as soon as possible (via an Incident Report and/or an Accident Report), but in no case later than 24 hours after the incident.

Chestnut vehicles and/or property are not to be used for personal and/or private use, except when direct permission is granted by the applicable Executive Leadership Council member.

When transporting clients or other Chestnut employees in a Chestnut vehicle or a private vehicle, Chestnut employees are prohibited from engaging in activities considered to be distracted driving. This would include, but not be limited to, the operation of cell phones, tablets, pagers, Personal Digital Assistants, laptops or other electronic devices used for communication, texting, e-mails, etc. Use of such devices in the vehicle would be limited to when the vehicle is parked. Exceptions to this would be for emergency communication. Other examples of prohibited distracted driving while transporting clients include reading and eating. Chestnut employees should comply with all State and municipal laws related to distracted driving when operating a Chestnut vehicle or a private vehicle for work purposes.

All weapons, including handguns carried pursuant to a valid concealed carry license issued applicable state law and objects that could be used as weapons, are strictly prohibited in all Chestnut-owned or Chestnut-leased vehicles, see PP 355.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1605 Transportation Via Staff's Personal Vehicle		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1605 TRANSPORTATION VIA STAFF'S PERSONAL VEHICLE

If private vehicles (those not owned or leased by Chestnut) are used by personnel to transport clients, copies of the following must be provided to the supervisor and the Human Resources Department:

- Proof of valid driver's license
- Proof of current insurance

Staff are required to use seat belts when driving and ensure that all passengers are wearing seat belts or are properly secured in age-appropriate car seats at all times.

Staff will be provided a first aid kit to carry in the car while transporting clients.

If an accident, theft, or other damage occurs while a client is being transported, such incident must be reported to the Program Director and a facilities manager regardless of the extent of the damage or level of severity of injuries. Such reports must be made as soon as possible (via an Incident Report and an Accident Report), but in no case later than 24 hours after the incident.

When transporting clients or other Chestnut employees in a Chestnut vehicle or a private vehicle, Chestnut employees are prohibited from engaging in activities considered to be distracted driving. This would include, but not be limited to, the operation of cell phones, tablets, pagers, Personal Digital Assistants, laptops or other electronic devices used for communication, texting, e-mails, etc. Use of such devices in the vehicle would be limited to when the vehicle is parked. Exceptions to this would be for emergency communication. Other examples of prohibited distracted driving while transporting clients include reading and eating. Chestnut employees should comply with all State and municipal laws related to distracted driving when operating a Chestnut vehicle or a private vehicle for work purposes.

Staff must ensure that weapons or objects that could be used as weapons will be safeguarded and kept reasonably inaccessible from clients.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1610 Traffic Violations		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1610 TRAFFIC VIOLATIONS

Employees who drive Chestnut vehicles or transport clients and patients in their personal vehicle must immediately notify their supervisor and the Human Resources department of any changes in license status, such as suspension, revocation or license restrictions. Human Resources will then notify the Facilities department.

All traffic citations and parking tickets issued against an employee while on Chestnut business are the sole responsibility of the employee. When a traffic violation, such as an accident or moving violation, occurs while on Chestnut business, the employee must meet with his immediate supervisor no later than the next working day to discuss the violation. This includes violations occurring while the employee is using his/her personal vehicle while on Chestnut business. The immediate supervisor will notify the Human Resources Manager. The supervisor, in consultation with the Human Resources Manager, will determine the appropriate course of action. Disciplinary action may be taken up to and including termination.

Failure to comply with this section will result in disciplinary action and may include termination.

Chestnut will conduct driving history checks on all employees who drive as part of their job duties. This will take place at the time of hire and periodically thereafter.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1615 Business and Travel Expense		
Revision Date:	10/26/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	FS 90 – Business Travel and Expenses		
Citation(s):			

PP 1615 BUSINESS AND TRAVEL EXPENSE

Chestnut will reimburse employees for authorized travel expenses incurred while on Chestnut business if the expenses comply with Chestnut procedures and policies, state and/or federal contract guidelines, are authorized by a Chestnut supervisor, and are reasonable and appropriately documented. Employees should neither lose nor gain personal funds as a result of traveling on Chestnut business.

Non-exempt employees must have advance supervisor or Program Director written e-mail authorization prior to making arrangements for any overnight travel in conjunction with their position.

Employees who are required to travel for Chestnut business should consult their immediate supervisor or the Finance Department to obtain the complete policy and procedure (see Fiscal Policy FS 90).

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1620 Communicable and Infectious Diseases		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1620 COMMUNICABLE AND INFECTIOUS DISEASES

Employees are to be free of communicable and infectious diseases as required by law. The Director of Human Resources, in consultation with applicable employee's supervisor, shall have the authority to require employees to be checked by the Medical Director or designated alternate to verify the employee is medically and emotionally capable of performing assigned tasks and is free of communicable and infectious diseases. Prior to beginning work, employees must prove that they are free of active tuberculosis. Employees also will be periodically tested for tuberculosis in accordance with the policies and procedures set forth in the Surveillance, Prevention and Infection Control and Management of the Environment of Care section of the Chestnut Health Systems Policy Handbook.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1625 Personnel Identification Badge		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1625 PERSONNEL IDENTIFICATION BADGE

All Chestnut personnel (full- and part-time employees, interns and contracted staff) are required to visibly display a photo identification badge whenever they are in a Chestnut facility. This will allow the individual to be easily recognized as Chestnut personnel and as having authorized access to the facility. Identification badges of staff who evaluate or treat Chestnut clients will contain the staff member's name, licensure status (if applicable) and position.

All Chestnut personnel will be issued a photo identification badge within one week of employment.

An electronic door lock system with issued access cards is utilized at certain locations. Personnel assigned to these locations will be issued access cards in addition to their photo identification card.

All Chestnut personnel will visibly display the identification badge whenever they are in a Chestnut facility. Personnel who do not comply may be subject to discipline and/or termination.

Identifying information and the Chestnut logo must not be defaced and must be clearly visible. Badge must be worn on or above the waist.

During monthly surveillance of the facilities, and by observation by Safety, Infection Control, and Risk Management Committee members, the prevalence of displayed identification will be noted and reported to the appropriate supervisor when appropriate.

Chestnut supervisors will be instructed to confront, if necessary, individuals who are observed in the facilities without proper identification.

Personnel must report lost, stolen or destroyed badges to the Human Resources Department immediately. A replacement badge will be issued.

Temporary Badge Assignment: If an individual does not have access to his/her identification badge the individual can obtain a generic temporary badge from the Human Resources department. Temporary badges will be displayed as temporary and provided to an individual on an infrequent case-by-case basis. Temporary badges are not to be considered as a permanent or long-term replacement for the individual's personalized identification badge. Temporary badge assignments will expire after 48 hours and must be returned to HR.

Short-term Contract Assignments: Facilities contractors assigned to short-term assignments of fewer than 30 days will be issued a badge from the Facilities Department specifically designated as contractor identification. Contractors assigned to direct care clinical responsibilities will be issued a photo identification badge identical to Chestnut personnel by Human Resources.

Charges, Replacement and Renewal:

1. Within one week of employment, all personnel will receive their initial photo identification badge and access card (when required), free of charge.
2. All replacement badges requested as a result of loss, theft or damage will be assessed a $10.00 replacement fee.
3. Badges needing replacement as a result of a name change, damage from long-term wear, or a change in access privileges will be free of charge.
4. Requests for a replacement badge due to significant changes in appearance will be considered on a case-by-case basis.

Termination of Employment: All terminating personnel must turn in their photo ID badge to their direct supervisor or the Human Resources department at the end of their last workday.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1627 Tobacco-Free Workplace		
Revision Date:	06/28/2017		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1627 TOBACCO-FREE WORKPLACE

Chestnut Health Systems is committed to improving the quality of life and the promotion of quality health care, which includes the prevention of disease. With this commitment comes the responsibility of providing a safe and healthy work environment.

Chestnut has an ongoing commitment of educating and encouraging our employees to maintain a healthy lifestyle and to serve as a positive role model for our clients and communities.

To reinforce this commitment, the use of all tobacco products and electronic cigarettes is prohibited at all Chestnut facilities and grounds, with the exception of designated areas for adult clients and supervised/supported client living spaces (such as client apartments.)
Chestnut personnel and visitors are prohibited from using tobacco products and electronic cigarettes at all Chestnut facilities and grounds. This prohibition extends to all owned and leased Chestnut facilities, Chestnut assigned work locations (such as probation offices, schools, etc.) and vehicles, including:

- Chestnut owned or leased vehicles
- Personal vehicles while on Chestnut property
- Chestnut and personal vehicles during transportation of clients or other Chestnut employees or visitors while on Chestnut work time, or while driving to or from a Chestnut sponsored activity (such as an off-site meeting). This expectation applies regardless of whether the client and/or staff member is a tobacco user or not.

Any Chestnut staff member who violates these expectations will be asked by a fellow co-worker or member of management to discontinue use of the tobacco product or electronic cigarette. Supervisors are responsible for managing the expectations within their respective work areas.

If the Chestnut staff member continues to use the tobacco product or electronic cigarette while on Chestnut property, the issue will be addressed on a case-by-case basis and may result in discipline.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1628 Searches		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 830 – Personal Equipment		
Citation(s):			

PP 1628 SEARCHES

Chestnut at all times retains the right to access and search, with or without prior notice, all desks, work areas, lockers, equipment, diskettes, files, databases, e-mail messages, voicemail messages and any other electronic transmissions contained in or used in conjunction with the computer, electronic and voicemail systems and equipment owned by Chestnut. Consistent with PP 830, all e-mail and voicemail on Chestnut systems or equipment is the property of Chestnut. These communications are not considered private despite any such designation either by sender or the recipient. This right applies both during the time of employment and after separation from employment for any reason.

Chestnut also retains the right to conduct video monitoring in the public areas of its facilities, and audio monitoring of its telephone systems, as allowed under applicable state and federal law for safety, security and training purposes.

Any searches must be approved in advance by the Director of Human Resources (or designee) and the applicable member of the Executive Leadership Council.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1630 Resignation		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1630 RESIGNATION

The last day an employee works is the last date the employee is considered to be on the payroll. A 30-day notice is requested when a supervisory employee or a clinical employee with a client caseload intends to leave the agency. A two-week notice is requested when all other employees intend to leave the agency. Leaves of absence or the use of paid time off benefits will not be granted in lieu of working out the appropriate notice period. The use of any individual paid time off days during the notice period must be pre-approved by the supervisor.

Failure to comply with this policy may impact the employee's re-hire eligibility status.

Resigning employees are asked to provide a signed and dated letter of resignation to their supervisor at the time of providing the appropriate notice.

A terminating employee will normally receive his/her final check, including the monetary equivalent of all accrued vacation time and unused personal time, on the next regularly scheduled payday. Unused personal time is not paid if the employee has less than ninety (90) days of service.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1635 Temporary Layoff / Furlough		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1635 TEMPORARY LAYOFF / FURLOUGH

On limited occasions, Chestnut management may have to make temporary or permanent reductions in staffing levels to account for unexpected business downturns or emergencies.

Temporary Layoff – Takes place when full-time or part-time employees are temporarily removed completely from the work schedule for short, indefinite periods of time with the intention to be re-called when the business downturn or emergency resolves. Employees on temporary layoff are relieved from all job responsibilities and will not be paid during their absence. However, employees on temporary layoff status will remain employed with Chestnut.

Furlough (temporary reduction in hours) – Takes place when full-time or part-time employees have their scheduled work hours reduced for short, indefinite periods of time, with the intention of their regular hours to resume when the business downturn or emergency resolves. Impacted employees will retain their job responsibilities, just on a reduced schedule, whether working on-site or remotely. It is possible that employees may be transferred to other programs or departments where there is a need for their services.

- Hourly, non-exempt employees on furlough will simply continue to receive their hourly rate for the actual hours worked.

- Salaried, exempt employees on furlough will temporarily experience one of the following changes:

    - Salary reduces by an amount corresponding with reduced work hours, but continues to be paid on a salary basis, or
    - Salary converts to an hourly wage and pay is for the actual hours worked.

Paid Time off – Full-time employees will not be eligible to apply their available paid time off benefits to hours missed due to a temporary layoff or to a furlough

Paid time off benefits do not accrue during unpaid temporary layoffs or furloughs. This means that the next anniversary year's allotted vacation time will be reduced proportional to the unpaid time during the previous anniversary year's layoff or furlough.

Newly accrued or earned paid time off benefits may only be used after the employee's anniversary date, and only if the employee is back to working full-time.

Benefits – During a temporary layoff or furlough impacting any full-time employees, most benefits will remain in place, including health insurance coverage.

In the case of a temporary layoff where there are no earnings, Chestnut will pay the employee portion of any insurance premiums. However, when a temporarily laid off employee returns to work, the employee will repay the missed premiums through payroll deductions.

Internal secondary jobs – A secondary position within Chestnut held by an employee who is impacted by a temporary layoff or furlough in their primary position will not necessarily be affected.

Unemployment – Any full-time or part-time employees impacted by a temporary layoff or furlough may apply for unemployment benefits by filing a claim with their state's unemployment department.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1640 Dismissal		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1640 DISMISSAL

Whenever an employee is dismissed, Chestnut reserves the right to pay the employee two weeks wages in lieu of notice regardless of the length of notice provided. Employees terminated for reasons of misconduct, client abuse or client neglect will not be paid two weeks' wages in lieu of notice.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1650 Rehire of Former Employees		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1650 REHIRE OF FORMER EMPLOYEES

Former employees may be considered for re-employment at Chestnut's sole discretion. Each request for re-employment is reviewed based on the circumstances of the past employment and separation, and Chestnut's current hiring needs. All re-hire decisions must have the prior authorization of the Program Director and applicable ELC member. All re-hire applicants must complete all of the standard applications, paperwork, and other pre-employment processes.

Employees re-hired as full-time employees within 24 months of their separation from Chestnut employment will immediately restore their prior service for seniority and paid time off benefits, where applicable. Prior service under the retirement plan will be restored in accordance with the terms of that plan. Eligibility for group insurance programs will be the same as for all new hires.

Any former employee rehired as a full-time employee within 24 months of his/her separation from Chestnut will receive an "adjusted service date", which will reflect credit for prior service with Chestnut. Credit will be allowed for each full calendar month of prior service while the individual was employed in a full-time capacity. Former employees must have completed at least 12 continuous months of service during their prior employment time in order to receive an adjusted service date upon rehire.

During the first anniversary year following re-hire, the re-hired employee will be granted 5 personal days immediately and 5 Retention Reward days after 6 months. Vacation days will accrue per the accrual schedule in PP 1110 at a rate based on the "adjusted service date". Any unused sick time balance at the time of separation will be re-instated.

Any variance from this policy must be approved in writing by Chestnut's Chief Executive Officer or General Counsel, in consultation with the Director of Human Resources.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1655 Post-Employment Security		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1655 POST-EMPLOYEE SECURITY

In order to ensure the safety of Chestnut staff, certain security measures must be consistently followed when terminating an employee. At least one witness should be present at all dismissal interviews. All company property in the employee's possession, including cell phones, key cards, badges, pagers, and laptops will be collected. User IDs will be disabled and/or deleted upon termination of a workforce members' employment or other affiliation with the company.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1660 Verification of Employment		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1660 VERIFICATION OF EMPLOYMENT

All inquiries made of Chestnut staff and management from outside parties regarding the employment of current or former employees should be referred to the Human Resources department. Human Resources will evaluate each inquiry and determine what information can be provided or confirmed and whether a written release will be necessary.

Letters of reference for current or former employees may be provided by a direct supervisor or Program Director using Chestnut letterhead and his/her Chestnut job title under the following guidelines:

- The letter is requested directly by the current or former employee.
  Supervisors are not to respond to third parties (see above).
- The letter is factual and can be supported by the individual's personnel records
- The individual's performance met or exceeded minimum expectations
  (as demonstrated by personnel records)
- The individual has no recent performance deficiencies and is considered eligible for re-hire.
  (as demonstrated by personnel records)
- The reference letter has been reviewed and authorized by a member of Human Resources management.

Any requests for letters of reference not meeting these criteria should be declined citing this policy. Providing a letter of reference is a voluntary decision on the part of the supervisor, there is no obligation

It is the responsibility of each Chestnut supervisor to ensure these guidelines are strictly followed. Failure to comply with this policy by any Chestnut employee will result in disciplinary action.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Policies		
Policy Name and Number:	PP 1665 Retirement		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PP 1665 RETIREMENT

For this policy only, a Chestnut Health Systems employee will be considered to have retired and be eligible for a retirement gift when –

- The employee has designated the decision to resign from Chestnut as a retirement.
- The employee has provided appropriate notice of the resignation as per Chestnut personnel policy.
- The employee has had a minimum 5 years of consecutive service with Chestnut as a regular employee, either full-time or part-time.
- The employee's age plus years of service is equal to at least 65.

These eligibility criteria are not necessarily intended to coincide with criteria contained in other employee benefits, such as the group health plan or retirement savings plan.

The initiating supervisor should contact the Human Resources Manager for further details and authorization.

APPENDIX A

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WHD Publication 1420 · Revised February 2013

CHESTNUT HEALTH SYSTEMS

ADDENDUM – Arizona Supplement - 2024



Chestnut Health Systems

Personnel Policies

Arizona Supplement

2024

CHESTNUT
HEALTH SYSTEMS

GENERAL INFORMATION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Arizona Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Arizona employees will receive the Company's Personnel Policies and the Arizona Supplement to the Personnel Policies ("Arizona Supplement) (together the "Employee Handbook").

The Arizona Supplement applies only to Arizona employees. It is intended as a resource containing specific provisions derived under Arizona law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Arizona Supplement are different from or more generous than those in the National Handbook, the policies in the Arizona Supplement will apply.

The Arizona Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

Arizona Notification of Constructive Discharge

Any employee is encouraged to communicate to the Company by contacting Human Resources whenever the employee believes working conditions may become intolerable to the employee and may cause the employee to resign. Under Ariz. Rev. Stat. § 23-1502, the employee may be required to notify the Company in writing that a working condition exists that the employee believes is intolerable, that will compel the employee to resign, or that constitutes a constructive discharge, if the employee wants to preserve the right to bring a claim against the Company alleging that the working condition forced the employee to resign.

Under the law, the employee may be required to wait fifteen (15) calendar days after providing written notice before the employee may resign if the employee desires to preserve the right to bring a constructive discharge claim against the Company. The employee may be entitled to a paid or unpaid leave of absence of up to fifteen (15) calendar days while waiting for the Company to respond to the employee's written communication about the employee's working condition.

If employees have any questions regarding this policy, they should contact Human Resources.

TIME OFF AND LEAVES OF ABSENCE

Arizona Earned Paid Sick Time

Eligibility

The Company provides earned paid sick time to employees who work in Arizona. For employees who work in Arizona who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave law or *ordinance.*

Accrual

Employees begin accruing earned paid sick time pursuant to this policy at the start of employment. Eligible employees will accrue one (1) hour of earned paid sick time for every thirty (30) hours worked, up to a maximum accrual of twenty-four (24) hours each calendar year. Exempt employees are assumed to work forty (40) hours in each workweek unless their normal workweek is less than forty (40) hours, in which case earned paid sick time accrues based upon that normal workweek. For purposes of this policy, the calendar year is the consecutive 12-month period beginning January 1 and ending on December 31.

Usage

Employees may use earned paid sick time on the 90th calendar day of employment. Earned paid sick time must be used in 1-hour increments. The employee may not use more than twenty-four (24) hours of earned paid sick time in any calendar year.

Employees may use earned paid sick time for absences due to:

1. the employee's mental or physical illness, injury or health condition; the employee's need for medical diagnosis, care, or treatment of a mental or physical illness, injury or health condition; the employee's need for preventive medical care;
2. care of a family member with a mental or physical illness, injury or health condition; care of a family member who needs medical diagnosis, care, or treatment of a mental or physical illness, injury or health condition; care of a family member who needs preventive medical care;
3. closure of the employee's place of business by order of a public official due to a public health emergency or the employee's need to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency, or care for oneself or a family member when it has been determined by the health authorities having jurisdiction or by a health care provider that the employee's or family member's presence in the community may jeopardize

the health of others because of their exposure to a communicable disease, whether or not the employee or family member has actually contracted the communicable disease; or

4. a covered purpose relating to domestic violence, sexual violence, abuse or stalking to allow the employee to obtain (for himself or herself or for a family member) medical attention, services from a victims' organization, counseling, relocation and/or legal services.

For purposes of this policy, family member includes (regardless of age): a biological, adopted or foster child, stepchild or legal ward, a child of a domestic partner, a child to whom the employee stands in-loco-parentis or an individual to whom the employee stood in loco parentis when the individual was a minor; a biological, foster, stepparent or adoptive parent or legal guardian of the employee or the employee's spouse or domestic partner or a person who stood in loco parentis when the employee or employee's spouse or domestic partner was a minor child; spouse or domestic partner; a grandparent, grandchild or sibling (whether of a biological, foster, adoptive or step relationship) of the employee or the employee's spouse or domestic partner; or any other individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

The employee's use of earned paid sick time will not be conditioned upon searching for or finding a replacement worker.

The Company will assume, subject to applicable law, that employees want to use available earned paid sick time for absences for reasons set forth above and employees will be paid for such absences to the extent they have earned paid sick time available.

Employees will be advised of their earned paid sick time balance information on their itemized wage statement.

Notice and Documentation

Employees are required to make a reasonable effort to schedule the use of earned paid sick time in a manner that does not unduly disrupt business operations. Requests to use earned paid sick time may be made orally, in writing or electronically (e.g., via email), and whenever possible, the request must include the expected duration of the employee's absence. When the use of earned paid sick time is foreseeable, the employee is required to make a good faith effort to provide notice of the need for such time to their Supervisor in advance of the use of the earned paid sick time. When the use of earned sick time is not foreseeable, the employee is required to provide notice to their Supervisor at least one (1) hour prior to the start of their workday or as soon as possible under the circumstances.

For earned paid sick time of three (3) or more consecutive work days, the Company requires reasonable documentation that the earned paid sick time has been used for a covered purpose. For reason #1 and #2 above, documentation signed by a health-care professional indicating that earned paid sick time is necessary is reasonable. For reason #4 above, any of the following types of documentation selected by the employee is reasonable:

- a police report indicating that the employee or the employee's family member was a victim of domestic violence, sexual violence, abuse or stalking;
- a protective order; injunction against harassment; a general court order; or other evidence from a court or prosecuting attorney that the employee or employee's family member appeared or is

scheduled to appear, in court in connection with an incident of domestic violence, sexual violence, abuse or stalking;

- a signed statement from a domestic violence or sexual violence program or victim services organization affirming that the employee or employee's family member is receiving services related to domestic violence, sexual violence, abuse or stalking;
- a signed statement from a witness advocate affirming that the employee or employee's family member is receiving services from a victim services organization;
- a signed statement from an attorney, member of the clergy or a medical or other professional affirming that the employee or employee's family member is a victim of domestic violence, sexual violence, abuse or stalking; or
- the employee's written statement affirming that the employee or the employee's family member is a victim of domestic violence, sexual violence, abuse or stalking, and that the earned paid sick time was taken for one of the purposes described above.

Documentation provided to the Company should not explain the nature of the employee's or a family member's health condition or the details of the domestic violence, sexual violence, abuse or stalking.

Payment

Earned paid sick time will be paid at the same hourly rate the employee earns from their employment at the time the employee uses such time, but no less than the applicable minimum wage, unless otherwise required by applicable law. Use of earned paid sick time is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

The employee may carry over up to twenty-four (24) hours of accrued, unused earned paid sick time to the following calendar year. Unused earned paid sick time will not be paid at separation.

Enforcement and Retaliation

Retaliation against the employee who requests or uses earned paid sick time is prohibited. The employee has the right to file a complaint if earned paid sick time as required by law is denied by an employer or if the employee is subjected to retaliation for requesting or taking earned paid sick time. The Arizona Industrial Commission’s contact information is as follows: 800 W. Washington Street, Phoenix, AZ 85007 / 602-542-4515 / www.azica.gov.

Questions about rights and responsibilities under the law can be answered by Human Resources.

CHESTNUT
HEALTH SYSTEMS

ARIZONA SUPPLEMENT ACKNOWLEDGMENT

This Arizona Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Handbook.

> **I have received and read a copy of Chestnut Health Systems Arizona Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.**
>
> **I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.**
>
> **I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.**
>
> **I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.**

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as "protected characteristics"). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone's way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

1. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
2. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
3. obscene or vulgar gestures, posters or comments;
4. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;
5. propositions or suggestive or insulting comments of a sexual nature;
6. derogatory cartoons, posters and drawings;
7. sexually-explicit e-mails, text messages or voicemails;
8. uninvited touching of a sexual nature;
9. unwelcome sexually-related comments;
10. conversation about one's own or someone else's sex life;
11. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
12. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

CHESTNUT HEALTH SYSTEMS

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

ADDENDUM – California Supplement - 2024

Chestnut Health Systems

Personnel Policies

California Supplement

2024

CHESTNUT HEALTH SYSTEMS

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This California Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, California employees will receive the Company's Personnel Policies and the California Supplement to the Personnel Policies ("California Supplement) (together the "Employee Handbook").

The California Supplement applies only to California employees. It is intended as a resource containing specific provisions derived under California law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the California Supplement are different from or more generous than those in the National Handbook, the policies in the California Supplement will apply.

The California Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

California Equal Employment Opportunity

Chestnut Health Systems is an Equal Opportunity Employer that does not discriminate on the basis of actual or perceived race, color, religious creed, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth, and related medical conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, protected medical condition as defined by applicable state or local law (such

as cancer), reproductive health decision making, genetic information, , or any other characteristic protected by applicable federal, state, or local laws and ordinances. Chestnut Health Systems management team is dedicated to this policy with respect to recruitment, hiring, placement, promotion, transfer, training, compensation, benefits, employee activities, access to facilities and programs, and general treatment during employment.

The Company will endeavor to make a reasonable accommodation of an otherwise qualified applicant or employee related to an individual's: physical or mental disability; sincerely held religious beliefs and practices; needs as a victim of domestic violence, sex offenses, or stalking; needs related to pregnancy, childbirth, or related medical conditions; and/or any other reason required by applicable law, unless doing so would impose an undue hardship upon the Company's business operations. Any applicant or employee who needs an accommodation to perform the essential functions of the job should contact the CEO to request such an accommodation. The individual should specify what accommodation is needed to perform the job and submit supporting documentation explaining the basis for the requested accommodation, to the extent permitted and in accordance with applicable law. The Company will review and analyze the request, including engaging in an interactive process with the employee or applicant, to identify if such an accommodation can be made. The Company will evaluate requested accommodations, and as appropriate identify other possible accommodations, if any. The individual will be notified of the Company's decision within a reasonable period. The Company treats all medical information submitted as part of the accommodation process in a confidential manner.

Any employees with questions or concerns about equal employment opportunities in the workplace are encouraged to bring these issues to the attention of the CEO. The Company will not allow any form of retaliation against individuals who raise issues of equal employment opportunity. If employees feel they have been subjected to any such retaliation, they should contact the CEO. To ensure our workplace is free of artificial barriers, violation of this policy including any improper retaliatory conduct will lead to discipline, up to and including discharge. All employees must cooperate with all investigations conducted pursuant to this policy.

California Discrimination, Harassment, And Retaliation Prevention

Chestnut Health Systems does not tolerate and prohibits discrimination, harassment, or retaliation of or against job applicants, contractors, interns, volunteers, or employees by another employee, supervisor, vendor, customer, or third party based on actual or perceived race, color, creed, religion, age, sex, or gender (including pregnancy, childbirth, and related medical conditions), sexual orientation, gender identity, or gender expression (including transgender status), national origin, ancestry, marital status, protected medical condition as defined by state law (including cancer or genetic characteristics), physical or mental disability, military and veteran status, reproductive health decision making, genetic information, or any other characteristic protected by applicable federal, state, or local laws and ordinances. The Company is committed to a workplace free of discrimination, harassment, and retaliation.

Our management team is dedicated to ensuring the fulfillment of this policy as it applies to all terms and conditions of employment, including recruitment, hiring, placement, promotion, transfer, training, compensation, benefits, employee activities, and general treatment during employment.

Discrimination Defined

Discrimination under this policy means treating differently or denying or granting a benefit to an individual because of the individual's protected characteristic.

Harassment Defined

Harassment is defined in this policy as unwelcome verbal, visual, or physical conduct creating an intimidating, an offensive or a hostile work environment that interferes with work performance. Harassment can be verbal (including slurs, jokes, insults, epithets, gestures, or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media, or e-mails), or physical conduct (including physically threatening another, blocking someone's way, etc.) that denigrates or shows hostility or aversion toward an individual because of any protected characteristic. Such conduct violates this policy, even if it is not unlawful. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities, and other verbal or physical conduct of a sexual nature. Sexual harassment includes unwelcome or unwanted conduct that is either of a sexual nature or directed at an individual because of that individual's sex when:

- Submission to that conduct or to those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment;
- Submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- The conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Examples of conduct that violate this policy include:

1. Unwelcome or unwanted sexual advances, flirtations, advances, leering, whistling, touching, pinching, assault, and blocking normal movement;
2. Requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
3. Obscene or vulgar gestures, posters, or comments;
4. Sexual jokes or comments about a person's body, sexual prowess, or sexual deficiencies;
5. Propositions or suggestive or insulting comments of a sexual nature;
6. Derogatory cartoons, posters, and drawings;
7. Sexually explicit e-mails, text messages, or voicemails;
8. Uninvited touching of a sexual nature;
9. Unwelcome or unwanted sexually related comments;
10. Conversation about one's own or someone else's sex life;
11. Conduct or comments consistently targeted at only one (1) gender, even if the content is not sexual; and
12. Teasing or other conduct directed toward a person because of the person's gender.

Retaliation Defined

Retaliation means adverse conduct taken because an individual reported an actual or a perceived violation of this policy, opposed practices prohibited by this policy, or participated in the reporting and investigation process described below. "Adverse conduct" includes but is not limited to:

- Shunning and avoiding an individual who reports harassment, discrimination, or retaliation;
- Express or implied threats or intimidation intended to prevent an individual from reporting harassment, discrimination, or retaliation; and
- Denying employment benefits because an applicant or employee reported harassment, discrimination, or retaliation or participated in the reporting and investigation process described below.

All discrimination, harassment, and retaliation is unacceptable in the workplace and in any work-related settings such as business trips and business-related social functions, regardless of whether the conduct is engaged in by a supervisor, a coworker, a client, a customer, a vendor, or another third party.

Reporting Procedures

The following steps have been put into place to ensure the work environment is respectful, professional, and free of discrimination, harassment, and retaliation. If the employee believes someone has violated this policy or the Equal Employment Opportunity Policy, the employee should promptly bring the matter to the immediate attention of the Employee's Supervisor. (Phone numbers are available through the Company directory.) If this individual is the person toward whom the complaint is directed, the employee should contact any higher-level manager in the reporting chain. If the employee makes a complaint under this policy and has not received a satisfactory response within five (5) business days, Human Resources should be contacted immediately. (Phone numbers are available through the Company directory.)

Every supervisor who learns of any employee's concern about conduct in violation of this policy or the Equal Employment Opportunity Policy, whether in a formal complaint or informally, or who otherwise is aware of conduct in violation of this policy or our Equal Employment Opportunity Policy must immediately report the issues raised to Human Resources.

Investigation Procedures

Upon receiving a complaint, the Company will promptly conduct a fair and thorough investigation into the facts and circumstances of any claim of a violation of this policy or the Equal Employment Opportunity policy. To the extent possible, the Company will endeavor to keep the reporting employee's concerns confidential. However, complete confidentiality may not be possible in all circumstances.

During the investigation, the Company generally will interview the complainant and the accused, conduct further interviews as necessary, and review any relevant documents or other information. Upon completion of the investigation, the Company shall determine whether this policy has been violated based on its reasonable evaluation of the information gathered during the investigation. The Company will inform the complainant and the accused of the results of the investigation.

The Company will take corrective measures against any person who it finds to have engaged in conduct in violation of this policy, if the Company determines such measures are necessary. These measures may

include, but are not limited to, counseling, suspension, or immediate termination. Anyone, regardless of position or title, who the Company determines has engaged in conduct that violates this policy will be subject to discipline up to and including termination.

Training

All Employees are required to undergo harassment prevention training as required by applicable law. For more information about this training requirement, visit https://calcivilrights.ca.gov/shpt/.

Retaliation Prohibited

In addition to being a violation of this policy, harassment, discrimination, or retaliation also can be against the law. Employees who engage in conduct that rises to the level of a violation of law can be held personally liable for such conduct.

Remember, the Company cannot remedy claimed discrimination, harassment, or retaliation unless employees bring these claims to the attention of management. Employees should not hesitate to report any conduct they believe violates this policy.

California Workers' Compensation

On-the-job injuries are covered by Chestnut Health Systems Workers' Compensation Insurance Policy, which is provided at no cost to employees. If injured on the job, no matter how slightly, employees should report the incident immediately to their supervisor. Failure to follow Company procedures may affect one's ability to receive Workers' Compensation benefits.

Any leave of absence due to a workplace injury runs concurrently with all other Company leaves of absence. Reinstatement from leave is guaranteed only if required by law. Employees who need to miss work due to a workplace injury must also request a formal leave of absence. See the Leave of Absence sections of this handbook for more information.

GENERAL EMPLOYMENT PRACTICES

California Working Hours and Schedule

Employees will be assigned a work schedule and will be expected to begin and end work according to the schedule. To accommodate the needs of the business, at some point Chestnut Health Systems may need to change individual work schedules on either a short-term or long-term basis.

Rest Breaks

Non-exempt employees who work three-and-one-half (3-1/2) or more hours per day are authorized and permitted one (1) ten (10)-minute rest break for every four (4) hours or major fraction thereof worked. For purposes of this policy, "major fraction" means any time greater than two (2) hours. For example, if employees work more than six (6) hours, but no more than ten (10) hours in a workday, they are authorized and permitted to take two (2) ten- (10-) minute rest breaks: one (1) during the first half of a shift and a

second rest break during the second half of the shift. If employees work more than ten (10) hours but no more than fourteen (14) hours in a day, they are authorized and permitted to take three (3) ten- (10-) minute rest breaks, and so on.

Rest breaks should be taken as close to the middle of each work period of four (4) hours or major fraction thereof as is practical. Employees do not need to obtain their supervisor's approval or notify their supervisor when taking a rest break. Employees are encouraged to take their rest breaks; they are not expected to and should not work during their rest breaks. Non-exempt employees are paid for all rest break periods and do not need to clock out when taking a rest break.

Rest breaks may not be combined with another rest break or with the meal period. In addition, rest breaks may not be taken at the beginning or end of the work day to arrive late or leave early. Each rest break must be a separate break, meeting the requirements described above. If any work is performed during a rest break, or if the rest break is interrupted for any work-related reason, the employee is entitled to another uninterrupted paid rest break.

Chestnut Health Systems also provides cool down rest and recovery periods as needed to prevent heat illness for employees that perform work outdoors as required under applicable state law.

Meal Periods

Employees who work more than five (5) hours in a workday are provided an unpaid, off-duty meal period of at least thirty (30) minutes. Employees are responsible for scheduling their own meal periods, but they should confirm them with their supervisor. Meal periods must begin no later than the end of the fifth hour of work. For example, the employee who begins working at 8:00 a.m. must begin the meal period no later than 12:59 p.m. When scheduling a meal period, employees should try to anticipate work flow and deadlines.

Employees who work more than ten (10) hours in a day are entitled to a second unpaid, off-duty thirty- (30-) minute meal period. Employees entitled to a second meal period should schedule their second meal period so it begins no later than before the end of their tenth hour of work, meaning the meal period should begin after working no more than nine (9) hours, 59 minutes.

During meal periods, employees are relieved of all duty and should not work during this time. When taking a meal period, employees should completely stop working for at least thirty (30) minutes. Employees are prohibited from working "off the clock" during their meal period.

Those employees who use a time clock must clock out for their meal periods. These employees are expected to clock back in and promptly return to work at the end of any meal period. Those employees who record their time manually must accurately record their meal periods by recording the beginning and end of each work period. Unless otherwise directed by a supervisor in writing, employees do not need to obtain a supervisor's approval or notify a supervisor when taking a meal period. Employees are to immediately notify their supervisor if they believe that they are prevented by the nature of their work from taking a timely and/or complete meal period.

Meal Period Waiver

If no more than six (6) hours of work will complete the day's work, employees may voluntarily waive the meal period in writing. Employees should see Human Resources to obtain this waiver form. If the employee works no more than twelve (12) hours, the employee can waive the second meal period, but only if the first meal period was received and not waived in any manner. Any waiver of the second meal period must be in writing and submitted before the second meal period. Employees should see Human Resources to obtain this waiver form. Employees who work more than twelve (12) hours may not waive, and should take, their second unpaid, off-duty and uninterrupted thirty- (30-) minute meal period.

No Working During Rest Breaks and Meal Periods

Employees are completely relieved of all work duties and responsibilities during their rest breaks and meal periods. All rest breaks and meal periods must be taken outside the work area, such as in a break room. Employees may leave the premises during rest breaks and meal periods. Employees should not visit or socialize with employees who are working while they are taking a rest break or meal period. Employees, including those in a sensitive position like security or information technology, are not expected to remain “on call” or available to respond to messages, monitor radios, telephones, email or other devices during meal periods and rest breaks.

Employees are required to immediately notify their supervisor if they believe they are being pressured or coerced by any manager, supervisor or other employee to not take any portion of a provided rest break or meal period.

San Francisco Family Friendly Workplace Policy

Under the San Francisco Family Friendly Workplace Ordinance, San Francisco employees who regularly work at least eight (8) hours per week and have been employed for six (6) months or more may request, in writing, a flexible or predictable working arrangement to assist with caregiving responsibilities for:

- a child or children under the age of 18;
- a person or persons with a serious health condition in a family relationship with the employee; or
- a person age 65 or older in a family relationship with the employee.

A "family relationship" means a relationship in which a caregiver is related by blood, legal custody, marriage or domestic partnerships to another person as a spouse, domestic partner, child, parent, sibling, grandchild or grandparent.

"Flexible working arrangement" means a change in the employee's terms and conditions of employment that provides flexibility to assist with caregiving responsibilities. A flexible working arrangement may include but is not limited to:

- a modified work schedule;
- changes in start and/or end times for work;
- part-time employment;
- job-sharing arrangements;
- working from home;
- telecommuting;
- reduction or change in work duties; or

- part-year employment.

"Predictable working arrangement" means a change in the employee's terms and conditions of employment that provides scheduling predictability to assist that employee with caregiving responsibilities.

Employees who wish to request flexible or predictable working arrangements should contact Human Resources to obtain the necessary form to submit the request in writing.

Within fourteen (14) days of the employee's request, the Company will meet with the employee regarding the request. Within twenty-one (21) days of the employee's request, the Company will issue a written response either granting or denying the request. If the Company denies the request, the written response to the employee will explain the basis for denial and invite the employee to engage in an interactive process meeting for the purpose of attempting, in good faith, to determine a flexible or predictable working arrangement that is acceptable to both the employee and the Company. Any notice denying an employee request for a flexible or predictable working arrangement will advise the employee of the right to request reconsideration and include a copy of the San Francisco posting about the San Francisco Family Friendly Workplace Ordinance.

If it is later determined that a flexible or a predictable working arrangement that was previously granted is causing an undue hardship, the Company will invite the employee to engage in an interactive process. If this interactive process is unsuccessful in determining a different flexible or predictable working arrangement, the Company may revoke any existing arrangement with fourteen- (14-) days written notice.

California Business Expense Reimbursement

Chestnut Health Systems will reimburse employees for reasonable expenses incurred for business purposes including, but not limited to, meals, lodging, and transportation. Mileage driven in a personal automobile for business purposes will be reimbursed at the current IRS-approved rate per mile. All business travel and business purchases must be approved in advance by the employee's Supervisor.

Employees should complete expense reimbursement reports within 30 days of incurring the expenses and submit the reports and receipts to the employee's Supervisor.

PAY PRACTICES

California Overtime

Like most successful companies, Chestnut Health Systems experiences periods of extremely high activity. During these busy periods, additional work is required from all of us. Supervisors are responsible for monitoring business activity and requesting overtime work if it is necessary. Effort will be made to provide employees with adequate advance notice in such situations.

Non-exempt employees generally will be paid overtime at the rate of time and one-half (1.5) times their normal hourly wage for all hours worked in excess of eight (8) hours in one (1) day or forty (40) hours in one (1) week, or for the first eight (8) hours on the seventh (7th) consecutive day in the same workweek.

Non-exempt employees generally will be paid double-time for hours worked in excess of twelve (12) in any workday or in excess of eight (8) on the seventh (7th) day of the workweek.

Employees may work overtime only with management authorization.

For purposes of calculating overtime for non-exempt employees, the workweek begins at 12 a.m. on Sunday and ends 168 hours later at 12 a.m. on the following Sunday.

California Travel Time for Non-Exempt Employees

Overnight, Out-of-Town Trips

Non-exempt employees will be compensated for time spent traveling (except for meal periods) during their normal working hours, on days they are scheduled to work and on unscheduled work days (such as weekends). Non-exempt employees also will be paid for any time spent performing job duties during otherwise non-compensable travel time; however, such work should be limited absent advance management authorization.

Out-of-Town Trips for One Day

Non-exempt employees who travel out of town for a one-day assignment will be paid for all travel time, except for, among other things: time spent traveling between the employee's home and the local railroad, bus or plane terminal; and meal periods.

Local Travel

Non-exempt employees will be compensated for time spent traveling from one job site to another job site during a workday. The trip home, however, is non-compensable when the employee goes directly home from the final job site, unless it is much longer than the regular commute home from the regular worksite. In such case, the portion of the trip home in excess of the regular commute is compensable.

Commuting Time

Under the Portal to Portal Act, travel from home to work and from work to home is generally non-compensable. However, if a non-exempt employee regularly reports to a worksite near their home, but is required to report to a worksite farther away than the regular worksite, the additional time spent traveling is compensable.

If compensable travel time results in more than forty (40) hours worked by a non-exempt employee, the employee will be compensated at an overtime rate of one and one-half (1-1/2) times the regular rate.

To the extent that applicable state law provides greater benefits, state law applies.

California Safe Harbor Policy for Exempt Employees

It is Company policy and practice to accurately compensate employees and to do so in compliance with all applicable state and federal laws. To ensure employees are paid properly and no improper deductions are made, employees must review their pay stubs promptly to identify and to report all errors.

If the employee believes a mistake has occurred or if the employee has any questions, the employee should use the reporting procedure outlined below.

Exempt salaried employees receive a salary which is intended to compensate for all hours worked for the Company. This salary will be established at the time of hire or when the employee becomes classified as an exempt employee. Although it may be subject to review and modification from time-to-time, such as during salary review times, the salary will be a predetermined amount that will not be subject to deductions for variations in the quantity or quality of the work performed.

Under state law, salary is subject to certain deductions. For example, the employee's salary can be reduced for the following reasons:

- full-day absences for personal reasons;
- full-day absences for sickness or disability, if the available paid sick leave has been exhausted;
- intermittent absences, including partial-day absences, covered by the federal Family and Medical Leave Act, if other available paid leave has been exhausted;
- to offset amounts received as payment for jury and witness fees or military pay;
- during the first or last week of employment in the event the employee works less than a full week; and
- any work week in which the employee performs no work for the Company.

Salary also may be reduced for certain types of deductions, such as the employee portion of health, dental or life insurance premiums; state, federal or local taxes, social security; or, voluntary contributions to a 401(k) or pension plan.

In any workweek in which the employee performed any work, the employee's salary will not be reduced for any of the following reasons:

- partial-day absences for personal reasons, sickness or disability;
- absence on a holiday when the facility is closed or because the facility is otherwise closed on a scheduled workday;
- absences for jury duty, attendance as a witness or military leave in any week in which the employee has performed any work; and
- any other deductions prohibited by state or federal law.

If employees believe they have been subject to any improper deductions, they should immediately report the matter to their supervisor. If the supervisor is unavailable or if employees believe it would be inappropriate to contact that person (or if they have not received a prompt and fully acceptable reply), they should immediately contact Human Resources or any other supervisor in the Company with whom the employee feels comfortable. If employees are unsure of whom to contact if they have not received a satisfactory response within five (5) business days after reporting the incident, they should immediately contact the CEO.

Every report will be fully investigated and corrective action will be taken where appropriate, up to and including termination for any employee who violates this policy. In addition, the Company will not allow any form of retaliation against individuals who report alleged violations of this policy or who cooperate in the investigation of such reports. Retaliation is unacceptable, and any form of retaliation in violation of this policy will result in disciplinary action, up to and including termination.

California Lactation Breaks

Chestnut Health Systems supports the legal right and necessity of employees who choose to express milk in the workplace. This policy establishes guidelines for promoting a breastfeeding-friendly work environment and supporting lactating employees for as long as they desire to express breast milk.

The Company will provide a reasonable amount of break time for employees who wish to express breast milk for their infant child each time the employee has a need to express milk, in accordance with applicable local, state, and federal law. If possible, the break time must run concurrently with rest and meal periods already provided. If break time cannot run concurrently with rest and meal periods, it will be unpaid, to the extent permitted by applicable law.

The Company will provide breastfeeding employees with space, in close proximity to their work area, that is shielded from view and free from intrusion from co-workers and the public. The room or location may include the place where the employee normally works if it otherwise meets the requirements of the lactation space. Restrooms are prohibited from being used for lactation purposes.

Employees who need a lactation accommodation should submit a request for possible accommodation to Human Resources. Upon receiving an accommodation request, the Company will respond to the employee within five (5) business days. The Company and the employee shall engage in an interactive process to determine the appropriate accommodations.

California law expressly prohibits discrimination or retaliation against lactating employees for exercising their rights granted by the ordinance. This includes those who request time to express breast milk at work and/or who lodge a complaint related to the right to lactation accommodations.

Employees have the right to file a complaint with the Labor Commissioner for any violation of the rights underlying this policy.

Employees can consult Human Resources with questions regarding this policy.

San Francisco Lactation Breaks

Chestnut Health Systems supports the legal right and necessity of employees who choose to express milk in the workplace. This policy establishes guidelines for promoting a breastfeeding-friendly work environment and supporting lactating employees for as long as they desire to express breast milk.

The Company will provide a reasonable amount of break time to accommodate the employee desiring to express breast milk for the employee's infant child each time the employee has need to express milk, to the extent required by and in accordance with applicable local, state and federal law. If possible, the break

time must run concurrently with rest and meal periods already provided to the employee. Break time that cannot run concurrently with rest and meal periods already provided to the employee is unpaid, to the extent permitted by applicable law.

The Company will provide breastfeeding employees with space to express breast milk. The space will be in close proximity to the employee's work area, will be shielded from view and will be free from intrusion from co-workers and the public. The room or location may include the place where the employee normally works if it otherwise meets the requirements of the lactation space. Restrooms are prohibited from being used for lactation purposes.

Employees who believe they need a lactation accommodation should submit a request for possible accommodation in writing to Human Resources. Upon receiving an accommodation request, the Company will respond to the employee within five (5) business days. The Company and the employee shall work together to determine the appropriate accommodations.

The San Francisco Lactation in the Workplace Ordinance and California law expressly prohibit retaliation against lactating employees for exercising their rights granted by the ordinance. This includes those who request time to express breast milk at work and/or who lodge a complaint related to the right to lactation accommodations.

Employees can contact Human Resources with questions about this policy.

San Francisco Mass Transit Commuter Benefits

All employees who work ten (10) or more hours a week within the City and County of San Francisco are eligible to receive mass transit commuter benefits. Chestnut Health Systems has elected to provide a program that permits employees to exclude certain commuting costs from taxable wages. Please contact Human Resources for more information about the program or to sign up for benefits.

TIME OFF AND LEAVES OF ABSENCE

California Paid Vacations

Chestnut Health Systems appreciates how hard employees work and recognizes the importance of providing time for rest and relaxation. Chestnut Health Systems fully encourages employees to get this rest by taking vacation time. Full-time employees accrue paid vacation time as follows:

During the first partial calendar year of employment and the first five (5) full calendar years of employment, full-time employees accrue up to ten (10) days of vacation per year. Vacation is accrued on a pro-rata basis throughout the year.

Thereafter, full-time employees accrue up to fifteen (15) days of vacation per year. Vacation is accrued on a pro-rata basis throughout the year.

The maximum vacation entitlement for part-time employees is pro-rated based on hours worked.

Eligible employees accrue vacation up to a cap of one (1) times their maximum yearly accrual. At that point, accrual stops until banked vacation is used.

Every effort will be made to grant employees' vacation preference, consistent with the operating schedule. However, if too many people request the same period of time off, the Company reserves the right to choose who may take vacation during that period. Employees with the longest length of service generally will be given preference. Vacation requests must be submitted to managers at least two (2) weeks in advance of requested vacation dates.

Vacation may be used only in full-day increments.

Accrued, unused vacation is paid out upon separation.

California Paid Personal Days

Full-time employees are eligible to accrue up to four (4) paid personal days per calendar year on a pro-rata basis. However, during the calendar year in which a full-time employee is first hired, those full-time employees hired after June 30 will be eligible to accrue personal days on a pro-rata basis and to use up to two (2) paid personal days. Any additional personal time taken by eligible employees generally will be unpaid.

Part-time employees accrue personal days in a similar manner, except on a pro-rated basis depending upon the number of hours they work.

Accrued, unused personal days will be paid out at the end of each calendar year.

Accrued, unused personal days are paid out at separation.

Personal days must be used in at least half- (1/2-) day increments.

Personal days must be scheduled at least two (2) weeks in advance. Management reserves the right in its sole discretion to deny any requests.

California Sick and Safe Time

Eligibility

Pursuant to the Healthy Workplaces, Healthy Families Act, the Company provides paid sick leave to employees who work for Chestnut Health Systems in California for thirty (30) or more days within a year. For employees who work in California who are eligible for sick time under another policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing paid sick leave at the start of employment. Paid sick leave will accumulate at the rate of one (1) hour for every thirty (30) hours worked, up to a total maximum accrual of ten (10) days or eighty (80) hours. Employees who are exempt from overtime pursuant to the executive, administrative, and professional exemptions under California law are assumed to work forty (40) hours in each workweek unless their normal workweek is less than forty (40) hours, in which case paid sick leave accrues based upon that normal workweek. For purposes of this policy, the year is the consecutive 12-month period beginning January 1 and ending December 31.

Usage

Employees can use accrued paid sick leave beginning on the 90th day of employment. Paid sick leave may be used in minimum increments of two (2) hours. An employee may use up to five (5) days or forty (40) hours of paid sick leave in any year.

Paid sick leave may be used for the following reasons:

- For diagnosis, care, or treatment of an existing health condition of or preventive care for, the employee or the employee's family member; or
- For the employee who is a victim of domestic violence, sexual assault, or stalking:

    1. To obtain or attempt to obtain a temporary restraining order, restraining order, or other injunctive relief;
    2. To help ensure the health, safety, or welfare of the victim or the victim's child;
    3. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;
    4. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;
    5. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking; or
    6. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation.

For purposes of this policy, family member means a child (including biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee stands *in loco parentis*, all regardless of age or dependency status); spouse; registered domestic partner; parent (including biological, adoptive, or foster parent, stepparent, or legal guardian of the employee or the employee's spouse or registered domestic partner or a person who stood *in loco parentis* when the employee was a minor child); grandparent; grandchild; sibling; or a designated person. Employees are limited to selecting one (1) designated person per 12- month period for paid sick days.

Unless the employee advises the Employee's Supervisor otherwise, the Company will assume employees want to use available paid sick leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have paid sick leave available.

Employees will be notified of their available paid sick leave on each itemized wage statement.

Notice and Documentation

Notice to the Employee's Supervisor may be given orally or in writing. If the need for paid sick leave is foreseeable, the employee must provide reasonable advance notification. If the need for paid sick leave is unforeseeable, the employee must provide notice of the need for the leave as soon as practicable.

Payment

Eligible employees will receive payment for paid sick leave at the same wage as the employee normally earns during regular work hours, unless otherwise required by applicable law, by the next regular payroll period after the leave was taken. Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued paid sick leave carries over from year to year, but is subject to the accrual cap of ten (10) days or eighty (80) hours. Once the accrual cap is reached, paid sick leave will stop accruing until some paid sick leave is used.

Accrued but unused paid sick leave under this policy will not be paid at separation.

Enforcement and Retaliation

Retaliation or discrimination against any employee who requests paid sick days or uses paid sick days or both is prohibited and employees may file a complaint with the Labor Commissioner against an employer who retaliates or discriminates against any employee.

If employees have any questions regarding this policy, they should contact Human Resources.

Berkeley Sick and Safe Time (Including The HWHFA)

Eligibility

The Company provides paid sick leave to employees who perform at least two (2) hours of work in the City of Berkeley in a calendar week. For employees who work in Berkeley who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing paid sick leave at the start of employment. Paid sick leave accrues at the rate of one (1) hour for every thirty (30) hours worked, up to a maximum accrual of eighty (80) hours. Employees who are exempt from overtime pursuant to the California executive, administrative, and professional exemptions are assumed to work a forty- (40-) hour workweek unless their normal workweek is less than forty (40) hours, in which case, paid sick leave accrues based upon that regular workweek. For purposes of this policy, the calendar year is the consecutive 12-month period beginning January 1 and ending on December 31.

Usage

Employees can use accrued paid sick leave on the 90th day of employment. Paid sick leave must be used in a minimum increment of two (2) hours.

Paid sick leave may be used for the following reasons:

1. When the employees are physically or mentally unable to perform their duties due to illness, injury, pregnancy, or a related medical condition;
2. To obtain a professional diagnosis or treatment of the employee's medical condition or undergo a physical examination;
3. To aid or care for a family member or designated person who is ill, injured, or receiving medical care, treatment, or diagnosis; or
4. For the employee who is a victim of domestic violence, sexual assault, or stalking:

    a. To obtain or attempt to obtain a temporary restraining order, restraining order, or other injunctive relief;
    b. To help ensure the health, safety, or welfare of the victim or the victim's child;
    c. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;
    d. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;
    e. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking; or
    f. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation.

For purposes of this policy, "family member" means child (including a child of a domestic partner and a child of a person standing *in loco parentis*), parent, legal guardian or ward, sibling, grandparent, grandchild, spouse, or registered domestic partner under any state or local law, or a designated person. These relationships include not only biological relationships but also relationships resulting from adoption, step-relationships, and foster care relationships. Employees are limited to selecting one (1) designated person per 12- month period for paid sick days.

Unless the employee advises otherwise, the Company will assume, subject to applicable law, that employees want to use available paid sick leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have paid sick leave available.

Employees will be notified of their available paid sick leave on each itemized wage statement.

Notice and Documentation

Employees are required to provide reasonable notification of an absence taken under this policy. In the case of foreseeable absences, the Company requests reasonable advance notification, and what is reasonable will generally depend on the specific situation. In the case of unforeseeable absences, the employee must provide notice of the need for the leave as soon as practicable. The Company may also take reasonable measures to verify that employees' use of paid sick leave is lawful, to the maximum extent permitted by applicable law.

Payment

Eligible employees will receive payment for paid sick leave, at the same rate of pay as the employee normally earns during regular work hours, unless otherwise required by applicable law, by the next regular payroll period after the leave was taken, and in no event will the rate of pay be less than the Berkeley or California minimum wage, whichever is higher. Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued paid sick leave carries over from year to year, but is subject to the maximum accrual (accrual cap) of eighty (80) hours. Once the accrual cap is reached, paid sick leave will stop accruing until some paid sick leave is used. Accrued but unused paid sick leave under this policy will not be paid at separation.

Enforcement and Retaliation

Retaliation or discrimination against the employee who requests paid sick days or uses paid sick days, or both, is prohibited, and employees may file a complaint with the California Labor Commissioner or the City of Berkeley against an employer who retaliates or discriminates against the employee.

If employees have any questions regarding this policy, they should contact Human Resources.

Emeryville Sick and Safe Time for Non-Exempt Employees (Including The HWHFA)

Eligibility

The Company provides paid sick leave to employees who perform at least two (2) hours of work per week in Emeryville. For employees who work in Emeryville who are eligible for sick time under another policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing paid sick leave at the start of employment. Paid sick leave will accumulate at the rate of one (1) hour for every thirty (30) hours worked, up to a maximum accrual of eighty (80) hours. For purposes of this policy, the year is the consecutive 12-month period beginning on January 1 and ending on December 31.

Usage

Employees can use accrued paid sick leave beginning on the 90th day of employment. Paid sick leave may be used in a minimum increment of two (2) hours. The employee may use up to forty-eight (48) hours of paid sick leave in any year.

Paid sick leave may be used for the following reasons:

1. For diagnosis, care, or treatment of an existing health condition of or preventive care for, the employee or the employee's family member;
2. For the employee who is a victim of domestic violence, sexual assault, or stalking:

    a. To obtain or attempt to obtain a temporary restraining order, restraining order, or other injunctive relief;
    b. To help ensure the health, safety, or welfare of the victim or the victim's child;
    c. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;
    d. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;
    e. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking; or
    f. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation;

3. To aid or care for a guide dog, signal dog, or service dog (as those terms are defined under applicable state law) of the employee or the employee's family member.

For purposes of this policy, family member means a child (including biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee stands *in loco parentis*, all regardless of age or dependency status); spouse; registered domestic partner; parent (including biological, adoptive, or foster parent, stepparent or legal guardian of the employee or the employee's spouse or registered domestic partner or a person who stood *in loco parentis* when the employee was a minor child); grandparent; grandchild; or a sibling; or designated person. Employees are limited to selecting one (1) designated person per 12- month period for paid sick days.

Unless the employee advises the Employee's Supervisor otherwise, the Company will assume employees want to use available paid sick leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have paid sick leave available.

Employees will be notified of their available paid sick leave on each itemized wage statement.

Notice and Documentation

Notice to the Employee's Supervisor may be given orally or in writing. If the need for paid sick leave is foreseeable, the employee must provide reasonable advance notification by phone or email. If the need for paid sick leave is unforeseeable, the employee must provide notice of the need for the leave as soon as practicable. In the case of unforeseeable absences, the Company generally requests advanced notification of at least two (2) hours prior to the start of the employee's shift or, if such notice is not possible, as soon as practicable. The Company may also take reasonable measures to verify that employees' use of paid sick leave is lawful, to the maximum extent permitted by applicable law.

Payment

Eligible employees will receive payment for paid sick leave, at the same wage as the employee normally earns during regular work hours, unless otherwise required by applicable law, by next regular payroll period after the leave was taken. Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued, unused paid sick leave carries over from year to year but is subject to the maximum accrual (accrual cap) of eighty (80) hours. Once the accrual cap is reached, paid sick leave will stop accruing until some paid sick leave is used.

Accrued but unused paid sick leave under this policy will not be paid at separation.

Enforcement and Retaliation

Retaliation or discrimination against the employee who requests paid sick days or uses paid sick days or both, is prohibited and employees may file a complaint with the Labor Commissioner or the City of Emeryville against an employer who retaliates or discriminates against the employee.

If employees have any questions regarding this policy, they should contact Human Resources.

Los Angeles Sick and Safe Time for Non-Exempt Employees (Including The HWHFA)

Eligibility

The Company provides paid sick leave to employees who work in the City of Los Angeles for the Company for thirty (30) days or more within a year from the commencement of employment and who, in a particular week, perform at least two (2) hours of work per week for the Company in the City of Los Angeles. For employees who work in the City of Los Angeles who are eligible for paid sick time under another policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing paid sick leave at the start of employment. Paid sick leave accrues at the rate of one (1) hour for every thirty (30) hours worked, up to a maximum accrual of eighty (80) hours. For purposes of this policy, the year is the consecutive 12-month period beginning on January 1 and ending on December 31.

Usage

Employees can use accrued paid sick leave on the 90th day of employment. Paid sick leave must be used in a minimum increment of two (2) hours. Employees cannot use more than 48 hours of paid sick leave per year.

Paid sick leave may be used for the following reasons:

- For diagnosis, care, or treatment of an existing health condition of, or preventive care for, the employee or the employee's family member; or
- For the employee who is a victim of domestic violence, sexual assault, or stalking:

1. To obtain or attempt to obtain a temporary restraining order, restraining order, or other injunctive relief;
2. To help ensure the health, safety, or welfare of the victim or the victim's child;
3. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;
4. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;
5. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking; or
6. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation.

For purposes of this policy, "family member" means a child (including biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee stands *in loco parentis*, all regardless of age or dependency status); spouse; registered domestic partner; parent (including biological, adoptive, or foster parent, stepparent, or legal guardian of the employee or the employee's spouse or registered domestic partner or a person who stood *in loco parentis* when the employee was a minor child); grandparent; grandchild; sibling; designated person; or any individual related by blood or affinity whose close association with the employee is equivalent of a family relationship. Employees are limited to selecting one (1) designated person per 12- month period for paid sick days.

Unless the employee advises the Employee's Supervisor otherwise, the Company will assume, subject to applicable law, that employees want to use available paid sick leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have paid sick leave available.

Employees will be notified of their available paid sick leave on each itemized wage statement.

Notice and Documentation

Notice to the Employee's Supervisor may be given orally or in writing. If the need for paid sick leave is foreseeable, the employee must provide reasonable advance notification. If the need for paid sick leave is unforeseeable, the employee must provide notice of the need for the leave as soon as practicable. In the case of unforeseeable absences, the Company generally requests advanced notification of at least two (2) hours prior to the start of the employee's shift or, if such notice is not possible, as soon as practicable. The Company may also take reasonable measures to verify that employees' use of paid sick leave is lawful, to the maximum extent permitted by applicable law.

Payment

Eligible employees will receive payment for paid sick leave, at the same rate of pay they normally earn during regular work hours, unless otherwise required by applicable law, by the next regular payroll period after the leave was taken, and in no event will the rate of pay be less than the Los Angeles or California minimum wage, whichever is higher.

Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Unused paid sick leave carries over from year to year, but is subject to the maximum accrual (accrual cap) of eighty (80) hours. Once the accrual cap is reached, paid sick leave will stop accruing until some paid sick leave is used. Accrued but unused paid sick leave under this policy will not be paid at separation.

Enforcement and Retaliation

Retaliation or discrimination against the employee who requests paid sick leave or uses paid sick leave, or both, is prohibited, and employees may file a complaint with the California Labor Commissioner or the appropriate city designated administrative agency against an employer who retaliates or discriminates against the employee.

If employees have any questions regarding this policy, they should contact the Employee's Supervisor.

Oakland Sick and Safe Time (Including The HWHFA)

Eligibility

The Company provides paid sick leave to employees who perform at least two (2) hours of work per week in Oakland. For employees who work in Oakland who are eligible for sick days under another policy and/or any other applicable sick time/leave ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave ordinance.

Accrual

Employees begin accruing paid sick leave at the start of employment. Paid sick leave accrues at the rate of one (1) hour for every thirty (30) hours worked, up to a maximum accrual of eighty (80) hours. Employees who are exempt from overtime pursuant to the California executive, administrative, and professional exemptions are assumed to work a forty- (40-) hour work week unless their normal workweek is less than forty (40) hours, in which case, paid sick leave accrues based upon that regular work week.

Usage

Employees can use accrued paid sick leave on the 90th day of employment. Paid sick leave must be used in a minimum increment of one (1) hour.

Paid sick leave may be used for the following reasons:

1. When the employees are physically or mentally unable to perform their duties due to illness, injury, pregnancy, or a related medical condition;
2. To obtain a professional diagnosis or treatment of the employee's medical condition or undergo a physical examination;
3. To aid or care for a family member who is ill, injured, or receiving medical care, treatment, or diagnosis; or
4. For the employee who is a victim of domestic violence, sexual assault, or stalking:

a. To obtain or attempt to obtain a temporary restraining order, restraining order, or other injunctive relief;
b. To help ensure the health, safety, or welfare of the victim or the victim's child;
c. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;
d. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;
e. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking; or
f. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation.

For purposes of this policy, family member means child (including a child of a domestic partner and a child of a person standing *in loco parentis*); parent; legal guardian or ward; sibling; grandparent; grandchild; spouse or registered domestic partner under any state or local law; or a designated person. These relationships include not only biological relationships but also relationships resulting from adoption, step-relationships, and foster care relationships. Employees are limited to selecting one (1) designated person per 12- month period for paid sick days.

Unless the employee advises the employee's supervisor otherwise, the Company will assume employees want to use available paid sick leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have paid sick leave available.

Employees will be notified of their available paid sick leave on each itemized wage statement.

Notice and Documentation

Employees are required to provide reasonable notification of an absence taken under this policy by contacting the employee's supervisor by phone or email. In the case of foreseeable absences, the Company requests reasonable advance notification, and what is reasonable will generally depend on the specific situation. In the case of unforeseeable absences, the Company generally requests advanced notification of at least two (2) hours prior to the start of the employee's shift or, if such notice is not possible, as soon as practicable. The Company may also take reasonable measures to verify that employees' use of paid sick leave is lawful, to the maximum extent permitted by applicable law.

Payment

Eligible employees will receive payment for paid sick leave at their normal base rate of pay, unless otherwise required by applicable law, by the next regular payroll period after the leave was taken, and in no event will the rate of pay be less than the Oakland or California minimum wage, whichever is higher. Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued paid sick leave carries over from year to year, but is subject to the maximum accrual (accrual cap) of eighty (80) hours. Once the accrual cap is reached, paid sick leave will stop accruing until some paid sick leave is used.

Accrued but unused paid sick leave under this policy will not be paid at separation.

Enforcement and Retaliation

Retaliation or discrimination against the employee who requests paid sick days or uses paid sick days or both is prohibited. Employees have the right to file a complaint with the California Labor Commissioner or the City of Oakland against an employer who retaliates or discriminates against the employee.

Questions

If employees have any questions regarding this policy, they should contact Human Resources.

San Diego Sick and Safe Time (Including The HWHFA)

Eligibility

The Company provides earned sick leave to non-exempt employees who, in one (1) or more calendar weeks of the year, perform at least two (2) hours of work for the Company in the City of San Diego. For employees who work in San Diego who are eligible for sick time under another policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave law or ordinance.

Employees begin accruing earned sick leave at the start of employment. Earned sick leave accrues at the rate of one (1) hour for every thirty (30) hours worked, subject to a maximum accrual of eighty (80) hours. For purposes of this policy, the year is the consecutive 12-month period beginning on January 1 and ending on December 31.

Usage

Employees can use accrued earned sick leave on the 90th calendar day of employment. Earned sick leave must be used in a minimum increment of two (2) hours. Employees cannot use more than forty (40) hours of earned sick leave in any year.

Earned sick leave may be used for the following reasons:

- When the employees are physically or mentally unable to perform their duties due to illness, injury, pregnancy or another medical condition;
- To obtain a physical examination or a professional diagnosis or treatment of the employee's medical condition;
- To aid, assist, or care for a family member with an illness, injury, or medical condition, including assistance in obtaining professional diagnosis or treatment of a medical condition;
- For time away from work that is necessary due to domestic violence, sexual assault, or stalking, provided the time is used to allow the employees to obtain for themselves for a family member one (1) or more of the following:

    1. Medical attention needed to recover from physical or psychological injury or disability caused by domestic violence, sexual assault, or stalking;
    2. Services from a victim services organization;
    3. Psychological or other counseling;

4. Relocation due to the domestic violence, sexual assault, or stalking; or
5. Legal services, including preparing for or participating in any civil or criminal legal proceeding related to or resulting from the domestic violence, sexual assault, or stalking.

- The employee's place of business is closed by order of a public official due to a public health emergency, or the employee is providing care or assistance to a child, whose school or child care provider is closed by order of a public official due to a public health emergency.

For purposes of this policy, family member means a child (a biological, adopted, or foster child; a stepchild; a legal ward; a child of a domestic partner; or a child of the employee standing *in loco parentis*); spouse (a person to whom the employee is legally married under California laws or the employee's domestic partner); parent (a biological, foster, or adoptive parent; a step-parent; a legal guardian; or a person who stood *in loco parentis* when the employee was a minor child); grandparent; grandchild; sibling (a brother or sister, whether related through half blood, whole blood, or adoption or one who is a stepsibling); the child or parent of a spouse; or a designated person. Employees are limited to selecting one designated person per 12-month period for paid sick days.

Unless the employee advises the Employee's Supervisor otherwise, the Company will assume, subject to applicable law, that employees want to use available earned sick leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have earned sick leave available.

Employees will be notified of their available earned sick leave on each itemized wage statement.

Notice and Documentation

Employees are required to provide reasonable notification of an absence taken under this policy. In the case of foreseeable absences, the Company requires reasonable advance notification. In the case of unforeseeable absences, the Company requires notice of the need to use earned sick leave as soon as practicable. To the maximum extent permitted by applicable law, the Company may request documentation for the use of earned sick leave of more than three (3) consecutive work days. Acceptable documentation includes documentation signed by a licensed health care provider indicating the need for the amount of earned sick leave taken.

Payment

Eligible employees will receive payment for earned sick leave, at the same rate of pay as the employee normally earns during regular work hours, by the next regular payroll period after the leave was taken, and in no event will the rate of pay be less than the San Diego or California minimum wage, whichever is higher. Use of earned sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued, unused earned sick leave carries over from year to year, but is subject to a maximum accrual (accrual cap) of eighty (80) hours. Once the accrual cap is reached, earned sick leave will stop accruing until some earned sick leave is used.

Accrued but unused earned sick leave under this policy will not be paid at separation.

Enforcement and Retaliation

Retaliation or discrimination against the employee who requests earned sick days or uses earned sick days, or both, is prohibited, and employees may file a complaint with the California Labor Commissioner or the San Diego Enforcement Office or a court of competent jurisdiction against an employer who retaliates or discriminates against the employee.

If employees have any questions regarding this policy, they should contact the Employee's Supervisor.

San Francisco Sick and Safe Time (Including The HWHFA)

Eligibility

The Company provides paid sick leave to employees who perform fifty-six (56) or more hours of work within a calendar year in the City and County of San Francisco. For employees who work in the City and County of San Francisco who are eligible for sick time under another policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing paid sick leave at the start of employment. Paid sick leave accrues at the rate of one (1) hour for every thirty (30) hours worked, up to a total maximum accrual of eighty (80) hours at any time. Employees who are exempt from overtime pursuant to the California executive, administrative, and professional exemptions are assumed to work a forty- (40-) hour workweek unless their regular workweek is less than forty (40) hours, in which case, paid sick leave accrues based upon that regular workweek. For purposes of this policy, the calendar year is the consecutive 12-month period beginning January 1 and ending on December 31.

Usage

Employees can use accrued paid sick leave beginning on the 90th day of employment. Paid sick leave must be used in a minimum increment of one (1) hour.

Paid sick leave may be used for the following reasons:

1. For the employee or a family member to receive preventative care (such as annual physicals or flu shots);
2. For the employee's or a family member's illness, injury, or for medical care, treatment, or diagnosis;
3. For the employee, who is a victim of domestic violence, sexual assault, or stalking:

    a. To obtain or attempt to obtain a temporary restraining order, restraining order, or other injunctive relief;
    b. To help ensure the health, safety, or welfare of the victim or the victim's child;
    c. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;
    d. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;

e. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking; or
f. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation.

4. For purposes related to donating the employee's bone marrow or an organ to another person, or to care for or assist a family member donating bone marrow or an organ.

For purposes of this policy, family member includes any of the following: parent, child (including a biological child, a registered domestic partner's child, and a child of a person standing *in loco parentis*), spouse or registered domestic partner, grandparent, grandchild, sibling, or a designated person and applies not only to biological relationships, but also applies to those resulting from adoption, step-relationships, and foster care relationships. Employees are limited to selecting one (1) designated person per 12- month period for paid sick days.

Unless the employee advises the employee's supervisor otherwise, the Company will assume employees want to use available paid sick leave for absences due to reasons set forth above and employees will be paid for such absences to the extent they have paid sick leave available.

Employees will be notified of their available paid sick leave on each itemized wage statement.

Notice and Documentation

Notice may be given orally or in writing. If the need for paid sick leave is foreseeable, the employee must provide reasonable advance notification. In most cases, "reasonable" generally means notifying the employee's supervisor three (3) days in advance of the foreseeable absence. If the need for paid sick leave is unforeseeable, the employee must provide notice as soon as practicable. In most cases, "as soon as practicable" generally means notifying the employee's supervisor at least two (2) hours prior to the start of a work shift, if possible. In cases of accidents or sudden illnesses when the employee is not able to provide such notice under the circumstances, notice should be provided as soon as possible.

To the maximum extent permitted by applicable law, employees who are absent from work on paid sick leave for more than three (3) consecutive work days or twenty-four (24) hours, whichever is greater, must present a certificate from their medical practitioner stating the leave was necessitated by an illness or injury, releasing their return to work and setting forth any restrictions or limitations on the ability to perform the job. Similarly, when the employee uses paid sick leave for more than three (3) consecutive work days or twenty-four (24) hours, whichever is greater, to care for a family member, the employee also must present a certificate from that person's medical practitioner stating leave was necessitated by that person's illness.

Payment

Eligible employees will receive payment for paid sick leave at the same rate of pay as the employee normally earns during regular work hours by the next regular payroll period after the leave was taken and in no event will the rate of pay be less than the San Francisco or California minimum wage, whichever is higher. Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued paid sick leave carries over from year to year, but is subject to the maximum accrual (accrual cap) of eighty (80) hours. Once the accrual cap is reached, paid sick leave will stop accruing until some paid sick leave is used. Accrued but unused paid sick leave under this policy will not be paid at separation.

Enforcement and Retaliation

The Company prohibits discrimination and retaliation against employees who assert their rights to receive and use paid sick leave under this policy, file a complaint, or allege a violation of their rights with respect to paid sick leave, cooperate in an investigation or prosecution or oppose a policy of practice prohibited by applicable state or local law. Employees may file a complaint with the California Labor Commissioner or the San Francisco Office of Labor Standards Enforcement.

Questions

If employees have any questions regarding this policy, they should contact Human Resources.

Santa Monica Sick and Safe Time for Non-Exempt Employees (Including The HWHFA)

Eligibility

The Company provides paid sick leave to eligible employees who, in a particular week, perform at least two (2) hours of work per week for the Company in the City of Santa Monica.

For employees who work in the City of Santa Monica who are eligible for paid sick time under another policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Eligible employees begin accruing paid sick leave at the start of employment. Paid sick leave accrues at the rate of one (1) hour for every thirty (30) hours worked, up to a maximum accrual of eighty (80) hours. To the maximum extent permitted by law, employees who are exempt from overtime pursuant to the executive, administrative, and professional exemptions under California law are assumed to work forty (40) hours in each workweek unless their normal workweek is less than forty (40) hours, in which case paid sick leave accrues based upon that normal workweek. For purposes of this policy, the year is the consecutive 12-month period beginning on January 1 and ending on December 31.

Usage

Employees can use accrued paid sick leave on the 90th day of employment. Paid sick leave must be used in a minimum increment of two (2) hours.

Paid sick leave may be used for the following reasons:

1. For diagnosis, care or treatment of an existing health condition of, or preventive care for, the employee or the employee's family member; or
2. For the employee who is a victim of domestic violence, sexual assault, or stalking:

    a. To obtain or attempt to obtain a temporary restraining order, restraining order, or other injunctive relief;
    b. To help ensure the health, safety, or welfare of the victim or the victim's child;
    c. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;
    d. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;
    e. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking; or
    f. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation.

For purposes of this policy, "family member" means a child (including biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee stands *in loco parentis*, all regardless of age or dependency status); spouse; registered domestic partner; parent (including biological, adoptive or foster parent, stepparent or legal guardian of the employee or the employee's spouse or registered domestic partner or a person who stood *in loco parentis* when the employee was a minor child); grandparent; grandchild; a sibling; or a designated person. Employees are limited to selecting one (1) designated person per 12-month period for paid sick days.

Unless the employee advises Human Resources otherwise, the Company will assume employees want to use available paid sick leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have paid sick leave available.

Employees will be notified of their available paid sick leave on each itemized wage statement.

Notice and Documentation

Notice to use paid sick leave should be provided to orally or in writing. If the need for paid sick leave is foreseeable, the employee must provide reasonable advance notification. If the need for paid sick leave is unforeseeable, the employee must provide notice of the need for the leave as soon as practicable. To the maximum extent permitted by applicable law, the Company may require the employee to provide reasonable documentation of an absence from work for which paid sick leave was used for more than three (3) consecutive days.

Payment

Eligible employees will receive payment for paid sick leave, at the same rate of pay as the employee normally earns during regular work hours, by the next regular payroll period after the leave was taken, and in no event will the rate of pay be less than the Santa Monica or California minimum wage, whichever is higher. Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued, unused paid sick leave carries over from year to year, but is subject to the maximum accrual (accrual cap) of eighty (80) hours. Once the accrual cap is reached, paid sick leave will stop accruing until some paid sick leave is used.

Accrued, unused paid sick leave under this policy will not be paid at separation.

Enforcement and Retaliation

Retaliation or discrimination against the employee who requests paid sick leave or uses paid sick leave, or both, is prohibited, and employees may file a complaint with the California Labor Commissioner or the appropriate City designated administrative agency against an employer who retaliates or discriminates against the employee.

If employees have any questions regarding this policy, they should contact Human Resources.

West Hollywood Paid and Unpaid Time Off for Non-Exempt Employees (Including The HWHFA)

Eligibility

Pursuant to the West Hollywood Ordinance, Chestnut Health Systems provides paid leave and unpaid leave to non-exempt employees who perform at least two (2) hours of work in a particular week of the year within the geographic boundaries of West Hollywood. Compensated leave is provided in the form of paid sick leave and paid vacation/personal necessity leave. For employees who work in West Hollywood who are eligible for paid time off under another policy and and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Non-exempt employees begin accruing paid sick leave, paid vacation/personal necessity leave, and unpaid leave pursuant to this policy at the start of employment. Paid sick leave will accrue at the rate of 0.0333 hours for each hour worked, up to an overall maximum accrual of ninety-six (96) hours. Paid vacation/personal necessity leave will accrue at the rate of 0.0235 hours for each hour worked, up to a maximum annual accrual of forty-eight (48) hours and an overall maximum accrual of 96 hours. Accordingly, employees may accrue up to an overall maximum combined accrual amount of 192 hours for paid sick leave and paid vacation/personal necessity leave. Unpaid leave will accrue at the rate of 0.039 hours for each hour worked, up to a maximum annual accrual and an overall maximum accrual of eighty (80) hours. Employees will not accrue paid vacation/personal necessity leave or unpaid leave for hours worked in excess of forty (40) hours each week.

For purposes of this policy, the year is the consecutive 12-month period beginning January 1 and ending on December 31.

Usage

Employees can use paid sick leave beginning on the 90th day of employment. Employees can use accrued paid vacation/personal necessity leave and unpaid leave beginning on the 120th day of employment of employment. Paid and unpaid leave may be used in a minimum increment of two (2) hours.

Paid vacation/personal necessity leave may be used for any reason the employee chooses.

Paid sick leave may be used for the following reasons:

1. For diagnosis, care, or treatment of an existing health condition of, or preventive care for, the employee or the employee's family member; or
2. For employees who are a victim of domestic violence, sexual assault, or stalking:

    a. To obtain or attempt to obtain a temporary restraining order, restraining order, or other injunctive relief;
    b. To help ensure the health, safety, or welfare of the victim or the victim's child;
    c. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;
    d. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;
    e. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking; or
    f. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation.

For purposes of use of paid sick leave under this policy, "family member" means a child (including biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee stands *in loco parentis*, all regardless of age or dependency status), spouse, registered domestic partner, parent (including biological, adoptive, or foster parent, stepparent, or legal guardian of the employee or the employee's spouse or registered domestic partner, or a person who stood *in loco parentis* when the employee was a minor child), grandparent, grandchild, sibling, or a designated person. Employees are limited to selecting one (1) designated person per 12-month period for paid sick leave.

Unpaid leave may be used only for sick leave for the illness of the employee or the employee's immediate family member, as defined by the California Family Rights Act (CFRA). In addition, employees may use unpaid leave only if they have fully exhausted their paid leave or are ineligible to use paid leave.

Unless the employee advises the Company otherwise, we will assume, subject to applicable law, that employees want to use available paid sick leave for reasons set forth above, and employees will be paid for such absences to the extent they have paid sick leave available. In the event the employee has no paid sick leave available, unless the employee advises the Company otherwise, we will assume, subject to applicable law, that the employee wants to use available unpaid leave for absences for the illness of the employee or the employee's immediate family member.

Employees will be notified of their available paid sick leave, paid vacation/personal necessity leave, and unpaid leave on each itemized wage statement.

Notice

Notice of the need for paid sick leave, unpaid leave, and paid vacation/personal necessity leave should be given to the Employee's Supervisor either orally or in writing. If the need for leave is foreseeable, the employee must provide reasonable advance notification. If the need for leave is unforeseeable, the employee must provide notice of the need for the leave as soon as practicable.

Requests for paid vacation/personal necessity leave will be reviewed based on a number of factors, including business needs and staffing requirements. Although the Company will attempt to accommodate a timely request, the Company cannot guarantee that such a request will be granted on all occasions, unless otherwise required by law. The Company will not unreasonably deny an eligible employee's request to use accrued vacation/personal necessity leave.

Payment

Eligible employees will receive payment for paid sick leave and paid vacation/personal necessity leave at the same wage as the employee normally earns during regular work hours, unless otherwise required by applicable law, by next regular payroll period after the leave was taken. Eligible employees will receive no payment for unpaid leave. Use of paid sick leave, paid vacation/personal necessity leave, and unpaid leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued paid sick leave carries over from year to year but is subject to an overall maximum of ninety-six (96) hours. Accrued unused paid vacation/personal necessity leave carries over from year to year but is subject to an overall maximum of 96 hours. Accordingly, employees may carry over up to the maximum combined total of 192 hours of paid sick leave and paid vacation/personal necessity leave. Accrued unpaid leave also carries over from year to year but is subject to overall maximum accrual of eighty (80) hours. Once the applicable overall maximum accrual is reached, leave will stop accruing until some of the applicable leave is used.

Accrued but unused paid vacation/personal necessity leave under this policy is paid at separation.
Accrued but unused paid sick leave and unpaid leave under this policy will not be paid at separation.

Enforcement and Retaliation

Retaliation or discrimination against employees who request or use paid sick leave, paid vacation/personal necessity leave or unpaid leave is prohibited, and employees may file a complaint with the Labor Commissioner or City Manager against an employer who retaliates or discriminates against them.

If employees have any questions regarding this policy, they should contact Human Resources.

California Witness Leave

Employees called to serve as an expert witness in a judicial proceeding on behalf of the State will be granted leave with pay. Employees summoned to appear in court as an expert witness, but not on behalf of the State may use available vacation and personal time to cover the period of absence.

Employees subpoenaed for witness duty must notify their supervisor as soon as possible.

California Voting Leave

In the event employees do not have sufficient time outside of working hours to vote in a statewide election, employees may take off sufficient working time to vote. This time should be taken at the beginning or end of the regular work schedule, whichever allows the most free time for voting and the least time off from work. Employees will be allowed a maximum of two (2) hours of voting leave on Election Day without loss of pay. Where possible, supervisors should be notified of the need for leave at least three (3) working days prior to the Election Day.

California Statutory Short-Term Disability Benefits

Chestnut Health Systems also provides statutory short-term disability insurance.

This is solely a monetary benefit and not a leave of absence. Employees who will be out of work must also request a formal leave of absence. See the Leave of Absence sections of this handbook for more information.

California Paid Family Leave Benefits

Employees may be eligible to receive benefits through the California Paid Family Leave (PFL) program, which is administered by the Employment Development Department (EDD), when they take leave to:

- Care for a child, spouse, parent, grandparent, grandchild, sibling, parent-in-law, or registered domestic partner, with a serious health condition;
- Bond with a minor child within the first year of the child's birth or placement in connection with foster care or adoption; or
- Participate in a qualifying exigency related to the covered active duty or call to covered active duty of the employee's spouse, domestic partner, child or parent in the Armed Forces of the United States.

These benefits are financed solely through employee contributions to the PFL program. That program is solely responsible for determining if the employee is eligible for such benefits.

If employees need to take time off work for any of the reasons set forth above, they must advise Chestnut Health Systems, and they will be given information about the EDD's PFL program and how to apply for benefits. Employees also may contact their local EDD Office for further information. Employees should maintain regular contact with the Company during the time off work so the Company may monitor the employee's return-to-work status. In addition, the employee should contact the Company when ready to return to work so the Company may determine what positions, if any, are open.

When the employee applies for PFL benefits, the Human Resources Department will determine if the employee has any accrued but unused vacation and personal days available. If the employee has accrued but unused time available, then the employee will be required to use up to two (2) weeks of such time before becoming eligible for PFL benefits.

Employees taking time off work for any of the reasons set forth above are not guaranteed job reinstatement unless they qualify for such reinstatement under federal or state family and medical leave laws.

Any time off for Paid Family Leave purposes will run concurrently with other leaves of absence, such as Family and Medical Leave/California Family Rights Act Leave, if applicable. Please see the "Family and Medical Leave/California Family Rights Act" policies in this handbook for eligibility requirements, if applicable.

San Francisco Paid Parental Leave Benefits

In accordance with the San Francisco Paid Parental Leave Ordinance, Chestnut Health Systems provides partial wage replacement benefits (Supplemental Compensation) to eligible employees who are on an approved leave of absence to bond with a new child through birth, adoption or foster care placement. Eligible employees may receive up to eight (8) weeks of Supplemental Compensation in a 12-month period.

Eligible Employees

To be eligible to receive benefits under this policy, employees must meet **all** of the following criteria:

1. be absent from work due to an approved leave of absence for the purpose of bonding with a new child during the first year after birth of the child or placement of the child with the employee through foster care or adoption;
2. have worked at least 180 calendar days for the Company before beginning any parental leave;
3. perform at least eight (8) hours of work per week for the Company within the geographic boundaries of the City and County of San Francisco;
4. perform at least 40% of their total weekly hours within the geographic boundaries of the City and County of San Francisco;
5. be receiving wage replacement benefits from the State of California's Paid Family Leave (PFL) program for the purpose of bonding with a new child;
6. agree to allow the Company to deduct up to two (2) weeks of accrued vacation from the employee's leave bank to offset the cost of any Supplemental Compensation benefits; and
7. comply with the procedures for requesting Supplemental Compensation benefits described below.

Employees who ***do not*** meet all of the above criteria are not eligible to receive Supplemental Compensation under this policy, but may still be eligible for benefits in accordance with the State of California PFL program.

Supplemental Compensation Benefit

The weekly Supplemental Compensation benefit is calculated based on the employee's wages and will be calculated in accordance with the San Francisco Paid Parental Leave Ordinance. Unless otherwise provided by law, the employee's weekly Supplement Compensation benefit will be equal to the difference between the weekly benefit received by the employee from the State of California PFL program and the weekly wage associated with that PFL benefit amount. Supplemental Compensation is only available during the period the employee is eligible for and is receiving weekly PFL benefits for the purpose of bonding with a new child. Employees can receive up to eight (8) weeks of Supplemental Compensation benefits.

Procedure for Receiving Supplemental Compensation

To receive Supplemental Compensation, employees must comply with the following procedures:

1. send an email to Human Resources stating they understand and agree that up to two (2) weeks of vacation will be deducted from their leave bank to offset the costs in providing Supplemental Compensation;
2. provide the Company with a copy of the employee's Notice of Computation of California Paid Family Leave Benefits (Notice) from California's Employment Development Department (EDD) and provide EDD with permission to share the employee's California PFL weekly benefit amount with the Company;
3. complete and sign the San Francisco Paid Parental Leave Employee Form (PPL Form) (available from Human Resources). The Notice and PPL Form must be submitted within a reasonable time following the Covered Employee's receipt of the Notice from EDD;
4. notify the Company in writing upon the employee's receipt of the first payment from EDD; and
5. submit a copy of the Notice of Payment from EDD to confirm the Covered Employee's receipt of PFL benefits.

Employees who do not fully comply with this procedure may be denied Supplemental Compensation benefits, or receipt of these benefits may be delayed. If the employee completes the above procedures for receiving Supplemental Compensation prior to or during the period in which the employee is also receiving PFL benefits, the Company will make a good faith effort to make the first Supplemental Compensation benefit payment on the payday associated with the next full pay period following the employee's satisfaction of the above procedures. If the employee completes the above procedures after the period in which the employee received PFL benefits has been completed, the employee will receive the total Supplemental Compensation no later than 30 days after satisfaction of the above procedures.

Employees may be required to reimburse the Company for any Supplemental Compensation benefits provided under this policy if they:

- do not return to work from a leave of absence during which they received Supplemental Compensation benefits, or
- voluntarily resign from employment within 90 days of the end of any leave during which they received Supplemental Compensation benefits.

Employees with questions regarding this benefit can contact Human Resources.

California Unpaid Personal Leave

If employees are ineligible for any other Company leave of absence, Chestnut Health Systems, under certain circumstances, may grant a personal leave of absence without pay. A written request for a personal leave should be presented to management at least two (2) weeks before the anticipated start of the leave. If the leave is requested for medical reasons and employees are not eligible for FMLA and CFRA, medical certification also must be submitted. The request will be considered on the basis of staffing requirements and the reasons for the requested leave, as well as performance and attendance records.

Normally, a leave of absence will be granted for a period of up to eight (8) weeks. However, a personal leave may be extended if, prior to the end of leave, employees submit a written request for an extension to management and the request is granted. During the leave, employees will not earn vacation, personal days or sick days. We will continue health insurance coverage during the leave if employees submit their share

of the monthly premium payments to the Company in a timely manner, subject to the terms of the plan documents.

When the employees anticipate returning to work, they should notify management of the expected return date. This notification should be made at least one week before the end of the leave.

Upon completion of the personal leave of absence, the Company will attempt to return employees to their original job or a similar position, subject to prevailing business considerations. Reinstatement, however, is not guaranteed.

Failure to advise management of availability to return to work, failure to return to work when notified or a continued absence from work beyond the time approved by the Company will be considered a voluntary resignation of employment.

Personal leave runs concurrently with any Company-provided Short-Term Disability Leave of Absence.

California Time Off for Military Spouses

If the employee works, on average, at least twenty (20) hours per week and their spouse is a qualified member of the United States Armed Forces, the National Guard or the Reserves, the employee is eligible to take leave for a period of up to ten (10) days while their spouse is home during a qualified leave period. When the employee is also eligible for military family member exigency leave, leave under this policy shall also count toward the employee's leave entitlement under the Family and Medical Leave Act (FMLA), where the time off meets the definition of FMLA military exigency leave.

Required Notice to Employer

Within two (2) business days of receiving official notice that the employee’s spouse will be on leave the employee must provide notice to the Company of their intent to take military spouse leave.

Required Documentation

The employee must submit written documentation to the Company certifying that during the requested time off, the employee’s spouse will be on leave from deployment during a period of military conflict.

Leave is Unpaid

Leave granted under this policy is unpaid. However, employees may substitute the following for any period of unpaid military spouse leave: unused vacation time or personal days.

Definitions

For the purposes of this policy, the following definitions apply:

"Qualified Member**"** means any of the following:

- a member of the United States Armed Forces who is deployed during a period of military conflict to an area designated as a combat theater or combat zone by the President of the United States; or
- a member of the National Guard who is deployed during a period of military conflict; or
- a member of the Reserves who is deployed during a period of military conflict.

"Period of Military Conflict**"** means any of the following:

- a period of war declared by the U.S. Congress; or
- a period of deployment for which members of the Reserves are ordered to active duty.

"Qualified Leave Period**"** means the period during which the qualified member is on leave from deployment during a period of military conflict.

San Francisco Military Leave Pay Protection Benefits

In accordance with San Francisco's Military Leave Pay Protection Act, the Company provides supplemental compensation to eligible employees who are on an approved military leave of absence. Eligible employees may receive up to thirty (30) days of supplemental compensation in a calendar year under this policy.

Eligible Employees

To be eligible to receive supplemental compensation under this policy, an employee must:

- Work within the geographic boundaries of San Francisco;
- Be a member of the reserve corps of the United States Armed Forces, National Guard, or other uniformed service organization of the United States; and
- Be on approved leave for military duty.

Amount of Supplemental Compensation

An eligible employee shall receive supplemental compensation in an amount equal to the difference between the employee's gross military pay and the amount of gross pay the employee would have received from the Company had the employee worked their regular work schedule in San Francisco. Overtime hours (unless regularly scheduled) and hours scheduled to work outside of San Francisco do not count toward the employee's gross pay calculation. Supplemental compensation is paid in daily increments. Eligible employees may receive up to 30 days of supplemental compensation in a calendar year.

For employees who do not work a regular work schedule, supplemental compensation shall be determined by looking at the bi-weekly immediately preceding the employee's leave, not including any pay periods during which the employee was on unpaid or partially paid leave. The Company will endeavor to provide the employee with the supplemental compensation no later than the payday for the payroll period when the employee's military leave began.

Benefits

Eligible employees will continue to receive all benefits as if they had worked their regular schedule during any period of time during which they receive supplemental compensation.

Documentation

Employees may be requested to provide their written military orders or a wage statement verifying the military gross pay they received or will receive to ensure accurate payment of supplemental compensation.

Repayment by Employee

Employees receiving supplemental compensation under this policy who can return to their position after completion of military leave but fail to return within sixty (60) days of release from duty shall be required to repay any supplemental compensation received.

Coordination with Other Policies

Any supplemental compensation paid under this policy will be coordinated with and offset by amounts required to be paid under any other law or policy so that employees on military leave do not receive more in total pay then they would have received if they had worked their regular work schedule.

Employees with questions about this policy can contact Human Resources.

California Bone Marrow Donation Leave

The employee who has been employed for at least 90 days may request a leave of absence for up to five (5) business days in any one-year period to undergo a medical procedure to donate bone marrow. Employees must provide a certification from their physician regarding the purpose and length of each leave requested. The employee must use any accrued vacation time, sick leave or paid time off for this leave, but the use of vacation accrual, sick leave or paid time off does not extend the term of this leave. If accrued vacation, sick leave or paid time off is not available, the time off for such procedure shall be paid, but the paid time off shall not exceed five (5) days. Bone marrow donation leave will not be designated as FMLA or CFRA leave time. Employees will receive health benefits for the duration of their Bone Marrow Donation Leave and upon returning from such leave will have a right to return to the same or equivalent positions they held before such leave.

California Organ Donation Leave

Employees who have been employed for at least ninety (90) days may request a paid leave of absence for up to thirty (30) business days in any one-year period to undergo a medical procedure to donate an organ. Employees can request an additional thirty (30) days of unpaid leave in any one-year period for this same purpose. Employees must provide a certification from their physician regarding the purpose and length of each leave requested. The one-year period is measured from the start of the leave.

For an initial request for organ donation leave, the employee must use up to two weeks of accrued vacation, sick leave or paid time off for this leave, but the use of vacation accrual, sick leave or paid time off does not extend the term of the leave. If accrued vacation, sick leave or paid time off is not available, the time off for such procedure shall be paid however the paid time off shall not exceed thirty (30) days. Organ donation leave will not be designated as FMLA or CFRA leave time. Employees will receive health benefits for the duration of their organ donation leave and upon returning from such leave will have a right to return to the

same or equivalent positions they held before such leave. Absences due to organ donation leave do not count as a break in service for the purpose of the employee's right to salary adjustments, sick leave, vacation and paid time off or seniority.

California Family and Medical Leave (CFRA)

Employees may be entitled to a leave of absence under the Family and Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA). Additionally, employees who are CFRA-eligible have certain rights to take both a pregnancy disability leave (PDL) and CFRA leave for the birth of a child.

This policy provides employees with information concerning FMLA/CFRA entitlements and obligations they may have during such leaves and also explains differences between FMLA, CFRA, and PDL. Where more than one (1) of the laws applies, leave taken may be counted under more than one law at the same time to the extent permitted by the applicable law(s). For example, where leave for a pregnancy disability is also FMLA-qualifying, the leave will count against both FMLA and PDL entitlements. However, PDL is separate from and does not count against employees' CFRA leave entitlement. (Please consult the Pregnancy Disability Leave policy for more information on PDL.) This policy will be interpreted to comply with the law(s) that apply to a particular leave.

If employees have any questions concerning FMLA/CFRA leave, they should contact Human Resources.

I. Eligibility

The FMLA and CFRA provide eligible employees with a right to leave, health insurance benefits, and, with some limited exceptions, job restoration. To be an "eligible employee," the employee must: 1) have been employed by the Company for at least 12 months (which need not be consecutive) and 2) have worked for at least 1,250 hours during the 12-month period immediately preceding the commencement of the leave. All California employees who meet these two (2) criteria are eligible for CFRA leave. California employees also may be eligible to take leave for FMLA reasons if they are eligible for CFRA leave and work at a worksite where 50 or more employees are located within 75 miles.

*Special hours of service eligibility requirements apply to airline flight crew employees.

II. Entitlements for FMLA/CFRA Leave

A. Basic FMLA/CFRA Leave Entitlement

The FMLA/CFRA provides eligible employees up to 12 workweeks of unpaid leave for certain family and medical reasons during a 12-month period. The 12-month period is determined by a rolling 12-month period measured backward from the date the employee uses their FMLA leave. In some instances, leave may be counted under the FMLA but not CFRA or CFRA but not the FMLA. Leave may be taken for any one (1), or for a combination, of the following reasons:

1. Disability due to pregnancy, childbirth, or related medical condition (counts only toward FMLA leave and PDL leave entitlements);

2. Bonding and/or caring for a newborn child (counts toward FMLA and CFRA leave entitlements);

3. For placement with the employee of a child for adoption or foster care and to care for the newly placed child (counts toward FMLA and CFRA leave entitlements);

4. To care for the employee's spouse, child, or parent with a **serious health condition** (counts toward FMLA and CFRA leave entitlements);

5. To care for the employee's registered domestic partner, parent-in-law, grandparent, grandchild, sibling, or designated person with a serious health condition (counts towards CFRA entitlements only, except when grandparent, grandchild, or sibling meets FMLA definition of parent or child);

6. For the employee's own **serious health condition** (excluding pregnancy) that makes the employee unable to perform (1) one or more of the essential functions of their job (counts toward FMLA and CFRA leave entitlements); and/or

7. Because of any **qualifying exigency** arising out of the fact that the employee's spouse, registered domestic partner, son, daughter, or parent is a military member on covered active duty status (or has been notified of an impending call or order to covered active duty status) in the Reserve component of the Armed Forces for deployment to a foreign country in support of a contingency operation or Regular Armed Forces for deployment to a foreign country (counts toward FMLA/CFRA leave entitlements, except that leave taken for a registered domestic partner counts towards CFRA leave entitlement only).

Leave to care for child after birth or placement for adoption or foster care must be taken within one (1) year of the child's birth or placement.

Under the **FMLA**, a **serious health condition** is an illness, injury, impairment, or physical or mental condition that involves a period of incapacity or treatment connected with inpatient care (e.g., an overnight stay) in a medical care facility, hospice, or residential health care facility; or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of their job or prevents the qualified family member from participating in school or other daily activities.

Under the **CFRA**, a **serious health condition** is an illness, injury, impairment, or physical or mental condition that involves either inpatient care in a hospital, hospice, or residential health care facility, any subsequent treatment in connection with such inpatient care or any period of incapacity, or continuing treatment by a health care provider. The CFRA defines "inpatient care" broadly and includes a stay in a hospital, hospice, or residential health care facility, any subsequent treatment in connection with inpatient care, or any period of incapacity. A person will be considered an "inpatient" when they are formally admitted to a health care facility with the expectation that they will remain at least overnight and occupy a bed, even if the person is ultimately discharged or transferred to another facility and does not actually remain overnight. The CFRA defines "incapacity" as the inability to work, attend school, or perform other regular daily activities due to a serious health condition, its treatment or the recovery that it requires.

Under the CFRA, a "designated person" means any individual related by blood or whose relationship with the employee is the equivalent of a family relationship. The designated person may be identified by the

employee at the time the employee requests the leave. Chestnut Health Systems may limit an employee to one designated person every 12-month period for family care and medical leave.

Under the FMLA and CFRA, subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) consecutive calendar days combined with at least two (2) visits to a health care provider or one (1) visit and a regimen of continuing treatment or incapacity due to pregnancy (FMLA only) or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, caring for the parents of the military member on covered active duty, and attending post-deployment reintegration briefings.

A leave of absence in connection with a workers' compensation injury/illness or for which the employee receives disability or State of California Paid Family Leave benefits shall run concurrently with FMLA/CFRA leave.

B. Additional Military Family Leave Entitlement (FMLA Only)

In addition to the basic FMLA/CFRA leave entitlement described above, an eligible employee who is the spouse, son, daughter, parent, or next of kin of a **covered servicemember** is entitled to take up to 26 weeks of leave during a 12-month period to care for the servicemember with a serious injury or illness. Leave to care for a servicemember is available during a single 12-month period and, when combined with other FMLA-qualifying leave, may not exceed 26 weeks during the single 12-month period. The single 12-month period begins on the first day an eligible employee takes leave to care for the injured servicemember.

A **"covered servicemember"** is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is on the temporary retired list for a serious injury or illness. These individuals are referred to in this policy as "current members of the Armed Forces." Covered servicemembers also include a veteran who is discharged or released from military service under conditions other than dishonorable at any time during the five-(5-) year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. These individuals are referred to in this policy as "covered veterans."

The FMLA definition of a serious illness or injury for current Armed Forces members and covered Veterans are distinct from the definition of "serious health condition" applicable to leave to care for a family member or the employee's own illness or injury.

C. Intermittent Leave and Reduced Leave Schedules

FMLA/CFRA leave usually will be taken for a period of consecutive days, weeks, or months. However, employees also are entitled to take FMLA/CFRA leave intermittently or on a reduced leave schedule when medically necessary due to a serious health condition of the employee or covered family member or the serious injury or illness of a covered servicemember (FMLA only). Intermittent or reduced work schedule

leave may be taken for absences where the employee or family member is incapacitated or unable to perform the essential functions of the position because of a chronic serious health condition, even if they do not receive treatment by a health care provider. Intermittent leave can also be taken for any qualifying exigency.

Employees also are eligible for intermittent leave for bonding with a child following birth or placement. Intermittent leave for bonding purposes generally must be taken in two-(2-)week increments, but the Company permits two (2) occasions where the leave may be for less than two (2) weeks.

D. Health Insurance Benefits Schedules

During FMLA/CFRA leave, eligible employees are entitled to receive group health plan coverage on the same terms and conditions as if they had continued work.

E. No Work While on Leave

The taking of another job while on FMLA/CFRA leave or any other approved leave of absence is prohibited except as authorized by the Company or permitted by applicable law.

F. Restoration of Employment and Benefits

At the end of FMLA/CFRA leave, employees generally have a right to return to the same or equivalent positions they held before the FMLA/CFRA leave. There is an exception for certain "key employees" under the FMLA that applies to leave for a seriously ill or injured covered servicemember (the CFRA does not have an exception for "key employees"). The Company will provide notice if employees qualify as "key employees" if it intends to deny reinstatement and any applicable rights in such instances.

Use of FMLA/CFRA leave will not result in the loss of any employment benefit that accrued prior to the start of an eligible employee's FMLA/CFRA leave.

G. Notice of Eligibility for, and Designation of, FMLA/CFRA Leave

Employees requesting FMLA/CFRA leave are entitled to receive written notice from the Company telling them whether they are eligible for FMLA/CFRA leave and, if not eligible, the reasons why they are not eligible. When eligible for FMLA/CFRA leave, employees are entitled to receive written notice of: 1) their rights and responsibilities in connection with such leave; 2) the Company's designation of leave as FMLA/CFRA-qualifying or non-qualifying, if not FMLA/CFRA-qualifying, the reasons why; and 3) the amount of leave, if known, that will be counted against the employee's leave entitlement.

The Company will respond to a leave request within five (5) business days. Once given, approval shall be deemed retroactive to the date of the first day of the leave. The Company may designate FMLA/CFRA leave retroactively with appropriate notice provided that doing so does not cause harm or injury to employees. In other cases, the Company and employees can mutually agree that leave is retroactively designated as FMLA/CFRA leave.

H. Employee Obligations for FMLA/CFRA Leaves

a. Provide Notice of the Need for Leave

Employees who take FMLA/CFRA leave must notify, in a timely manner, the Company of their need for FMLA/CFRA leave. The following describes the content and timing of such notices.

i. Content of Notice

To trigger FMLA/CFRA leave protections, employees must inform Human Resources of the need for FMLA/CFRA-qualifying leave and the anticipated timing and duration of the leave, if known. Employees may do this by either requesting FMLA/CFRA leave specifically or explaining the reasons for leave so as to allow the Company to determine that the leave is FMLA/CFRA-qualifying. For example, employees might explain that:

1. A medical condition renders them unable to perform the functions of their job;

2. They are pregnant;

3. They or a covered family member have been hospitalized overnight;

4. They or a covered family member are under the continuing care of a health care provider;

5. The leave is due to a qualifying exigency caused by a military member being on covered active duty or called to covered active-duty status; or

6. If the leave is for a family member, that the condition renders the family member unable to perform daily activities or that the family member is a covered servicemember with a serious injury or illness.

Calling in "sick," without providing the reasons for the needed leave, will not be considered sufficient notice for FMLA/CFRA leave under this policy. Employees must respond to the Company's lawful questions to determine if absences are potentially FMLA/CFRA-qualifying.

If employees fail to explain the reasons for FMLA/CFRA leave, the leave may be denied. When employees seek leave due to FMLA/CFRA-qualifying reasons for which the Company has previously provided FMLA/CFRA-protected leave, they must specifically reference the qualifying reason for the leave or the need for FMLA/CFRA leave.

ii. Timing of Notice

Employees must provide 30 days' advance notice of the need to take FMLA/CFRA leave when the need is foreseeable. When 30 days' notice is not possible, or the approximate timing of the need for leave is not foreseeable, employees must notify the Company of the need for leave as soon as practicable under the circumstances. Employees who fail to give 30 days' notice for foreseeable leave without a reasonable excuse for the delay, or otherwise fail to satisfy FMLA/CFRA notice obligations, may have FMLA/CFRA leave delayed or denied.

b. Cooperating in the Scheduling of Leave

When planning medical treatment for themselves or family members or requesting to take leave on an intermittent or reduced schedule work basis, employees must consult with the Company and make a reasonable effort to schedule treatment so as not to unduly disrupt Company operations. Employees must consult with the Company prior to scheduling treatment to work out a treatment schedule that best suits the needs of both the Company and the employees, subject to the approval of the applicable health care provider. To the extent permitted by applicable law, when employees take intermittent or reduced work schedule leave for foreseeable planned medical treatment for employees or family members, including a period of recovery from a serious health condition or to care for a covered servicemember, the Company may temporarily transfer employees to alternative positions with equivalent pay and benefits for which the employees are qualified and which better accommodate recurring periods of leave.

c. Submit Initial Medical Certifications Supporting Need for Leave (Unrelated to Requests for Military Family Leave)

Depending on the nature of FMLA/CFRA leave sought, employees may be required to submit medical certifications supporting their need for FMLA/CFRA-qualifying leave. As described below, there generally are three types of FMLA/CFRA medical certifications: an **initial certification**, a **recertification**, and a **return to work/fitness for duty certification**.

It is the responsibility of employees to provide the Company with timely, complete, and sufficient medical certifications. Whenever the Company requests employees to provide FMLA/CFRA medical certifications, they must provide the requested certifications within 15 calendar days after the request, unless it is not practicable to do so despite diligent, good faith efforts. The Company will inform employees if submitted medical certifications are incomplete or insufficient and provide them at least seven (7) calendar days to address deficiencies. The Company will delay or deny FMLA/CFRA leave to employees who fail to address deficiencies or otherwise fail to submit requested medical certifications in a timely manner.

The Company (through individuals other than the employee's direct supervisor) may contact the employee's health care provider to authenticate a medical certification.

Whenever the Company deems it appropriate to do so, it may waive its right to receive timely, complete, and/or sufficient FMLA/CFRA medical certifications.

i. Initial Medical Certifications

Employees requesting leave because of their own or a covered family member's serious health condition, or to care for a covered servicemember, must supply medical certification supporting the need for such leave from their health care provider or, if applicable, the health care provider of their covered family or service member. If employees provide at least 30 days' notice of medical leave, they should submit the medical certification before leave begins.

If the Company has reason to doubt the validity of an initial medical certification regarding the employee's own serious health condition, it may require the employee to obtain a second opinion at the Company's expense. If the opinions of the initial and second health care providers differ, the Company may, at its expense, require the employee to obtain a third, final and binding certification from a health care provider

designated or approved jointly by the Company and the employee. The Company will reimburse employees for any reasonable "out of pocket" travel expenses incurred to obtain second or third medical opinions.

ii. Medical Recertifications

Depending on the circumstances and duration of FMLA/CFRA leave, the Company may require employees to provide recertification of medical conditions giving rise to the need for leave. The Company will notify employees if recertification is required and will give employees at least 15 calendar days to provide medical recertification. In cases of leave that qualifies under CFRA, recertification will be requested only when the original certification has expired and additional leave is requested.

iii. Return-to-Work Release

Unless notified that providing such certifications is not necessary, employees returning to work from FMLA/CFRA leaves that were taken because of their own serious health conditions must provide the Company with a release to return to work from their healthcare provider stating they are able to resume work. Employees taking intermittent leave may be required to provide a return-to-work release for such absences up to once every 30 days if reasonable safety concerns exist regarding their ability to perform their duties. The Company may delay and/or deny job restoration until employees provide return-to-work releases.

d. Submit Certifications Supporting Need for Military Family Leave

Upon request, the first time employees seek leave due to qualifying exigencies arising out of the covered active duty or call to covered active duty status of a military member, the Company may require them to provide: 1) a copy of the military member's active duty orders or other documentation issued by the military indicating the military member is on covered active duty or call to active duty status and the dates of the military member's covered active duty service and, 2) a certification from the employee setting forth information concerning the nature of the qualifying exigency for which leave is requested. Employees shall provide a copy of new active-duty orders or other documentation issued by the military for leaves arising out of qualifying exigencies arising out of a different covered active duty or call to covered active-duty status of the same or a different military member.

When leave is taken to care for a covered servicemember with a serious injury or illness as allowed by the FMLA only, the Company may require employees to obtain certifications completed by an authorized health care provider of the covered servicemember. In addition, and in accordance with the FMLA regulations, the Company may request that the certification submitted set forth additional information provided by the employee and/or the covered servicemember confirming entitlement to such leave.

e. Reporting Changes to Anticipated Return Date

If the anticipated return to work date changes and it becomes necessary for the employee to take more or less leave than originally anticipated, the employee must provide the Company with reasonable notice (i.e., within two (2) business days) of their changed circumstances and new return-to-work date. If employees give the Company unequivocal notice of their intent not to return to work, they will be considered to have

voluntarily resigned and the Company's obligation to maintain health benefits (subject to COBRA requirements) and to restore their positions will cease.

f. Substitute Paid Leave for Unpaid FMLA Leave

Employees are required to substitute accrued paid time while taking an unpaid FMLA/CFRA leave as follows:

- If employees request FMLA/PDL leave because of disability due to pregnancy, childbirth, or related medical conditions (excluding absences for which they are receiving short-term disability benefits), they must first substitute any accrued paid sick leave for unpaid family/medical leave. Employees may make a written request to substitute accrued, unused vacation, or other paid time off benefits for unpaid FMLA/PDL leave once their sick time is exhausted.
- If employees request FMLA/CFRA leave because of their own serious health condition (excluding absences for which they are receiving workers' compensation or short-term disability benefits), they must first substitute any accrued paid vacation, sick, or other paid time off for unpaid family/medical leave.
- If employees request FMLA/CFRA leave to care for a covered family member with a serious health condition (excluding absences for which they are receiving Paid Family Leave benefits), they must first substitute any accrued paid vacation or other paid time off for unpaid family/medical leave. Once vacation or other paid time off is exhausted, upon their request, they can substitute paid sick leave for unpaid FMLA/CFRA leave to care for a covered family member with a serious health condition.
- If employees request FMLA/CFRA leave to bond with a newborn or newly placed child (excluding absences for which they are receiving Paid Family Leave benefits), they must first substitute any accrued paid vacation or other paid time off for unpaid leave.

For purposes of this substitution requirement, leave is not "unpaid" during any time for which the employee is receiving compensation from the State of California under its State Disability Insurance or Paid Family Leave programs or when receiving compensation from worker's compensation. Employees will not be required to use accrued paid leave hours during any time off under this policy for which they are receiving compensation under these programs. However, where applicable and permitted by law, they will be required to use paid leave accruals during any waiting periods applicable to these programs, and upon written request, the Company will allow them to use accrued paid time off to supplement any paid workers' compensation, disability, or Paid Family Leave benefits.

The substitution of paid time off for unpaid family/medical leave time does not extend the length of FMLA/CFRA leaves and the paid time off runs concurrently with the FMLA/CFRA entitlement.

g. Pay Employee's Share of Health Insurance Premiums

As noted above, during FMLA/CFRA leave, employees are entitled to continued group health plan coverage under the same conditions as if they had continued to work. If paid leave is substituted for unpaid family/medical leave, the Company will deduct employees' shares of the health plan premium as a regular payroll deduction. If FMLA/CFRA leave is unpaid, employees must pay their portion of the premium through a method determined by the Company upon leave. The Company's obligation to maintain health care coverage ceases if the premium payment is more than 30 days late. If the payment is more than 15 days late, the Company will send a letter notifying the employee that coverage will be dropped on a specified date unless the co-payment is received before that date.

If employees do not return to work for at least 30 calendar days after the end of the leave period (unless they cannot return to work because of a serious health condition or other circumstances beyond their control), they will be required to reimburse the Company for the cost of the premiums the Company paid for maintaining coverage during their unpaid FMLA/CFRA leave.

I. Coordination of FMLA Leave with Other Leave Policies

The FMLA and CFRA do not affect any federal, state, or local law prohibiting discrimination, or supersede any State or local law which provides greater family or medical leave rights. For additional information concerning leave entitlements and obligations that might arise when FMLA/CFRA leave is either not available or exhausted, please consult the Company's other leave policies in this handbook or contact Human Resources.

QUESTIONS AND/OR COMPLAINTS ABOUT FMLA/CFRA LEAVE

If employees have questions regarding this policy, they should contact Human Resources. The Company is committed to complying with the FMLA and CFRA and, whenever necessary, shall interpret and apply this policy in a manner consistent with the FMLA and CFRA.

The FMLA makes it unlawful for employers to: 1) interfere with, restrain, or deny the exercise of any right provided under FMLA; or 2) discharge or discriminate against any person for opposing any practice made unlawful by FMLA or involvement in any proceeding under or relating to FMLA. If employees believe their FMLA rights have been violated, they should contact Human Resources immediately. The Company will investigate any FMLA complaints and take prompt and appropriate remedial action to address and/or remedy any FMLA violation. Employees also may file FMLA complaints with the United States Department of Labor or may bring private lawsuits alleging FMLA violations.

California Leave for Victims of Crime or Abuse (Including Domestic Violence, Sexual Assault or Stalking)

Employees who are victims of a crime or abuse, including domestic violence, sexual assault or stalking, may take unpaid leave for up to twelve (12) weeks for the following reasons:

- to seek medical attention for injuries caused by crime or abuse;
- to obtain services from a domestic violence shelter, program, rape crisis center or victim services organization or agency as a result of the crime or abuse;
- to obtain psychological counseling or mental health services related to an experience of crime or abuse; or
- to participate in safety planning and take other actions to increase safety from future crime or abuse, including temporary or permanent relocation.

Employees are covered as victims and entitled to leave under this policy if they are:

- a victim of stalking, domestic violence or sexual assault;
- a victim of a crime that caused physical injury or that caused mental injury and a threat of physical injury; or
- a person whose immediate family member is deceased as the direct result of a crime.

Chestnut Health Systems may require proof of the employee's participation in these activities. Whenever possible, employees must provide their supervisor reasonable notice before taking any time off under this policy.

Employees may substitute any accrued vacation, sick or other time off for the leave under this policy. Leave under this policy does not extend the time allowable under the "Family and Medical Leave" policy in this handbook.

No employees will be subject to discrimination or retaliation because of their status as a victim of a crime or abuse, including crime or abuse related to domestic violence, sexual assault or stalking. Victims of a crime or abuse, including crime or abuse related to domestic violence, sexual assault or stalking, may request other accommodations in the workplace such as implementation of safety measures.

California Bereavement Leave

Employees who have been employed for at least thirty (30) days may take bereavement leave of up to five (5) days upon the death of a family member. For the purposes of this policy a family member includes a spouse or a child, parent, sibling, grandparent, grandchild, domestic partner, or parent-in-law.

Bereavement leave need not be consecutive but must be completed within three (3) months of the family member's death.

Bereavement leave will be paid at the employee's base rate of pay at the time of absence for the number of hours the employee otherwise would have worked that day. Bereavement leave is not counted as hours worked for purposes of calculating overtime.

Employees, if requested by the Company, within 30 days of the first day's leave must provide documentation of the death of the family member. Documentation includes, but is not limited to, a death certificate, a published obituary, or written verification of death, burial, or memorial services from a mortuary, funeral home, burial society, crematorium, religious institution, or governmental agency.

The Company will maintain the confidentiality of any employee requesting leave under this policy including documentation provided to the Company related to a request for leave. Employees wishing to utilize bereavement leave should contact Human Resources. Employees will not be subject to adverse action for exercising rights or attempting to exercise rights under this policy, opposing practices that they believe to be in violation of this policy, or supporting the exercise of rights of another under this policy.

California Reproductive Loss Leave

Employees who have been employed for at least thirty (30) days will be provided with up to five (5) days of reproductive loss leave following a reproductive loss event. Employees who experience more than one (1) reproductive loss event within a twelve- (12-) month period are limited to twenty (20) days of reproductive loss leave in a twelve- (12) -month period. For purposes of this policy, a reproductive loss event means the day or, for a multiple-day event, the final day of a failed adoption, failed surrogacy, miscarriage, stillbirth, or an unsuccessful assisted reproduction via artificial insemination or an embryo transfer.

Leave may only be taken on regularly scheduled workdays. Leave does not need to be taken on consecutive days. Leave must be completed within three (3) months of the reproductive loss event, except that if the employee is on some other leave from work prior to or immediately following a reproductive loss event, the reproductive loss leave is available for use during the three (3) months following the end date of the other leave.

Reproductive loss leave is unpaid, except to the extent the employee is eligible for paid leave for these purposes under other the Company policies. The employee may elect to use accrued (vacation, personal days, or sick leave) to receive pay during any unpaid leave taken under this policy. Leave provided pursuant to this policy will run concurrently with any other applicable leave of absence for covered reasons, to the maximum extent permitted by applicable law. The substitution of paid time for unpaid leave time does not extend the length of leave and the paid time will run concurrently with the employee's reproductive loss leave entitlement.

Employees must inform their supervisor prior to commencing reproductive loss leave. The Company will maintain the confidentiality of any employee requesting leave under this policy including information provided to the Company related to a request for leave.

California Time Off for Crime Victims

Employees who have been victims of serious or violent felonies, as specified under California law, or felonies relating to theft or embezzlement, may take time off work to attend judicial proceedings related to the crime. Employees also may take time off if an immediate family member has been a victim of such crimes and the employee needs to attend judicial proceedings related to the crime. "Immediate family member" is defined as spouse, registered domestic partner, child, child of registered domestic partner, stepchild, brother, stepbrother, sister, stepsister, mother, stepmother, father or stepfather.

Employees must give their supervisor a copy of the court notice given to the victim of each scheduled proceeding before taking time off, unless advance notice to Chestnut Health Systems of the need for time off is not feasible. When advance notice is not feasible, the employee must provide the Company with documentation evidencing the judicial proceeding, within a reasonable time after the absence. The documentation may be from the court or government agency setting the hearing, the district attorney or prosecuting attorney's office or the victim/witness office that is advocating on behalf of the victim.

Employees may elect to use accrued paid vacation time, paid sick leave time or other paid time off for the absence. If the employee does not elect to use paid time off, the absence will be unpaid. However, exempt employees will be paid their full salary for any workweek interrupted by the need for time off under this policy.

California Pregnancy Disability Leave

If employees are disabled by pregnancy, childbirth or related medical conditions, they are eligible to take a pregnancy disability leave (PDL). If affected by pregnancy or a related medical condition, employees also are eligible to transfer to a less strenuous or hazardous position or to less strenuous or hazardous duties, if such a transfer is medically advisable and can be reasonably accommodated. Employees disabled by qualifying conditions may also be entitled to other reasonable accommodations where doing so is medically

necessary. In addition, if it is medically advisable for employees to take intermittent leave or work a reduced schedule, the Company may require them to transfer temporarily to an alternative position with equivalent pay and benefits that can better accommodate recurring periods of leave.

The PDL is for any period(s) of actual disability caused by pregnancy, childbirth or related medical condition up to four (4) months per pregnancy. For purposes of this policy, "four months" means time off for the number of days the employee would normally work within the four (4) calendar months (one-third of a year or 17 1/3 weeks), following the commencement date of taking a pregnancy disability leave. For a full-time employee who works 40 hours per week, "four months" means 693 hours of leave entitlement, based on forty (40) hours per week times 17 1/3 weeks. Employees working a part-time schedule will have their PDL calculated on a pro-rata basis.

The PDL does not need to be taken in one continuous period of time, but can be taken on an intermittent basis pursuant to the law.

Time off needed for prenatal or postnatal care, severe morning sickness, gestational diabetes, pregnancy-induced hypertension, preeclampsia, doctor-ordered bed rest, postpartum depression, loss or end of pregnancy, and recovery from childbirth or loss or end of pregnancy are all covered by PDL.

To receive reasonable accommodation, obtain a transfer or take a PDL, employees must provide sufficient notice so the Company can make appropriate plans. Thirty days' advance notice is required if the need for the reasonable accommodation, transfer or PDL is foreseeable, otherwise as soon as practicable if the need is an emergency or unforeseeable.

Employees are required to obtain a certification from their health care provider of the need for pregnancy disability leave or the medical advisability of an accommodation or for a transfer. The certification is sufficient if it contains: (1) a description of the requested reasonable accommodation or transfer; (2) a statement describing the medical advisability of the reasonable accommodation or transfer because of pregnancy; and (3) the date on which the need for reasonable accommodation or transfer became or will become medically advisable and the estimated duration of the reasonable accommodation or transfer.

A medical certification indicating disability necessitating a leave is sufficient if it contains: (1) a statement that the employee needs to take pregnancy disability leave because of disability due to pregnancy, childbirth or a related medical condition; (2) the date on which the employee became disabled because of pregnancy; and (3) the estimated duration of the leave.

Upon request, the employee will be provided with a medical certification form that the employee can take to the doctor.

As a condition of returning from pregnancy disability leave or transfer, the Company requires the employee to obtain a release from a health care provider stating ability to resume the original job duties with or without reasonable accommodation.

PDL is unpaid. At the employee's option, the employee can use any accrued vacation time or other accrued paid time off as part of the PDL before taking the remainder of leave on an unpaid basis. Chestnut Health Systems requires, however, that the employee use any available sick time during the PDL. The substitution

of any paid leave will not extend the duration of the PDL. Employees who participate in the Company's group health insurance plan will continue to participate in the plan while on PDL under the same terms and conditions as if they were working. Benefit continuation under PDL is distinct from benefit continuation for employees who also take birth bonding leave under the California Family Rights Act. Employees should make arrangements for payment of their share of the insurance premiums.

Chestnut Health Systems encourages employees to contact the California Employment Development Department regarding eligibility for state disability insurance for the unpaid portion of the leave.

If employees do not return to work on the originally scheduled return date, nor request in advance an extension of the agreed upon leave with appropriate medical documentation, they may be deemed to have voluntarily terminated their employment with the Company. Failure to notify the Company of their ability to return to work when it occurs or continued absence from work because the leave must extend beyond the maximum time allowed, may be deemed a voluntary termination of employment with the Company, unless employees are entitled to Family and Medical Leave or entitled to further leave pursuant to applicable law.

Upon return from a covered PDL, the employee, in most instances, will be reinstated to the same position.

Taking a PDL may affect some benefits and the employee's seniority date. The employee may request more information regarding eligibility for PDL and the impact of the leave on seniority and benefits.

Any request for leave after the disability has ended will be treated as a request for family care leave under the California Family Rights Act (CFRA) and the federal Family and Medical Leave Act (FMLA), if the employee is eligible for that type of leave. PDL runs concurrently with FMLA (but not CFRA). Employees should refer to the FMLA policy. Employees who are not eligible for leave under the CFRA or FMLA will have a request for additional leave treated as a request for disability accommodation.

California Time Off for Volunteer Emergency Personnel

Employees who are volunteer firefighters, reserve peace officers, or emergency rescue personnel are permitted unpaid time off, not to exceed 14 days per calendar year, for the purpose of engaging in fire, law enforcement, or emergency rescue training.

Employees are also permitted unpaid time off from work to perform emergency duty as a volunteer firefighter, reserve peace officer, or emergency rescue personnel.

If the employees request time off under the policy, they must notify their direct supervisor immediately after the need for the leave becomes known.

CHESTNUT
HEALTH SYSTEMS

CALIFORNIA SUPPLEMENT ACKNOWLEDGMENT

This California Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

> **I have received and read a copy of Chestnut Health Systems California Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.**
>
> **I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.**
>
> **I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.**
>
> **I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.**

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT HEALTH SYSTEMS

RECEIPT OF CALIFORNIA ANTI-DISCRIMINATION AND HARASSMENT POLICY

Chestnut Health Systems does not tolerate and prohibits discrimination, harassment, or retaliation of or against job applicants, contractors, interns, volunteers, or employees by another employee, supervisor, vendor, customer, or third party based on actual or perceived race, color, creed, religion, age, sex, or gender (including pregnancy, childbirth, and related medical conditions), sexual orientation, gender identity, or gender expression (including transgender status), national origin, ancestry, marital status, protected medical condition as defined by state law (including cancer or genetic characteristics), physical or mental disability, military and veteran status, reproductive health decision making, genetic information, or any other characteristic protected by applicable federal, state, or local laws and ordinances. The Company is committed to a workplace free of discrimination, harassment, and retaliation.

Our management team is dedicated to ensuring the fulfillment of this policy as it applies to all terms and conditions of employment, including recruitment, hiring, placement, promotion, transfer, training, compensation, benefits, employee activities, and general treatment during employment.

Discrimination Defined

Discrimination under this policy means treating differently or denying or granting a benefit to an individual because of the individual's protected characteristic.

Harassment Defined

Harassment is defined in this policy as unwelcome verbal, visual, or physical conduct creating an intimidating, an offensive or a hostile work environment that interferes with work performance. Harassment can be verbal (including slurs, jokes, insults, epithets, gestures, or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media, or e-mails), or physical conduct (including physically threatening another, blocking someone's way, etc.) that denigrates or shows hostility or aversion toward an individual because of any protected characteristic. Such conduct violates this policy, even if it is not unlawful. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities, and other verbal or physical conduct of a sexual nature. Sexual harassment includes unwelcome or unwanted conduct that is either of a sexual nature or directed at an individual because of that individual's sex when:

- Submission to that conduct or to those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment;
- Submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- The conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Examples of conduct that violate this policy include:

1. Unwelcome or unwanted sexual advances, flirtations, advances, leering, whistling, touching, pinching, assault, and blocking normal movement;
2. Requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
3. Obscene or vulgar gestures, posters, or comments;
4. Sexual jokes or comments about a person's body, sexual prowess, or sexual deficiencies;
5. Propositions or suggestive or insulting comments of a sexual nature;
6. Derogatory cartoons, posters, and drawings;
7. Sexually explicit e-mails, text messages, or voicemails;
8. Uninvited touching of a sexual nature;
9. Unwelcome or unwanted sexually related comments;
10. Conversation about one's own or someone else's sex life;
11. Conduct or comments consistently targeted at only one (1) gender, even if the content is not sexual; and
12. Teasing or other conduct directed toward a person because of the person's gender.

Retaliation Defined

Retaliation means adverse conduct taken because an individual reported an actual or a perceived violation of this policy, opposed practices prohibited by this policy, or participated in the reporting and investigation process described below. "Adverse conduct" includes but is not limited to:

- Shunning and avoiding an individual who reports harassment, discrimination, or retaliation;
- Express or implied threats or intimidation intended to prevent an individual from reporting harassment, discrimination, or retaliation; and
- Denying employment benefits because an applicant or employee reported harassment, discrimination, or retaliation or participated in the reporting and investigation process described below.

All discrimination, harassment, and retaliation is unacceptable in the workplace and in any work-related settings such as business trips and business-related social functions, regardless of whether the conduct is engaged in by a supervisor, a coworker, a client, a customer, a vendor, or another third party.

Reporting Procedures

The following steps have been put into place to ensure the work environment is respectful, professional, and free of discrimination, harassment, and retaliation. If the employee believes someone has violated this policy or the Equal Employment Opportunity Policy, the employee should promptly bring the matter to the immediate attention of the Employee's Supervisor. (Phone numbers are available through the Company directory.) If this individual is the person toward whom the complaint is directed, the employee should contact any higher-level manager in the reporting chain. If the employee makes a complaint under this policy and has not received a satisfactory response within five (5) business days, Human Resources should be contacted immediately. (Phone numbers are available through the Company directory.)

Every supervisor who learns of any employee's concern about conduct in violation of this policy or the Equal Employment Opportunity Policy, whether in a formal complaint or informally, or who otherwise is aware of

conduct in violation of this policy or our Equal Employment Opportunity Policy must immediately report the issues raised to Human Resources.

Investigation Procedures

Upon receiving a complaint, the Company will promptly conduct a fair and thorough investigation into the facts and circumstances of any claim of a violation of this policy or the Equal Employment Opportunity policy. To the extent possible, the Company will endeavor to keep the reporting employee's concerns confidential. However, complete confidentiality may not be possible in all circumstances.

During the investigation, the Company generally will interview the complainant and the accused, conduct further interviews as necessary, and review any relevant documents or other information. Upon completion of the investigation, the Company shall determine whether this policy has been violated based on its reasonable evaluation of the information gathered during the investigation. The Company will inform the complainant and the accused of the results of the investigation.

The Company will take corrective measures against any person who it finds to have engaged in conduct in violation of this policy, if the Company determines such measures are necessary. These measures may include, but are not limited to, counseling, suspension, or immediate termination. Anyone, regardless of position or title, who the Company determines has engaged in conduct that violates this policy will be subject to discipline up to and including termination.

Training

All Employees are required to undergo harassment prevention training as required by applicable law. For more information about this training requirement, visit https://calcivilrights.ca.gov/shpt/.

Retaliation Prohibited

In addition to being a violation of this policy, harassment, discrimination, or retaliation also can be against the law. Employees who engage in conduct that rises to the level of a violation of law can be held personally liable for such conduct.

Remember, the Company cannot remedy claimed discrimination, harassment, or retaliation unless employees bring these claims to the attention of management. Employees should not hesitate to report any conduct they believe violates this policy.

I acknowledge that I have received, read, and understand Chestnut Health Systems Discrimination, Harassment, and Retaliation Prevention Policy. I agree to abide by and be bound by the rules, provisions and standards set forth in Chestnut Health Systems policy. I further acknowledge that Chestnut Health Systems reserves the right to revise, delete, and add to the provisions of the Discrimination, Harassment and Retaliation Prevention Policy at any time. I also acknowledge I have received the California Civil Rights Department's brochure, Sexual Harassment Fact Sheet (CRD-185 brochure).

CHESTNUT HEALTH SYSTEMS

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

ADDENDUM – Colorado Supplement – 2024



Chestnut Health Systems

Personnel Policies

Colorado Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Colorado Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Colorado employees will receive the Company's Personnel Policies and the Colorado Supplement to the Personnel Policies ("Colorado Supplement) (together the "Employee Handbook").

The Colorado Supplement applies only to Colorado employees. It is intended as a resource containing specific provisions derived under Colorado law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Colorado Supplement are different from or more generous than those in the National Handbook, the policies in the Colorado Supplement will apply.

The Colorado Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

Colorado Pregnancy Accommodations

In compliance with Colorado law, Chestnut Health Systems will not discriminate against employees because of pregnancy, childbirth, or related conditions. If employees request reasonable accommodation due to health conditions related to pregnancy or the physical recovery from childbirth, the Company will endeavor to provide a reasonable accommodation to enable applicants and employees to perform the essential functions of the job, unless the accommodation would impose an undue hardship on the operation of the business. The Company will engage in a timely, good faith, and interactive process with the employee to determine effective, reasonable accommodations for conditions related to pregnancy, physical recovery from childbirth, or a related condition.

Reasonable accommodations may include, but are not limited to more frequent or longer break periods; more frequent restroom, food, and water breaks; acquisition or modification of equipment or seating; limitations on lifting; temporary transfer to a less strenuous or hazardous position if available, with return to the current position after pregnancy; job restructuring; light duty, if available; assistance with manual labor; or modified work schedules.

The Company will not require employees affected by pregnancy, physical recovery from childbirth, or a related condition to accept an accommodation that they choose not to accept if they did not request an accommodation or if the accommodation is not necessary for the employees to perform the essential functions of the job, nor will the Company require a pregnant employee to take leave if another reasonable accommodation is available which will permit the employee to continue working.

The Company reserves the right to require employees to provide a note stating the necessity of a reasonable accommodation from a licensed health care provider before providing a reasonable accommodation.

The Company will not take adverse action against pregnant employees who request or use a reasonable accommodation related to pregnancy, physical recovery from childbirth, or a related condition. The Company will not deny employment opportunities to employees based on the need to make a reasonable accommodation related to pregnancy, physical recovery from childbirth, or a related condition.

If employees have any questions about this policy or would like to request a reasonable accommodation, they should contact Human Resources.

PAY PRACTICES

Overtime

Non-exempt Colorado employees are entitled to overtime pay at one and one-half (1.5) times their regular rate of pay for all hours worked in excess of twelve (12) hours in a day, twelve (12) hours consecutively (without regard to the starting and ending time of the workday), or forty (40) hours per workweek, whichever calculation results in the greater payment of wages. Time paid but not worked, such as sick time or paid time off (PTO), will not be counted as hours worked in calculating hours worked for purposes of determining if overtime pay is due.

Please review the Colorado Overtime and Minimum Pay Standards (COMPS) Order for information regarding your rights under Colorado law, available below.

Please contact the Human Resources if you have any questions about overtime requirements or the COMPS Order.

For your convenience, below is the full text of the current COMPS Order #39 poster, as provided by the Colorado Department of Labor and Employment, effective 1/1/24. A copy of the poster is included at the end.

Colorado Overtime & Minimum Pay Standards order ("COMPS Order") #39, Poster & Notice *Effective 1/1/24: must update annually; new poster available each mid-December. This poster is from the Colorado Department of Labor and Employment, online at https://cdle.colorado.gov/posters-0*

Colorado Minimum Wage: $14.42/hour, or $11.40 for Tipped Employees, in 2024 *(Rule 3)*

- The minimum wage is adjusted each year for inflation, so the above amounts are for only 2024
- All employees must be paid at least the minimum wage (unless exempt in Rule 2), whether paid hourly or another way (salary, commission, piecework, etc.), except unemancipated minors can be paid fifteen percent (15%) under full minimum wage
- Use the highest standard if other labor laws also apply, such as Denver's minimum wage ($18.29 in 2024)

Overtime: 1½ times regular pay rates for hours over 40 weekly, 12 daily, or 12 consecutive *(Rule 4)*

- Overtime is required each week over forty (40) hours, or day over twelve (12), even if two (2) or more weeks or days average fewer hours
- Employers cannot provide time off ("comp time") instead of time-and-a-half premium pay for overtime hours
- Key variances/exemptions (all are detailed in Rules 2.3-2.4):
    - Modified overtime in a small number of health care jobs; exemption for certain heavy vehicle drivers
    - No forty- (40-) hour weekly overtime in downhill ski/snowboard jobs (but 56-hour overtime for many under federal law)
    - Agriculture: overtime after 48-56 hours (based on size and seasonality); extra breaks and pay on long days

Meal Periods: 30 minutes uninterrupted and duty-free, for shifts over 5 hours *(Rule 1.9)*

- Can be unpaid, but only if employees are completely relieved of all duties, and allowed to pursue personal activities
- If work makes uninterrupted meal periods impractical, eating on-duty must be permitted, and the time must be paid
- To the extent practical, meal periods must be at least one (1) hour after starting and one (1) hour before ending shifts

Rest Periods: 10 minutes, paid, every 4 hours *(Rule 5.2)*

#Work Hours:	**Up to 2**	**>2, up to 6**	**>6, up to 10**	**>10, up to 14**	**>14, up to 18**	**>18, up to 22**	**>22**
#Rest Periods:	**0**	**1**	**2**	**3**	**4**	**5**	**6**

- Need not be off-site, but must not include work, and should be in the middle of the four (4) hours to the extent practical

- Rest periods are time worked for minimum wage and overtime purposes, and if employers do not authorize and permit rest periods, they must pay extra for time that would have been rest periods, including for non-hourly-paid employees

- Key variances/exemptions:

    - In some circumstances, ten- (10-) minute rest periods can be divided into two (2) of five (5) minutes (Rule 5.2.1)

    - Agriculture: certain work requires more breaks; other is exempt (Rule 2.3, & Agricultural Labor Conditions Rules)

Time Worked: Pay for time employers allow performing labor/service for their benefit *(Rule 1.9)*

- All time on-premises, on duty, or at workplaces (but not just letting off-duty employees be on-premises), including:

    - putting on/removing work clothes/gear (but not clothes worn outside work), cleanup/setup, or other off-clock duty,

    - waiting for assignments at work, or receiving or sharing work-related information,

    - security/safety screening, or clocking/checking in or out, or

    - waiting for any of the above tasks.

- Travel for employer benefit is time worked; normal home/work travel is not (details in Rule 1.9.2)

- Sleep time, if sufficiently uninterrupted and lengthy, can be excluded in certain situations (details in Rule 1.9.3).

Deductions, Credits, Charges, & Withheld Pay *(Rule 6, and Article 4 of C.R.S. Title 8)*

- Final pay: Owed promptly (if a termination by employer) or at next pay date (if employee resigned)

- Vacation pay: Departing employees must be paid all accrued and unused vacation pay, including paid time off usable for vacation, without deducting or declaring forfeiture based on cause for termination, lack of resignation notice, etc.

- Deductions from pay: Allowed if listed below or in C.R.S. 8-4-105 (including deductions required by law, in a written agreement for the benefit of the employee, for theft in a police report, or for property loss after audit/notice)

- Tip credits: Employers can pay up to $3.02 under minimum wage ($11.40 in 2024, or $15.27 in Denver), if: (a) tips (not mandatory service charges) raise pay to full minimum, and (b) tips aren't diverted to non-tipped staff/owners

- Meal credits/deductions: Allowed for the cost or value (without employer profit) of voluntarily accepted meals

- Lodging credits/deductions: Allowed if housing is voluntarily accepted by the employee, primarily for the employee's (not the employer's) benefit, recorded in writing, and limited to $25 or $100 per week (based on housing type)

- Uniforms: Must be provided at no cost unless they are ordinary clothes without special material or design; employers must pay for any special cleaning required, and cannot require deposits or deduct for ordinary wear and tear

Exemptions from COMPS *(Rule 2.2 lists all; key exemptions are below)*

- Executives/supervisors, administrators, and professionals paid at least a salary (not hourly wages) of $55,000 in 2024 (then inflation-adjusted), except $33.17/hour for highly technical computer work

- Other highly compensated, non-manual-labor employees paid at least 2.25 the above salary ($123,750 in 2024)

- Twenty percent (20%) owners, or at a nonprofit the highest-paid/highest-ranked employee, if actively engaged in management

- Various (not all) types of salespersons, taxi drivers, camp/outdoor education field staff, or property managers

Record-Keeping & Notices of Rights *(Rule 7)*

- Employers must give all employees (and keep for three years) pay statements that include time worked, pay rate (including any tips and credits), and total pay

- This year's poster must be displayed where easily accessible, or if not practical (such as for remote workers), provided within one month of beginning work and when employees request a copy

- Employers must include a copy of this poster, or a COMPS Order, in any employment handbook or manual

- Violation of notice of rights rules (posting or distribution), including by providing information undercutting this poster, may yield fines and/or ineligibility for employee-specific credits, deductions, or exemptions in COMPS

Complaint & Anti-Retaliation Rights *(Rule 8)*

- Employees can send the Division (contact info below) complaints or tips about violations, or file lawsuits in court

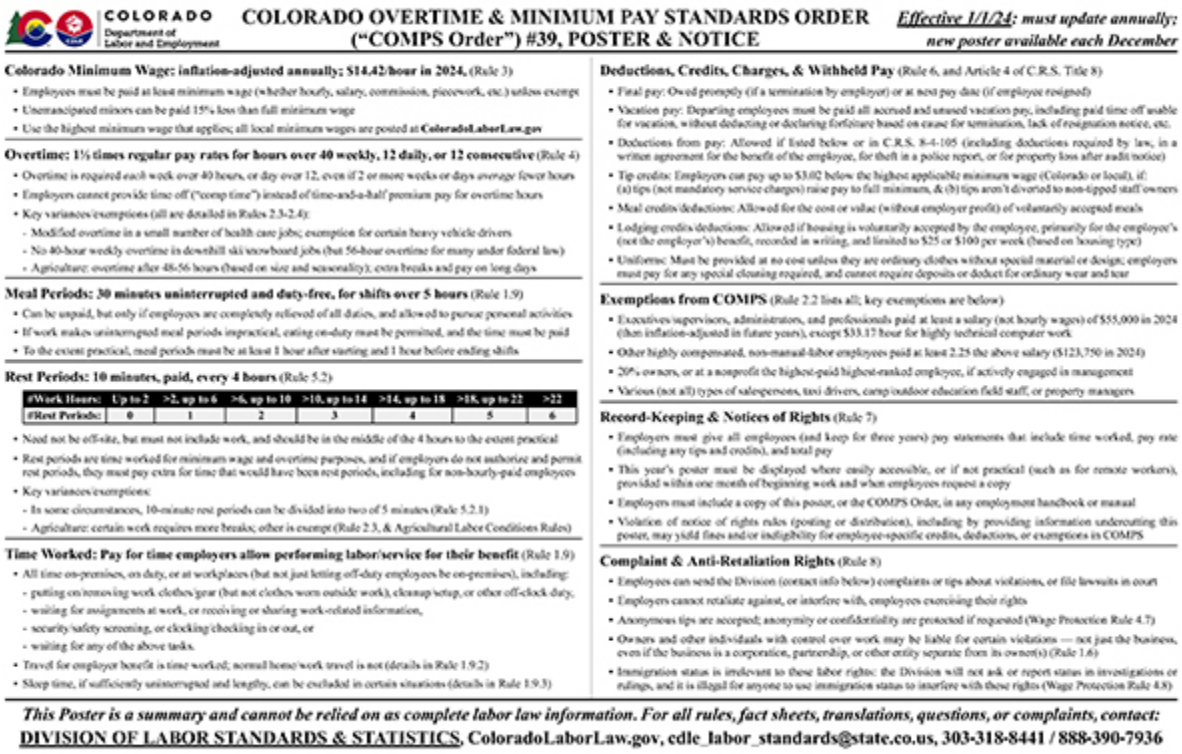
- Employers cannot retaliate against, or interfere with, employees exercising their rights

- Anonymous tips are accepted; anonymity or confidentiality are protected if requested (Wage Protection Rule 4.7)

- Owners and other individuals with control over work may be liable for certain violations — not just the business, even if the business is a corporation, partnership, or other entity separate from its owner(s) (Rule 1.6)

- Immigration status is irrelevant to these labor rights: the Division will not ask or report status in investigations or rulings, and it is illegal for anyone to use immigration status to interfere with these rights (Wage Protection Rule 4.8)

This Poster is a summary and cannot be relied on as complete labor law information. For all rules, fact sheets, translations, questions, or complaints, contact: **DIVISION OF LABOR STANDARDS & STATISTICS, ColoradoLaborLaw.gov, cdle_labor_standards@state.co.us, 303-318-8441 / 888-390-7936**



COLORADO Department of Labor and Employment

COLORADO OVERTIME & MINIMUM PAY STANDARDS ORDER ("COMPS Order") #39, POSTER & NOTICE

Effective 1/1/24: must update annually; new poster available each December

Colorado Minimum Wage: inflation-adjusted annually; $14.42/hour in 2024, (Rule 3)

- Employees must be paid at least minimum wage (whether hourly, salary, commission, piecework, etc.) unless exempt
- Unemancipated minors can be paid 15% less than full minimum wage
- Use the highest minimum wage that applies; all local minimum wages are posted at **ColoradoLaborLaw.gov**

Overtime: 1½ times regular pay rates for hours over 40 weekly, 12 daily, or 12 consecutive (Rule 4)

- Overtime is required each week over 40 hours, or day over 12, even if 2 or more weeks or days average fewer hours
- Employers cannot provide time off ("comp time") instead of time-and-a-half premium pay for overtime hours
- Key variances/exemptions (all are detailed in Rules 2.3-2.4):
  - Modified overtime in a small number of health care jobs; exemption for certain heavy vehicle drivers
  - No 40-hour weekly overtime in downhill ski/snowboard jobs (but 56-hour overtime for many under federal law)
  - Agriculture: overtime after 48-56 hours (based on size and seasonality); extra breaks and pay on long days

Meal Periods: 30 minutes uninterrupted and duty-free, for shifts over 5 hours (Rule 1.9)

- Can be unpaid, but only if employees are completely relieved of all duties, and allowed to pursue personal activities
- If work makes uninterrupted meal periods impractical, eating on-duty must be permitted, and the time must be paid
- To the extent practical, meal periods must be at least 1 hour after starting and 1 hour before ending shifts

Rest Periods: 10 minutes, paid, every 4 hours (Rule 5.2)

#Work Hours:	Up to 2	>2, up to 6	>6, up to 10	>10, up to 14	>14, up to 18	>18, up to 22	>22
#Rest Periods:	0	1	2	3	4	5	6

- Need not be off-site, but must not include work, and should be in the middle of the 4 hours to the extent practical
- Rest periods are time worked for minimum wage and overtime purposes, and if employers do not authorize and permit rest periods, they must pay extra for time that would have been rest periods, including for non-hourly-paid employees
- Key variances/exemptions:
  - In some circumstances, 10-minute rest periods can be divided into two of 5 minutes (Rule 5.2.1)
  - Agriculture: certain work requires more breaks; other is exempt (Rule 2.3, & Agricultural Labor Conditions Rules)

Time Worked: Pay for time employers allow performing labor/service for their benefit (Rule 1.9)

- All time on-premises, on duty, or at workplaces (but not just letting off-duty employees be on-premises), including:
  - putting on/removing work clothes/gear (but not clothes worn outside work), cleanup/setup, or other off-clock duty,
  - waiting for assignments at work, or receiving or sharing work-related information,
  - security/safety screening, or clocking/checking in or out, or
  - waiting for any of the above tasks.
- Travel for employer benefit is time worked; normal home/work travel is not (details in Rule 1.9.2)
- Sleep time, if sufficiently uninterrupted and lengthy, can be excluded in certain situations (details in Rule 1.9.3)

Deductions, Credits, Charges, & Withheld Pay (Rule 6, and Article 4 of C.R.S. Title 8)

- Final pay: Owed promptly (if a termination by employer) or at next pay date (if employee resigned)
- Vacation pay: Departing employees must be paid all accrued and unused vacation pay, including paid time off usable for vacation, without deducting or declaring forfeiture based on cause for termination, lack of resignation notice, etc.
- Deductions from pay: Allowed if listed below or in C.R.S. 8-4-105 (including deductions required by law, in a written agreement for the benefit of the employee, for theft in a police report, or for property loss after audit/notice)
- Tip credits: Employers can pay up to $3.02 below the highest applicable minimum wage (Colorado or local), if: (a) tips (not mandatory service charges) raise pay to full minimum, & (b) tips aren't diverted to non-tipped staff/owners
- Meal credits/deductions: Allowed for the cost or value (without employer profit) of voluntarily accepted meals
- Lodging credits/deductions: Allowed if housing is voluntarily accepted by the employee, primarily for the employee's (not the employer's) benefit, recorded in writing, and limited to $25 or $100 per week (based on housing type)
- Uniforms: Must be provided at no cost unless they are ordinary clothes without special material or design; employers must pay for any special cleaning required, and cannot require deposits or deduct for ordinary wear and tear

Exemptions from COMPS (Rule 2.2 lists all; key exemptions are below)

- Executives/supervisors, administrators, and professionals paid at least a salary (not hourly wages) of $55,000 in 2024 (then inflation-adjusted in future years), except $33.17/hour for highly technical computer work
- Other highly compensated, non-manual-labor employees paid at least 2.25 the above salary ($123,750 in 2024)
- 20% owners, or at a nonprofit the highest-paid highest-ranked employee, if actively engaged in management
- Various (not all) types of salespersons, taxi drivers, camp/outdoor education field staff, or property managers

Record-Keeping & Notices of Rights (Rule 7)

- Employers must give all employees (and keep for three years) pay statements that include time worked, pay rate (including any tips and credits), and total pay
- This year's poster must be displayed where easily accessible, or if not practical (such as for remote workers), provided within one month of beginning work and when employees request a copy
- Employers must include a copy of this poster, or the COMPS Order, in any employment handbook or manual
- Violation of notice of rights rules (posting or distribution), including by providing information undercutting this poster, may yield fines and/or ineligibility for employee-specific credits, deductions, or exemptions in COMPS

Complaint & Anti-Retaliation Rights (Rule 8)

- Employees can send the Division (contact info below) complaints or tips about violations, or file lawsuits in court
- Employers cannot retaliate against, or interfere with, employees exercising their rights
- Anonymous tips are accepted; anonymity or confidentiality are protected if requested (Wage Protection Rule 4.7)
- Owners and other individuals with control over work may be liable for certain violations — not just the business, even if the business is a corporation, partnership, or other entity separate from its owner(s) (Rule 1.6)
- Immigration status is irrelevant to these labor rights: the Division will not ask or report status in investigations or rulings, and it is illegal for anyone to use immigration status to interfere with these rights (Wage Protection Rule 4.8)

This Poster is a summary and cannot be relied on as complete labor law information. For all rules, fact sheets, translations, questions, or complaints, contact: DIVISION OF LABOR STANDARDS & STATISTICS, ColoradoLaborLaw.gov, cdle_labor_standards@state.co.us, 303-318-8441 / 888-390-7936

Colorado Breaks

Rest Breaks

Non-exempt employees are authorized and permitted paid ten- (10-) minute rest periods for each four (4) hours of work, or major fraction of that time. For purposes of this policy, "major fraction" means any time greater than two (2) hours. An additional rest period is required for any period that rounds up to four (4) hours. For example, a shift of two (2) hours or fewer requires no rest periods, a two (2) hour and one- (1-) minute shift requires a single rest period, and a six- (6-) hour shift also requires a single rest period, but a six- (6-) hour and one (1) minute shift requires two (2) rest periods.

Rest breaks should be taken as close to the middle of each work period of four (4) hours or major fraction thereof as is practical. Shorter or longer shifts and other factors that make such scheduling impractical may alter this general timing. Employees do not need to obtain approval from or notify their supervisor when taking a rest break. Employees are encouraged to take their rest breaks; they are not expected to and

should not work during their rest breaks. Employees are paid for all rest break periods and do not need to clock out when taking a rest break.

Rest breaks may not be combined with each other or with the meal period. In addition, rest breaks may not be taken at the beginning or end of the workday to arrive late or leave early. Each rest break must be a separate break, meeting the requirements described above. If any work is performed during a rest break, or if the rest break is interrupted for any work-related reason, the employee is entitled to another uninterrupted paid rest break.

Meal Periods

Non-exempt employees who work more than five (5) hours in a workday are provided an unpaid, off-duty and uninterrupted meal period of at least thirty (30) minutes. Employees are responsible for scheduling their own meal period, but should confirm them with their supervisor(s). To the extent practical, meal periods must be at least one (1) hour after starting and one (1) hour before ending shifts.

If an employee's type of work makes an uninterrupted, duty-free meal period impractical, the employee will be permitted to eat while working and paid for such time. Employees will be informed by their supervisor if they will be provided with on-duty meal periods.

When scheduling meal periods, employees should try to anticipate their workflow and deadlines. During a meal period, employees are relieved of all duties and should not work during this time. When taking a meal period, employees should completely stop working for at least thirty (30) minutes. Employees are prohibited from working "off the clock" during their meal periods.

Those employees who use a time clock must clock out for their meal periods. Employees are required to clock back in and promptly return to work at the end of any meal period. Employees who record their time manually must accurately record their meal periods by recording the beginning and end of each work period. Unless otherwise directed by their supervisor in writing, employees are not required to get approval from or notify their supervisor when taking a meal period. Employees are to immediately notify Human Resources and/or their supervisor if they believe that they are prevented by the nature of their work from taking a timely and/or complete meal period.

No Working During Rest Breaks and Meal Periods

Non-exempt employees are completely relieved of all work duties and responsibilities during their rest breaks and meal periods. All rest breaks and meal periods must be taken outside employees' work areas, such as in a break room. Employees may leave the premises during meal periods, but may not leave the premises during rest periods. Employees should not visit or socialize with employees who are working while taking their rest break or meal period. Employees are required to notify Human Resources immediately if they believe they are being pressured or coerced by any manager, supervisor, or other employee to forego any portion of a provided rest break or meal period. Additionally, employees are required to notify Human Resources immediately if they believe their workload, schedule, deadline, or other quota make rest break or meal periods infeasible.

Summary Chart

Below is a chart that generally summarizes the number of rest breaks and meal periods provided to non-exempt employees (these figures may vary depending on the timing of an employee's breaks).

Hours of Work	Rest Breaks	Meal Breaks
2 or fewer hours	0	0
Over 2 and up to 5 hours	1	0
Over 5 and up to 6 hours	1	1
Over 6, and up to 10 hours	2	1
Over 10, and up to 14 hours	3	1
Over 14, and up to 18 hours	4	1
Over 18, and up to 22 hours	5	1
Over 22 hours	6	1

TIME OFF AND LEAVES OF ABSENCE

Colorado Sick And Safe Time

Eligibility

Chestnut Health Systems provides paid sick leave to all employees. For employees who work in Colorado who are eligible for sick leave under another policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing paid sick leave pursuant to this policy at the start of employment. Employees will accrue one (1) hour of paid sick leave for every thirty (30) hours worked, up to a maximum accrual of forty-eight (48) hours each year, inclusive of any hours carried over from the prior year.

Exempt employees are assumed to work forty (40) hours in each workweek unless their normal workweek is less than forty (40) hours, in which case paid sick leave accrues based on that normal workweek.

For purposes of this policy, the year is the consecutive 12-month period beginning January 1 and ending on December 31.

Usage

Employees may begin using accrued paid sick leave immediately. Paid sick leave may be used in hourly increments. Employees may not use more than forty-eight (48) hours of accrued paid sick leave in any year.

Employees may use accrued paid sick leave for the following reasons:

1. Mental or physical illness, injury, or health condition that prevents the employee from working; the need to obtain a medical diagnosis, care, or treatment of a mental or physical illness, injury or health condition; the need to obtain preventive medical care; or the need to grieve, attend funeral services or a memorial, or deal with financial and legal matters that arise after the death of a family member;

2. To care for a family member who has a mental or physical illness, injury, or health condition; needs to obtain a medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition; or needs to obtain preventive medical care;

3. The employee or a family member has been the victim of domestic abuse, sexual assault, or harassment and the use of leave is to:

    - Seek medical attention to recover from a mental or physical illness, injury, or health condition caused by the domestic abuse, sexual assault, or harassment;

    - Obtain services from a victim services organization;

    - Obtain mental health or other counseling;

    - Seek relocation due to the domestic abuse, sexual assault, or harassment; or

    - Seek legal services, including preparation for or participation in a civil or criminal proceeding relating to or resulting from the domestic abuse, sexual assault, or harassment;

4. Due to a public health emergency, a public official has ordered closure of the employee's place of business or the school or place of care of the employee's child and the employee needs to be absent from work to care for the child.

5. The employee needs to care for a family member whose school or place of care has been closed due to inclement weather, loss of power, loss of heating, loss of water, or other unexpected occurrence or event that results in the closure of the family member’s school or place of care; or

6. The employee needs to evacuate the employee’s place of residence due to inclement weather, loss of power, loss of heating, loss of water, or other unexpected occurrence or event that results in the need to evacuate the employee's residence.

For purposes of this policy, "family member" means a person who is related to the employee by blood, marriage, civil union or adoption; a child to whom the employee stands *in loco parentis* or a person who stood *in loco parentis* when the employee was a minor; or a person for whom the employee is responsible for providing or arranging health- or safety-related care.

Use of paid sick leave will not be conditioned upon the employee searching for or finding a replacement worker.

Unless advised otherwise, the Company will assume, subject to applicable law, that employees want to use available paid sick leave for reasons set forth above. Employees will be paid for such absences to the extent they have paid sick leave available.

Notice and Documentation

Paid sick leave may be requested orally, in writing, electronically or by any other means acceptable to the Company. When possible, employees should include the expected duration of the absence. If the need is foreseeable employees must provide reasonable advance notice to their Supervisor of the need to use accrued paid sick leave, and also make a reasonable effort to schedule the paid sick leave in a manner that does not unduly disrupt Company operations. Where the need is not foreseeable, employees should provide notice as early as practicable.

For paid sick leave of four (4) or more consecutive work days, the Company may require reasonable documentation that the paid sick leave was used for an authorized purpose. The Company will not require the disclosure of details relating to domestic violence, sexual assault, or stalking or the details of the employee's or family member's health information as a condition of providing paid sick leave.

Payment

Paid sick leave will be paid at the same hourly rate or salary and with the same benefits, including health care benefits, as the employee normally earns during hours worked. Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Employees may carry over up to forty-eight (48) hours of accrued, unused paid sick leave to the following calendar year. If the employee carries over accrued, unused paid sick leave from the prior year, the employee will be eligible to accrue only enough hours of paid sick leave in the following year to bring the employee to the 48 hours maximum, regardless of how much paid sick leave the employee used in the previous year and when it was used. Accrued but unused paid sick leave will not be paid at separation.

Additional Public Health Emergency Paid Sick Leave

In addition to accrued paid sick leave explained above, on the date a public health emergency is declared, the Company will supplement each employee's accrued paid sick leave as necessary to ensure that the employee may take paid sick leave as follows:

- Employees who normally work 40 or more hours in a week may take at least eighty (80) hours of paid sick leave in a public health emergency;
- Employees who normally work fewer than forty (40) hours in a week may take at least the greater of either the amount of time the employee is scheduled to work in a fourteen- (14-) day period or the amount of time the employee actually works on average in a fourteen- (14-) day period.

The Company may count unused accrued paid sick leave, as explained above, toward the supplemental paid sick leave required for a public health emergency. Employees may use public health emergency paid sick leave until four (4) weeks after the official termination or suspension of the public health emergency. Employees may use public health emergency paid sick leave for the following absences related to a public health emergency:

1. To self-isolate and care for oneself when diagnosed with a communicable illness that is the cause of a public health emergency; self-isolate and care for oneself when experiencing symptoms of a communicable illness that is the cause of a public health emergency; seek or obtain medical diagnosis, care, or treatment if experiencing symptoms of a communicable illness that is the cause

of a public health emergency; seek preventive care concerning a communicable illness that is the cause of a public health emergency;

2. To care for a family member who is self-isolating after being diagnosed with a communicable illness that is the cause of a public health emergency; is experiencing symptoms of a communicable illness that is the cause of a public health emergency; needs medical diagnosis, care, or treatment if experiencing symptoms of a communicable illness that is the cause of a public health emergency; or is seeking preventive care concerning a communicable illness that is the cause of a public health emergency;

3. With respect to a communicable illness that is the cause of a public health emergency:

    - A local, state, or federal public official or health authority having jurisdiction over the location in which the Company is located or the Company determines that the employee's presence on the job or in the community would jeopardize the health of others because of the employee's exposure to the communicable illness or because the employee is exhibiting symptoms of the communicable illness, regardless of whether the employee has been diagnosed with the communicable illness; or

    - Care of a family member after a local, state, or federal public official or health authority, having jurisdiction over the location in which the family member's place of employment is located, or the family member's employer determines that the family member's presence on the job or in the community would jeopardize the health of others because of the family member's exposure to the communicable illness, or because the family member is exhibiting symptoms of the communicable illness, regardless of whether the family member has been diagnosed with the communicable illness;

4. Care of a child or other family member when the individual's child care provider is unavailable due to a public health emergency, or if the child's or family member's school or place of care has been closed by a local, state, or federal public official or at the discretion of the school or place of care due to a public health emergency, including if a school or place of care is physically closed but providing instruction remotely;

5. Inability to work because the employee has a health condition that may increase susceptibility to or risk of a communicable illness that is the cause of the public health emergency.

Employees must notify the Company of the need for public health emergency paid sick leave as soon as practicable when the need for paid sick leave is foreseeable and the Company's place of business has not been closed. Documentation is not required to take public health emergency paid sick leave.

Public health emergency paid sick leave in the amount described above may be taken once during the entirety of a public health emergency even if such public health emergency is amended, extended, restated, or prolonged.

Enforcement and Retaliation

The Company cannot retaliate against employees for requesting or using paid sick leave and employees have the right to file a complaint with the Division of Labor Standards and Statistics in the Colorado

Department of Labor and Employment or bring a civil action if paid sick leave is denied by the Company or the Company retaliates against employees for exercising their rights under applicable law.

If employees have any questions regarding this policy, they should contact Human Resources.

Colorado Paid Family and Medical Leave

Eligibility Requirements

Colorado employees who have a qualifying condition and who earned $2,500 over the previous year for work performed in Colorado will be eligible for paid family and medical leave, and to receive family and medical leave insurance benefits while taking paid family and medical leave, pursuant to Colorado's Family and Medical Leave Insurance (FAMLI) Program. All employees are required to contribute to the FAMLI Program and will be subject to payroll deductions not to exceed the maximum employee premium rate established by law.

Entitlement

Eligible employees are entitled to up to twelve (12) weeks of paid leave per year. Employees with serious health conditions caused by pregnancy complications or childbirth complications may be entitled to up to four (4) additional weeks of paid leave per year for a total of up to sixteen (16) weeks.

FAMLI leave is available for the following circumstances:

- Caring for a new child during the first year after the birth, adoption, or foster care placement of that child;
- Caring for a family member with a serious health condition;
- For the employee's own serious health condition;
- Because of any qualifying exigency leave; or
- For safe leave.

"Family member" means:

1. Regardless of age, a biological, adopted, or foster child, stepchild or legal ward, a child of a domestic partner, a child to whom the covered employee stands *in loco parentis*, or a person to whom the covered employee stood *in loco parentis* when the person was a minor;
2. A biological, adoptive, or foster parent, stepparent, or legal guardian of a covered employee or covered employee's spouse or domestic partner or a person who stood *in loco parentis* when the covered employee or covered employee's spouse or domestic partner was a minor child;
3. A person to whom the covered employee is legally married under the laws of any state, or a domestic partner of a covered individual as defined in Colo. Rev. Stat. § 24-50-603 (6.5);
4. A grandparent, grandchild, or sibling (whether a biological, foster, adoptive, or step relationship) of the covered employee or covered employee's spouse or domestic partner; or

5. As shown by the covered employee, any other individual with whom the covered employee has a significant personal bond that is or is like a family relationship, regardless of biological or legal relationship.

"Caring for a new child" means caring, bonding, and providing the basic needs of a child that is younger than eighteen (18) and sometimes up to the age of twenty-one (21) if still under jurisdiction of the juvenile court. Leave can be used once during the fostering and adopting of the same child. When using leave to "care for a new child," benefits are limited to parents and individuals standing *in loco parentis* to the child.

"Qualifying exigency leave" means leave based on a need arising out of a covered employee's family member's active-duty service or notice of an impending call or order to active duty in the armed forces. This type of leave includes things like providing for the care or other needs of the military member's child or other family member, making financial or legal arrangements for the military member, attending counseling, attending military events or ceremonies, spending time with the military member during a rest and recuperation leave or following return from deployment, or making arrangements following the death of the military member.

A "serious health condition" means an illness, injury, impairment, pregnancy, recovery from childbirth, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility, or continuing treatment by a health care provider.

"Safe leave" means any leave needed because the covered employee or the employee's family member is the victim of domestic violence, the victim of stalking, or the victim of sexual assault or abuse if the covered employee is using the leave from work to protect the covered individual or the covered employee's family member by:

1. Seeking a civil protection order to prevent domestic violence;

2. Obtaining medical care or mental health counseling or both for them or for their children to address physical or psychological injuries resulting from the act of domestic violence, stalking, or sexual assault or abuse;

3. Making their home secure from the perpetrator of the act of domestic violence, stalking, or sexual assault or abuse, or seeking new housing to escape said perpetrator; or

4. Seeking legal assistance to address issues arising from the act of domestic violence, stalking, or sexual assault or abuse, or attending and preparing for court-related proceedings arising from said act or crime.

Substitution of FAMLI Benefits with Chestnut Health Systems Benefits

Employees may choose to use sick leave or other paid time off before using FAMLI benefits, but are not required to do so. The Company and employees may mutually agree to supplement FAMLI benefits with sick leave or other paid time off to provide full wage replacement.

Use of Leave

Leave may be taken continuously, intermittently, or in the form of a reduced schedule. A covered employee may take intermittent leave in increments of either one (1) hour or shorter periods if consistent with the increments the Company typically uses to measure employee leave, except that benefits are not payable

until the covered employee accumulates at least eight (8) hours of family and medical leave insurance benefits. FAMLI wage replacement benefits will be paid at a rate of up to ninety percent (90%) of the employee's average weekly wage with lower wage earners receiving a higher percentage. Benefits are calculated on a sliding scale using the employee's average weekly wage from the previous five (5) calendar quarters in relation to the average weekly wage for the State of Colorado and may increase over time. Benefits are capped at $1,100 per week. Potential benefits can be estimated by using the calculator available at famli.colorado.gov.

Employee Notice to the Company

When the need for leave is foreseeable, individuals must provide not less than thirty (30) days' notice prior to the start of their planned leave to the Company when practicable and shall make a reasonable effort to schedule leave so as not to unduly disrupt the operations of the Company. When the need for leave is unforeseeable or providing thirty (30) days' notice is not possible, employees must provide notice as soon as possible and have up to thirty (30) days after the leave has begun to apply for FAMLI benefits.

Employee Application to the Department

Employees or their designated representatives will apply for FAMLI benefits by submitting an application, along with other required documents that support the need for leave. The Division of Family and Medical Leave Insurance Division of the Colorado Department Labor (Division) will establish reasonable procedures and forms for filing claims for benefits and will specify what supporting documentation is necessary to support a claim for benefits, including any documentation required from a health care provider for proof of a serious health condition and any documentation required by the Division with regards to a claim for safe leave. Instructions on how to apply for benefits will be available on famli.colorado.gov in the last quarter of 2023.

Employees will submit the application directly to the Division. Applications may be submitted in advance when the need for qualified leave is foreseeable. Approved applications will be paid by the FAMLI Division within two (2) weeks after the claim is properly filed, and every two (2) weeks thereafter. Employees can appeal claim determinations to the FAMLI Division.

Employees who attempt to defraud the FAMLI program may be disqualified from receiving benefits.

Job Benefits and Protection

Employees are entitled to the same healthcare benefits while on FAMLI leave, but also remain responsible for paying for those benefits in the same amounts as before the leave began.

Employees who have worked for the Company for at least 180 days are entitled to return to the same position, or an equivalent position, upon their return from FAMLI leave. Otherwise, employees taking FAMLI leave are not guaranteed job reinstatement unless they qualify for such reinstatement under federal and/or state leave laws or other applicable laws.

Interaction with Other Leave Policies

FAMLI leave is designed to run concurrently with the federal FMLA and Colorado Family Care Leave pursuant to Colo. Rev. Stat. § 8-13.3-203. If FAMLI leave is used for a reason that also qualifies as leave under FMLA or Colorado Family Care Leave, then the leave also may count as FMLA leave or Colorado Family Care Leave used, as applicable. Employees may choose to use sick leave or other employer-

provided paid time off before using FAMLI benefits, but are not required to do so. If mutually agreed upon with the Company, employees may supplement FAMLI benefit payments with sick leave or other paid time off to receive full wage replacement.

Questions and/or Complaints about FAMLI Leave

If employees have questions regarding this FAMLI policy, they should contact Human Resources. For questions about determinations by the Department on leave eligibility, entitlement, and/or benefits, employees should contact the Department directly. The Company is committed to complying with the FAMLI and, whenever necessary, shall interpret and apply this policy in a manner consistent with the FAMLI.

The FAMLI makes it unlawful for employers to discriminate, retaliate, threaten to retaliate, or interfere with the exercise of any rights under the FAMLI. In addition, employers may not retaliate or threaten to retaliate against any person who has filed a complaint, has caused a complaint to be filed, has or will participate or testify in proceeding relating to a violation of the FAMLI, or has given or is about to give information connected to a proceeding relating to a violation of the FAMLI. If employees believe their FAMLI rights have been violated, they should contact Human Resources immediately. The Company will investigate any FAMLI complaints and take prompt and appropriate remedial action to address and/or remedy any FAMLI violation. Employees also may file FAMLI complaints with the Department alleging FAMLI violations.

C**OLORADO COMPS ORDER ACKNOWLEDGMENT FORM**

I acknowledge that I have received the Colorado Overtime and Minimum Pay Standards Order ("COMPS Order") #39 poster.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

COLORADO SUPPLEMENT ACKNOWLEDGMENT

This Colorado Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Colorado Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

1. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
2. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
3. obscene or vulgar gestures, posters or comments;
4. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;
5. propositions or suggestive or insulting comments of a sexual nature;
6. derogatory cartoons, posters and drawings;
7. sexually-explicit e-mails, text messages or voicemails;
8. uninvited touching of a sexual nature;
9. unwelcome sexually-related comments;
10. conversation about one's own or someone else's sex life;
11. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
12. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

CHESTNUT
HEALTH SYSTEMS

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

ADDENDUM – Connecticut Supplement – 2024



Chestnut Health Systems

Personnel Policies

Connecticut Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Connecticut Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Connecticut employees will receive the Company's Personnel Policies and the Connecticut Supplement to the Personnel Policies ("Connecticut Supplement) (together the "Employee Handbook").

The Connecticut Supplement applies only to Connecticut employees. It is intended as a resource containing specific provisions derived under Connecticut law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Connecticut Supplement are different from or more generous than those in the National Handbook, the policies in the Connecticut Supplement will apply.

The Connecticut Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

Connecticut Pregnancy Accommodations

In compliance with Connecticut law, Chestnut Health Systems will not discriminate against the employee or prospective employee in the terms or conditions of the employee's employment in relation to pregnancy, childbirth, or a related condition including, but not limited to, lactation. The Company will not limit, segregate, or classify the employee in a way that would deprive the employee of employment opportunities due to the employee's pregnancy.

Reasonable Accommodations

The Company will endeavor to provide reasonable accommodations for conditions related to pregnancy, childbirth or a related condition, including, but not limited to, lactation, unless the accommodation would pose an undue hardship on the Company's business. Such accommodations include, but are not limited to:

1. Being permitted to sit while working;
2. More frequent or longer breaks;
3. Periodic rest;
4. Assistance with manual labor;
5. Job restructuring;
6. Light duty assignments;
7. Modified work schedules;
8. Temporary transfers to less strenuous or hazardous work;
9. Time off to recover from childbirth; or
10. Break time and appropriate facilities for expressing breast milk.

The Company will not force the employee or prospective employee affected by pregnancy to accept a reasonable accommodation if such employee or person seeking employment does not have a known limitation related to the employee's pregnancy, or does not require a reasonable accommodation to perform the essential duties related to the employee's employment. This includes, but is not limited to, forcing the employee to take leave if another reasonable accommodation can be provided to the employee's condition related to the pregnancy, childbirth, or a related medical condition.

Enforcement and Retaliation

The Company will not retaliate against the employee in the terms, conditions, or privileges of the employee's employment based upon the employee's request for a reasonable accommodation under this policy. Further, the Company will not deny employment opportunities to the employee or prospective employee due to the employee's or prospective employee's request for a reasonable accommodation related to pregnancy, childbirth, or a related medical condition.

If employees have any questions about or would like to request a reasonable accommodation under this policy, they should contact Human Resources.

Connecticut Non-Harassment

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers, or employees by another employee, supervisor, vendor, customer, or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth, and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military and veteran status, physical or mental disability, genetic information, or any other characteristic protected by applicable federal, state, or local laws (referred to as "protected characteristics"). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company

business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted, or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws is illegal and prohibited by Connecticut and federal law in the workplace, pursuant to § 46a-60(a)(8) of the Connecticut General Statutes and Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq*.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual, or physical conduct that denigrates or shows hostility or aversion toward an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures, or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts, or e-mails), or physical conduct (including physically threatening another, blocking someone's way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state, or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities, and other verbal, visual, or physical conduct of a sexual nature when:

- Submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- Submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- The conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Examples of conduct that violate this policy include:

1. Unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
2. Requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
3. Obscene or vulgar gestures, posters, or comments;
4. Sexual jokes or comments about a person's body, sexual prowess, or sexual deficiencies;
5. Propositions or suggestive or insulting comments of a sexual nature;
6. Derogatory cartoons, posters, and drawings;
7. Sexually-explicit e-mails, text messages, or voicemails;
8. Uninvited touching of a sexual nature;
9. Unwelcome sexually-related comments;

10. Conversation about one's own or someone else's sex life;
11. Conduct or comments consistently targeted at only one (1) gender, even if the content is not sexual; and
12. Teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedure

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If employees feel they have been subjected to any such retaliation, they should report it in the same manner in which they would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

Although employees are encouraged to report claims internally, if an employee believes that they have been subjected to sexual harassment or other harassment in violation of state law, the employee may file a formal complaint with the Connecticut Commission on Human Rights and Opportunities (the "Commission") at 860-541-3400, CT Toll Free 1-800-477-5737, or online at www.ct.gov/CHRO.

Individuals who engage in acts of sexual harassment or other harassment in violation of state law may be subject to civil penalties in the form of a cease and desist orders, back pay, compensatory damages, hiring, promotion, or reinstatement, emotional distress, as well as attorney's fees, costs, pre- and post- judgment interest, and punitive damages (if the case is tried in court). Individuals may also be subject to additional criminal penalties stemming from acts of sexual harassment.

Connecticut law requires that a written complaint be filed with the Commission within 300 days of the date the alleged harassment.

PAY PRACTICES

Connecticut Lactation Breaks

The Company will provide a reasonable amount of break time to accommodate employees desiring to express breast milk for their child, to the extent required by and in accordance with applicable law. If possible, the break time must run concurrently with rest and meal periods already provided to the employee. Break time that cannot run concurrently with rest and meal periods already provided to the employee will be unpaid, to the extent permitted by applicable law.

The Company will make reasonable efforts to provide the employee with use of a room or location in close proximity to the employee's work area, other than a bathroom, for the employee to express milk in private. This room or location may be the employee's private office, if applicable.

Unless otherwise required by applicable law, The Company may not be able to provide a room or location in close proximity to the employee's work area if doing so would impose an undue hardship by causing significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the Company's business.

Employees will not be discriminated against or retaliated against for exercising their rights under this policy. Employees can contact Human Resources with questions regarding this policy.

TIME OFF AND LEAVES OF ABSENCE

Connecticut Family and Medical Leave (CFMLA)

For Connecticut employers that are covered by the federal Family and Medical Leave Act.

Employees may be entitled to a leave of absence under the Family and Medical Leave Act ("FMLA") and/or the Connecticut Family and Medical Leave Act ("CFMLA"). This policy provides employees information concerning FMLA/CFMLA entitlements and obligations employees may have during such leaves. Whenever permitted by law, the Company will run FMLA leave concurrently with CFMLA and any other leave provided under state or local law. If employees have any questions concerning FMLA/CFMLA leave, they should contact Human Resources.

I. Eligibility

FMLA leave is available to "FMLA eligible employees." To be an "FMLA eligible employee," the employee must: 1) have been employed by the Company for at least 12 months (which need not be consecutive); 2) have been employed by the Company for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave; and 3) be employed at a worksite where 50 or more employees are located within 75 miles of the worksite.

Special hours of service eligibility requirements apply to airline flight crew employees.

CFMLA leave is available to "CFMLA eligible employees." To be a "CFMLA eligible employee," the employee must have been employed by the Company for at least three (3) months immediately preceding a request for leave.

II. Entitlements

As described below, the FMLA and/or CFMLA provide(s) eligible employees with a right to leave, health insurance benefits and, with some limited exceptions, job restoration.

A. Basic FMLA/CFMLA Leave Entitlement

The FMLA/CFMLA provides eligible employees up to twelve (12) workweeks of unpaid leave for certain family and medical reasons during a twelve- (12-) month period, with an additional two (2) weeks available under the CFMLA for an incapacitating serious health condition that occurs during pregnancy. The 12-month period is measured by a rolling twelve- (12-) month period measured backward from the date the employee uses their FMLA leave. Where both laws apply, the leave provided by each will run concurrently. It is the Company's policy to provide the greater leave benefit provided under the FMLA or CFMLA and to run leave concurrently under the FMLA and CFMLA whenever possible.

Leave may be taken for any one, or for a combination, of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, child or parent who has a **serious health condition**);
- To care for the employee's parent-in-law, sibling, grandparent, grandchild or any other individual related to the employee by blood or affinity whose close association the employee shows to be the equivalent of these family relationships or of a child, parent, or spouse who has a **serious health condition** (CFMLA only);
- To serve as an organ or bone marrow donor (CFMLA only);
- For the employee's own serious health condition (including any period of incapacity due to pregnancy, prenatal medical care or childbirth) that makes the employee unable to perform one or more of the essential functions of the employee's job; and/or
- Because of any **qualifying exigency** arising out of the fact that the employee's spouse, child or parent is a military member on covered active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty) in the Reserve component of the Armed Forces for deployment to a foreign country in support of contingency operations or Regular Armed Forces for deployment to a foreign country.

A **serious health condition** under the FMLA and/or CFMLA is an illness, injury, impairment or physical or mental condition that involves either an overnight stay in a medical care facility, including inpatient care in a hospital, hospice, nursing home or residential medical care facility; or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) consecutive calendar days combined with at least two (2) visits to a health care provider, or one visit and a regimen of continuing treatment, or incapacity due to pregnancy or incapacity due to a chronic condition. For additional information regarding conditions that qualify as serious health conditions, please contact Human Resources.

Qualifying exigencies under the FMLA and/or CFMLA may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, caring for the parents of the military member on covered active duty and attending post-deployment reintegration briefings.

B. Additional Military Family Leave Entitlement (Injured Servicemember Leave) Under the FMLA and/or CFMLA

In addition to the basic FMLA and/or CFMLA leave entitlements discussed above, under the FMLA and CFMLA, an eligible employee who is the spouse, child, parent or next of kin of a covered servicemember is entitled to take up to twenty-six (26) weeks of leave during a single twelve- (12-) month period to care for the servicemember with a serious injury or illness.

In addition to the entitlements outlined above, under the CFMLA an eligible employee is entitled to take up to 26 weeks of leave during a single twelve- (12-) month period to care for a covered servicemember with a serious injury or illness if the servicemember is the eligible employee's parent-in-law with a serious health condition.

Leave to care for a servicemember shall only be available during a single 12-month period and, when combined with other FMLA- and/or CFMLA-qualifying leave, may not exceed twenty-six (26) weeks during the single 12-month period. The single 12-month period begins on the first day an eligible employee takes leave to care for the injured servicemember.

When, during the single 12-month period, leave qualifies as both leave to care for a covered servicemember and leave to care for a family member with a serious health condition, the Company will designate such leave as leave to care for a covered servicemember in the first instance, and such leave shall not be designated and counted as both leave to care for a covered servicemember and leave to care for a family member with a serious health condition. As is the case with other FMLA and/or CFMLA leave, the Company may retroactively designate leave as leave to care for a covered servicemember.

A **"covered servicemember"** is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status or is on the temporary retired list, for a serious injury or illness. These individuals are referred to in this policy as "current members of the Armed Forces." **Covered servicemembers** also include a veteran who is discharged or released from military service under conditions other than dishonorable at any time during the five year period preceding the date the eligible employee takes FMLA and/or CFMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation or therapy for a serious injury or illness. These individuals are referred to in this policy as "covered veterans."

The FMLA and CFMLA definitions of a "serious injury or illness" for current Armed Forces members and covered veterans are distinct from the FMLA and CFMLA definition of "serious health condition" applicable to FMLA and CFMLA leave to care for a covered family member.

C. Intermittent Leave and Reduced Leave Schedules

FMLA/CFMLA leave usually will be taken for a period of consecutive days, weeks or months. However, employees also are entitled to take leave intermittently or on a reduced leave schedule when medically necessary due to a serious health condition of the employee or covered family member, or the serious injury or illness of a covered servicemember. Leave due to qualifying exigencies may also be taken on an intermittent or reduced schedule basis.

D. No Work While on Leave

The taking of another job while on FMLA/CFMLA leave or any other authorized leave of absence is grounds for immediate discharge, to the extent permitted by applicable law.

E. Protection of Group Health Insurance Benefits

During FMLA/CFMLA leave, eligible employees are entitled to receive group health plan coverage on the same terms and conditions as if they had continued to work.

F. Restoration of Employment and Benefits

At the end of FMLA leave, subject to some exceptions including situations where job restoration of "key employees" will cause the Company substantial and grievous economic injury, employees generally have a right to return to the same or equivalent positions with equivalent pay, benefits and other employment terms. The Company will notify employees if they qualify as "key employees," if it intends to deny reinstatement, and of their rights in such instances.

At the end of a leave under the CFMLA, the employees will be returned to their original job, unless that job is not available, in which case they will be returned to an equivalent position.

Use of FMLA and/or CFMLA leave will not result in the loss of any employment benefit that accrued prior to the start of an eligible employee's FMLA/CFMLA leave.

G. Notice of Eligibility for, and Designation of, FMLA/CFMLA Leave

Employees requesting FMLA/CFMLA leave are entitled to receive written notice from the Company telling them whether they are eligible for FMLA and/or CFMLA leave and, if not eligible, the reasons why. When eligible for FMLA/CFMLA leave, employees are entitled to receive written notice of 1) their rights and responsibilities in connection with such leave; 2) the Company's designation of leave as FMLA/CFMLA-qualifying or non-qualifying, and if not FMLA/CFMLA-qualifying, the reasons why; and 3) the amount of leave, if known, that will be counted against the employee's leave entitlement.

The Company may retroactively designate leave as FMLA/CFMLA leave with appropriate written notice to employees provided the Company's failure to designate leave as FMLA/CFMLA-qualifying at an earlier date did not cause harm or injury to the employee. In all cases where leaves qualify for FMLA/CFMLA protection, the Company and employee can mutually agree that leave be retroactively designated as FMLA/CFMLA leave.

III. Employee FMLA and CFMLA Leave Obligations

A. Provide Notice of the Need for Leave

Employees who wish to take FMLA/CFMLA leave must timely notify the Company of their need for FMLA/CFMLA leave. The following describes the content and timing of such employee notices.

1. Content of Employee Notice

To trigger FMLA/CFMLA leave protections, employees must inform Human Resources of the need for FMLA/CFMLA-qualifying leave and the anticipated timing and duration of the leave, if known. Employees may do this by either requesting FMLA/CFMLA leave specifically, or explaining the reasons for leave so as to allow the Company to determine that the leave is FMLA/CFMLA-qualifying. For example, employees might explain that:

- a medical condition renders them unable to perform the functions of their job;
- they are pregnant;
- they have been hospitalized overnight;
- they or a covered family member are under the continuing care of a health care provider;
- the leave is due to a qualifying exigency caused by a military member being on covered active duty or called to covered active duty status; or
- if the leave is for a family member, that the condition renders the family member unable to perform daily activities, or that the family member is a covered servicemember with a serious injury or illness.

Calling in "sick," without providing the reasons for the needed leave, will not be considered sufficient notice for FMLA/CFMLA leave under this policy. Employees must respond to the Company's requests for information to determine if absences are potentially FMLA/CFMLA-qualifying.

If the employee fails to explain the reasons for FMLA/CFMLA leave, the leave may be denied. When employees seek leave due to FMLA/CFMLA-qualifying reasons for which the Company has previously provided FMLA/CFMLA-protected leave, they must specifically reference the qualifying reason for the leave or the need for FMLA/CFMLA leave.

2. Timing of Employee Notice

Where the need for leave is foreseeable, employees must provide timely advance notice of the need to take family and medical leave; if leave is requested only under the FMLA, then thirty (30) days' notice is required. Where possible, the Company requests that employees provide at least thirty (30) days' notice of a foreseeable leave. When thirty (30) days' notice is not possible, or the approximate timing of the need for leave is not foreseeable, employees must provide the Company notice of the need for leave as soon as practicable under the facts and circumstances of the particular case (i.e., within one (1) or two (2) business days of learning of the need for the leave).

B. Cooperate in the Scheduling of Planned Medical Treatment (Including Accepting Transfers to Alternative Positions) and Intermittent Leave or Reduced Leave Schedules

When planning medical treatment, employees must consult with the Company and make a reasonable effort to schedule treatment so as not to unduly disrupt the Company's operations, subject to the approval

of the employee's health care provider. Employees must consult with the Company prior to the scheduling of treatment to work out a treatment schedule that best suits the needs of both the Company and the employees, subject to the approval of the employees' health care provider. If employees providing notice of the need to take FMLA/CFMLA leave on an intermittent basis for planned medical treatment neglect to fulfill this obligation, the Company may require employees to attempt to make such arrangements, subject to the approval of the employees' health care provider.

When employees take intermittent or reduced work schedule leave for foreseeable planned medical treatment for the employee or a family member, including during a period of recovery from a serious health condition or to care for a covered servicemember, the Company may temporarily transfer employees, during the period that the intermittent or reduced leave schedules are required, to alternative positions with equivalent pay and benefits for which the employees are qualified and which better accommodate recurring periods of leave.

When employees seek intermittent leave or a reduced leave schedule for reasons unrelated to the planning of medical treatment, upon request, employees must advise the Company of the reason why such leave is medically necessary. In such instances, the Company and employee shall attempt to work out a leave schedule that meets the employee's needs without unduly disrupting the Company's operations, subject to the approval of the employee's health care provider.

C. Submit Medical Certifications Supporting Need for FMLA/CFMLA Leave (Unrelated to Requests for Military Family Leave)

Depending on the nature of FMLA/CFMLA leave sought, employees may be required to submit medical certifications supporting their need for qualifying leave. As described below, there generally are three types of FMLA/CFMLA medical certifications: an **initial certification**, a **recertification** and a **return to work/fitness for duty certification**.

It is the employee's responsibility to provide the Company with timely, complete and sufficient medical certifications. Whenever the Company requests employees to provide FMLA/CFMLA medical certifications, employees must provide the requested certifications within 15 calendar days after the Company's request, unless it is not practicable to do so despite the employee's diligent, good faith efforts. The Company will inform employees if submitted medical certifications are incomplete or insufficient and provide employees at least seven (7) calendar days to cure deficiencies. The Company will deny FMLA/CFMLA leave to employees who fail to timely cure deficiencies or otherwise fail to timely submit requested medical certifications, to the extent permitted by applicable law.

With the employee's permission, the Company may contact the employee's health care provider to authenticate or clarify completed and sufficient medical certifications. If the employee chooses not to provide the Company with authorization allowing it to clarify or authenticate certifications with health care providers, the Company may deny FMLA/CFMLA leave if certifications are unclear, to the extent permitted by applicable law.

Whenever the Company deems it appropriate to do so, it may waive its right to receive timely, complete and/or sufficient FMLA/CFMLA medical certifications.

1. Initial Medical Certifications

Employees requesting leave because of their own, or a covered relation's, serious health condition, or to care for a covered servicemember, must supply medical certification supporting the need for such leave from their health care provider or, if applicable, the health care provider of their covered family or service member. If employees provide at least 30 days' notice of medical leave, they should submit the medical certification before leave begins. A new initial medical certification will be required on an annual basis for serious medical conditions lasting beyond a single leave year.

If the Company has reason to doubt initial medical certifications, it may require employees to obtain a second opinion at the Company's expense. If the opinions of the initial and second health care providers differ, the Company may, at its expense, require employees to obtain a third, final and binding certification from a health care provider designated or approved jointly by the Company and the employee.

The Company shall provide employees with copies of second or third medical opinions, upon request by employees. Requested copies shall be provided to employees within two business days unless extenuating circumstances prevent such action.

2. Medical Recertifications

Depending on the circumstances and duration of FMLA/CFMLA leave, the Company may require employees to provide recertification of medical conditions giving rise to the need for leave. The Company will notify employees if recertification is required and will give employees at least fifteen (15) calendar days to provide medical recertification.

3. Return to Work/Fitness for Duty Medical Certifications

Unless notified that providing such certifications is not necessary, employees returning to work from FMLA/CFMLA leaves that were taken because of their own serious health conditions that made them unable to perform their jobs must provide the Company medical certification confirming they are able to return to work and/or the employees' ability to perform the essential functions of the employees' position, with or without reasonable accommodation. The Company may delay job restoration following leave, other than an intermittent leave under the CFMLA, until employees provide return to work/fitness for duty certifications.

D. Submit Certifications Supporting Need for Military Family Leave

Upon request, the first time employees seek leave due to qualifying exigencies arising out of a covered active duty or call to a covered active duty status of a military member, the Company may require employees to provide 1) a copy of the military member's active duty orders or other documentation issued by the military indicating the military member is on a covered active duty or call to a covered active duty status and the dates of the military member's covered active duty service; and 2) a certification from the employee setting forth information concerning the nature of the qualifying exigency for which leave is requested. Employees shall provide a copy of new active duty orders or other documentation issued by the military for leaves arising out of qualifying exigencies arising out of a different covered active duty or call to a covered active duty status of the same or a different military member.

When leave is taken to care for a covered servicemember with a serious injury or illness, the Company may require employees to obtain certifications completed by an authorized health care provider of the covered servicemember. In addition, and in accordance with FMLA regulations and/or CFMLA regulations, the Company may request that the certification submitted by the employee set forth additional information provided by the employee and/or the covered servicemember confirming entitlement to such leave.

E. Substitute Paid Leave for Unpaid FMLA and CFMLA Leave

Employees must use any accrued paid time off while taking unpaid FMLA/CFMLA leave. The substitution of paid time for unpaid FMLA/CFMLA leave time does not extend the length of FMLA/CFMLA leaves and the paid time will run concurrently with the employee's FMLA/CFMLA entitlement.

Employees will not be required to use any paid time off during CFMLA leave to the extent it would result in a balance of less than two (2) weeks of paid time off.

Leaves of absence taken in connection with a disability leave plan or workers' compensation injury/illness shall run concurrently with any FMLA/CFMLA leave entitlement. Upon written request, the Company will allow *employees to use accrued paid time to supplement any paid disability benefits.*

F. Pay Employee's Share of Health Insurance Premiums

As noted above, during FMLA and/or CFMLA leave, employees are entitled to continued group health plan coverage under the same conditions as if they had continued to work. Unless the Company notifies employees of other arrangements, whenever employees are receiving pay from the Company during family and medical leave, the Company will deduct the employee portion of the group health plan premium from the employee's paycheck in the same manner as if the employee was actively working. If family and medical leave is unpaid, employees must pay their portion of the group health premium through a method determined by the Company upon leave.

The Company's obligation to maintain health care coverage ceases if the employee's premium payment is more than thirty (30) days late. If the employee's payment is more than 15 days late, the Company will send a letter notifying the employee that coverage will be dropped on a specified date unless the co-payment is received before that date. If employees do not return to work within thirty (30) calendar days at the end of the leave period (unless employees cannot return to work because of a serious health condition or other circumstances beyond their control), they will be required to reimburse the Company for the cost of the premiums the Company paid for maintaining coverage during their unpaid FMLA leave.

IV. Coordination of FMLA/CFMLA Leave with Other Leave Policies

The FMLA and CFMLA do not affect any federal, state or local law prohibiting discrimination, or supersede any State or local law which provides greater family or medical leave rights. However, whenever permissible by law, the Company will run FMLA and/or CFMLA leave concurrently with any other leave provided under state or local law. For additional information concerning leave entitlements and obligations that might arise when FMLA/CFMLA leave is either not available or exhausted, please consult the Company's other leave policies in this handbook or contact Human Resources.

V. Questions and/or Complaints about FMLA/CFMLA Leave

If employees have questions regarding this FMLA/CFMLA policy, they should contact Human Resources. The Company is committed to complying with the FMLA and CFMLA and, whenever necessary, shall interpret and apply this policy in a manner consistent with the FMLA and CFMLA.

The FMLA and CFMLA make it unlawful for employers to 1) interfere with, restrain or deny the exercise of any right provided under FMLA/CFMLA; or 2) discharge or discriminate against any person for opposing any practice made unlawful by FMLA/CFMLA or involvement in any proceeding under or relating to FMLA/CFMLA. If employees believe their FMLA and/or CFMLA rights have been violated, they should contact Human Resources immediately. The Company will investigate any FMLA/CFMLA complaints and take prompt and appropriate remedial action to address and/or remedy any FMLA/CFMLA violation. Employees also may file FMLA/CFMLA complaints with the United States Department of Labor or the Connecticut Department of Labor respectively or may bring private lawsuits alleging FMLA and/or CFMLA violations.

Connecticut Paid Leave Benefits

The Connecticut Paid Family and Medical Leave Act ("PFMLA") is a mandatory statewide insurance program administered by the state-created Connecticut Paid Leave Authority ("the Authority"). Employees may be eligible for Connecticut Paid Leave ("CPL") income replacement benefits beginning January 1, 2022. Benefits are financed through employee contributions to the program, which began on January 1, 2021. The Authority is solely responsible for determining whether the employee is eligible for benefits and the amount of any benefits payable.

It is the employee's responsibility to apply for CPL benefits and to cooperate in the CPL application process.

Receipt of CPL benefits does not, by itself, provide job protection to employees. For employees to be considered for job-protected leave, they must follow the process for requesting leave under the federal Family and Medical Leave Act (FMLA) and/or Connecticut Family and Medical Leave Act (CFMLA) or other job-protected leave. CPL benefit periods may run concurrently with FMLA/CFMLA or other leaves. Please see the Connecticut Family and Medical Leave policy for more information on employees' rights and obligations under this policy.

Eligibility Requirements

To be eligible for CPL benefits, the employee must have earned at least $2,325 during one of the first four (4) of the five (5) most recently completed quarters and be presently employed or employed in the previous 12 weeks. The amount of paid benefits will vary depending upon the employee's wages, and the maximum available benefit is capped at 60 times the state minimum wage. For additional information on benefits available, please visit https://ctpaidleave.org.

Amount of Benefits

Employees are eligible for up to twelve (12) weeks of CPL benefits, with an additional two (2) weeks of CPL benefits available for a serious health condition resulting in incapacitation that occurs during a pregnancy.

If benefits are to care for an injured servicemember, then up to twelve (12) weeks of CPL benefits are available, notwithstanding any additional approved leave for this reason. Up to twelve (12) days of CPL benefits are available for otherwise unpaid family violence leave pursuant to Conn. Gen. Stat. Sec. 31-51ss.

Entitlement

Employees may apply for CPL benefits:

- for the employee's own serious health condition;
- to care for the employee's child after birth or placement for adoption or foster care;
- to care for the serious health condition of the employee's family member;
- to serve as an organ or bone marrow donor;
- for any qualifying exigency;
- to care for an injured servicemember; and
- for otherwise unpaid family violence leave pursuant to Conn. Gen. Stat. Sec. 31-51ss.

"Family member" for the purpose of this policy means a spouse, sibling, child, grandparent, grandchild or parent, or an individual related to the employee by blood or affinity whose close association the employee shows to be the equivalent of those family relationships.

Interaction with Other Paid Benefits

If the employee needs time away from work for a reason covered by CPL benefits, they will not be eligible to use any paid benefits provided by the Company unless they apply for benefits from the Authority, including providing all required information to the Authority in connection with the application. That includes eligibility to use benefits provided by the Company to supplement CPL benefits up to 100% of the employee's regular pay. The Company may require the employee to provide proof of application and/or approval for CPL benefits.

If the employee has applied to the Authority to receive CPL benefits and such application is denied, the employee may be required to use accrued paid time off for the applicable time period (unless the period of time is covered by CFMLA and the employee has two (2) weeks or fewer of paid time off remaining).

Regardless of any remaining available benefits provided by the Company, employees who are unable to demonstrate entitlement to job protection for their time away from work may be subject to disciplinary action under the Company's attendance policy.

Questions and/or Complaints

If employees have questions regarding this policy, they should contact Human Resources.

The Company prohibits retaliation against employees for requesting or using paid leave benefits or otherwise exercising or attempting to exercise any right provided in this policy or by the PFMLA. Employees may file a complaint regarding CPL benefits with the **Connecticut Department of Labor, 200 Folly Brook Boulevard, Wethersfield, CT 06109, telephone 860-263-6000**.

Connecticut Leave for Family or Domestic Violence

Employees who are victims of family or domestic violence may take at least twelve (12) days of unpaid leave during any calendar year for a qualifying purpose. "Family violence" includes incidents resulting in physical harm, bodily injury, assault, or an act of threatened violence between family or household members. "Domestic violence" includes family violence, as well as stalking, threatening or intimidation, or coercive control.

Reasons for Leave

Employees may take leave under this policy to:

- seek medical care or counseling for injury or disability as a result of family or domestic violence (including for a child who is a victim of domestic violence, provided the employee is not the perpetrator of the domestic violence against the child);
- obtain services from a victim services organization;
- obtain psychological counseling related to an incident(s) of family or domestic violence (including for a child who is a victim of domestic violence, provided the employee is not the perpetrator of the domestic violence against the child);
- take action to increase safety from future incidents of domestic violence, including temporary or permanent relocation; or
- obtain legal services, assist in the prosecution of the offense, or otherwise participate in any civil or criminal proceeding related to or resulting from such family or domestic violence.

Notice

To the extent practicable, employees must provide reasonable notice (preferably seven (7) days) to request a domestic or family violence leave.

Documentation

Employees should provide one (1) of the following documents in connection with their use of family or domestic violence leave: a signed, written statement certifying that the leave is a result of an incident of family or domestic violence; a police or court record related to the incident of family or domestic violence; or a signed, written statement that the employee is a victim of family or domestic violence from an employee or agent of a victim services organization, an attorney, an employee of the office of victim services or victim advocate or a medical professional or other professional from whom the employee has sought assistance concerning the incident of family violence. The Company will make every attempt to ensure documents provided in support of a family or domestic leave request under this policy remain confidential and protected from disclosure unless required by law.

Unpaid Leave

Employees are not paid while on a domestic or family violence leave but may use any accrued and unused paid time off time in connection with use of this leave.

Eligible employees also may apply to the Connecticut Paid Leave Authority to receive benefits for the otherwise unpaid family violence leave under this policy (up to 12 days). For more information, please consult the Connecticut Paid Leave Benefits policy.

Reinstatement

Employees who take leave under this policy will be returned to the position they held at the time when the leave commenced or to a position with equivalent benefits, pay, and other terms and conditions of employment.

Enforcement and Retaliation

Employees will not be subject to discharge, harassment, or discrimination for exercising rights or attempting to exercise rights under this policy, opposing practices that they believe to be in violation of this policy, or supporting the exercise of rights of another under this policy.

If employees have any questions regarding this policy, they should contact Human Resources.

CHESTNUT
HEALTH SYSTEMS

CONNECTICUT SUPPLEMENT ACKNOWLEDGMENT

This Connecticut Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

> **I have received and read a copy of Chestnut Health Systems Connecticut Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.**
>
> **I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.**
>
> **I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.**
>
> **I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.**

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT HEALTH SYSTEMS

RECEIPT OF CONNECTICUT NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers, or employees by another employee, supervisor, vendor, customer, or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth, and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military and veteran status, physical or mental disability, genetic information, or any other characteristic protected by applicable federal, state, or local laws (referred to as "protected characteristics"). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted, or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws is illegal and prohibited by Connecticut and federal law in the workplace, pursuant to § 46a-60(a)(8) of the Connecticut General Statutes and Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq*.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual, or physical conduct that denigrates or shows hostility or aversion toward an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures, or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts, or e-mails), or physical conduct (including physically threatening another, blocking someone's way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state, or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities, and other verbal, visual, or physical conduct of a sexual nature when:

- Submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- Submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or

- The conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Examples of conduct that violate this policy include:

1. Unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
2. Requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
3. Obscene or vulgar gestures, posters, or comments;
4. Sexual jokes or comments about a person's body, sexual prowess, or sexual deficiencies;
5. Propositions or suggestive or insulting comments of a sexual nature;
6. Derogatory cartoons, posters, and drawings;
7. Sexually-explicit e-mails, text messages, or voicemails;
8. Uninvited touching of a sexual nature;
9. Unwelcome sexually-related comments;
10. Conversation about one's own or someone else's sex life;
11. Conduct or comments consistently targeted at only one (1) gender, even if the content is not sexual; and
12. Teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedure

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If employees feel they have been subjected to any such retaliation, they should report it in the same manner in which they would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

Although employees are encouraged to report claims internally, if an employee believes that they have been subjected to sexual harassment or other harassment in violation of state law, the employee may file a formal complaint with the Connecticut Commission on Human Rights and Opportunities (the "Commission") at 860-541-3400, CT Toll Free 1-800-477-5737, or online at www.ct.gov/CHRO.

Individuals who engage in acts of sexual harassment or other harassment in violation of state law may be subject to civil penalties in the form of a cease and desist orders, back pay, compensatory damages, hiring, promotion, or reinstatement, emotional distress, as well as attorney's fees, costs, pre- and post- judgment interest, and punitive damages (if the case is tried in court). Individuals may also be subject to additional criminal penalties stemming from acts of sexual harassment.

Connecticut law requires that a written complaint be filed with the Commission within 300 days of the date the alleged harassment.

I have read and I understand Chestnut Health Systems Connecticut Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____ Date: _____

The signed original copy of this receipt should be given to Human Resources - to be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

ADDENDUM – District of Columbia Supplement – 2024



Chestnut Health Systems

Personnel Policies

District of Columbia Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This District of Columbia Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, District of Columbia employees will receive the Company's Personnel Policies and the District of Columbia Supplement to the Personnel Policies ("District of Columbia Supplement) (together the "Employee Handbook").

The District of Columbia Supplement applies only to District of Columbia employees. It is intended as a resource containing specific provisions derived under District of Columbia law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the District of Columbia Supplement are different from or more generous than those in the National Handbook, the policies in the District of Columbia Supplement will apply.

The District of Columbia Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

DC Pregnancy Accommodations

Chestnut Health Systems will endeavor to provide reasonable accommodations to employees working in the District of Columbia who are affected by pregnancy, childbirth or related medical conditions as required by law, unless such accommodations would result in an undue hardship to the Company. The Company will engage in a good faith and timely interactive process to determine whether a reasonable accommodation can be provided for such employees. Employees may be asked to provide necessary

medical certification. Reasonable accommodations may include: more frequent or longer breaks, time off to recover from childbirth, equipment modification, light duty and having the employee refrain from heavy lifting.

Employees with questions regarding this policy can contact Human Resources.

TIME OFF AND LEAVES OF ABSENCE

DC Sick and Safe Time

Eligibility

The Company provides paid sick leave pursuant to the District of Columbia Accrued Sick and Safe Leave Act to all employees who spend fifty percent (50%) of their working time in the District of Columbia (the District) or whose employment is based in the District and who regularly spend a substantial part of their time working for the employer in the District and does not spend more than fifty percent (50%) of their work-time working for the employer in any particular state.

Accrual

Employees begin to accrue paid sick leave pursuant to this policy from the date of hire. Employees accrue paid sick leave at a rate of one (1) hour for every thirty-seven (37) hours worked up to a maximum of seven (7) days per calendar year. Exempt employees do not accrue paid sick leave for hours worked beyond a forty (40) hour workweek. For purposes of this policy, the calendar year is the consecutive 12-month period beginning January 1st and ending on December 31st.

Usage

Employees may begin using paid sick leave under this policy after the 90th day of employment. Paid sick leave may be used in minimum increments of one (1) hour. An employee may not use more than seven (7) days of accrued paid sick leave per calendar year.

The employee may use paid sick leave under this policy for the following reasons:

1. an absence resulting from a physical or mental illness, injury, or medical condition of the employee;
2. an absence resulting from obtaining professional medical diagnosis or care or preventive medical care for the employee; or
3. an absence for the purpose of caring for a family member who has any of the conditions or needs for diagnosis or care described in paragraphs (1) and (2) above.

The employee may also use paid leave for an absence if the employee or the employee's family member is a victim of stalking, domestic violence or sexual abuse and the absence is directly related to medical, social, or legal services pertaining to the stalking, domestic violence or sexual abuse for the purposes of:

1. seeking medical attention for the employee or the employee's family member to treat or recover from physical or psychological injury or disability caused by stalking, domestic violence or sexual abuse;

2. obtaining services for the employee or the employee's family member from a victim services organization;
3. obtaining psychological or other counseling services for the employee or the employee's family member;
4. the temporary or permanent relocation of the employee or the employee's family member;
5. taking legal action, including preparing for or participating in any criminal or civil proceeding related to or resulting from stalking, domestic violence or sexual abuse; or
6. taking other actions that could be reasonably determined to enhance the physical, psychological or economic health or safety of the employee or the employee's family member or the safety of those who work or associate with the employee.

For purposes of this policy, family member includes a child (including foster child and grandchild); parent; spouse; domestic partner; the parent of a spouse; spouse of child; sibling; spouse of sibling; a child who lives with an employee and for whom the employee permanently assumes and discharges parental responsibility; and a person with whom the employee shares or has shared, for not less than the preceding twelve (12) months, a mutual residence and with whom the employee maintains a committed relationship, as defined in D.C. Code § 32-701(1)).

Unless the employee advises the Company otherwise, we will assume, subject to applicable law, that employees want to use available paid sick leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have paid sick leave available.

Notice and Documentation

If possible, employees must provide at least ten (10) days prior notice of the planned use of paid sick leave under this policy to their Supervisor. Where ten (10) days prior notice is not possible, the employee must provide notice as soon as possible, ideally in writing to their Supervisor. In the case of an emergency, employees must notify the Company of need to use paid sick leave prior to the start of their next shift or within twenty-four (24) hours of the onset of the emergency, whichever is sooner. Employees are required to make a reasonable effort to schedule paid sick leave in a manner that does not unduly disrupt the Company's operations. If paid sick leave is requested in a non-emergency situation, the employee must consult with the Company regarding the date and time of the paid leave to be taken.

Employees are required to provide reasonable certification of the reason for leave within one business day of return to work where the requested leave under this policy is for three or more consecutive days. A reasonable certification may include:

1. a signed document from a health care provider affirming the illness of the employee or the employee's family member;
2. a police report indicating that the employee or the employee's family member was the victim of stalking, domestic violence or sexual abuse;
3. a court order indicating that the employee or employee's family member was the victim of stalking, domestic violence or sexual abuse;
4. a signed written statement from a victim and witness advocate affirming that the employee or employee's family member is involved in legal action or proceedings related to stalking, domestic violence or sexual abuse. The signed statement shall include only the name of the employee or employee's family member who is a victim and the date on which services were sought; or

5. a signed written statement from a victim and witness advocate, or domestic violence counselor affirming the employee or employee's family member sought services to enhance the physical, psychological or economic health or safety of the employee or employee's family member.

Payment

Paid sick leave under this policy will be calculated based on the employee's base pay rate at the time of absence, unless otherwise required by applicable law, which is no event will be less than minimum wage. It does not include overtime or any special forms of compensation such as incentives, commissions, or bonuses. Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Employees may carry over up to seven (7) days of accrued, unused paid sick leave under this policy. Accrued but unused paid sick leave under this policy will not be paid at separation.

Enforcement & Retaliation

The Company prohibits retaliation against any employees who assert their rights to receive paid sick leave under this policy. The Office of Wage-Hour of the D. C. Department of Employment Services can investigate possible violations. To request full text of the Act, to obtain a copy of the rules associated with this Act, or to file a complaint, contact the Office of Wage-Hour Compliance at (202) 671-1880, 4058 Minnesota Avenue, N.E., Washington, D.C. 20019, or visit https://does.dc.gov/service/office-wage-hour-compliance-0.

Employees with questions regarding this policy can contact Human Resources.

Jury Duty Leave

Chestnut Health Systems realizes that it is the obligation of all U.S. citizens to serve on a jury when summoned to do so. All employees will be allowed time off to perform such civic service as required by law. Employees are expected, however, to provide proper notice of a request to perform jury duty and verification of their service, including fees received for jury duty service.

Employees also are expected to keep management informed of the expected length of jury duty service and to report to work for the major portion of the day if excused by the court. If the required absence presents a serious conflict for management, employees may be asked to try to postpone jury duty.

The Company will pay full-time employees their regular wages, less the fee received for jury service, for up to five (5) days of jury service. Exempt employees will be paid their full salary less jury duty fees for any week in which they performed work for the Company and missed work due to jury service.

The employee will not be considered a full-time employed juror on any day of jury service in which that employee:

- would not have accrued regular wages to be paid by the Company if the employee were not serving as a juror on that day; or

- would not have worked more than half of a shift that extends into another day if the employee was not serving as a juror on that day.

Employers with 10 or fewer employees are not required to pay a juror-employee their usual compensation.

DC Family And Medical Leave

Employees may be entitled to a leave of absence under the Family and Medical Leave Act ("FMLA") and/or the D.C. Family and Medical Leave Act ("DC FMLA"). This policy provides employees with information concerning FMLA/DC FMLA entitlements and obligations employees may have during such leaves. Whenever permitted by law, the Company will run FMLA leave concurrently with DC FMLA and any other leave provided under state or local law. If employees have any questions concerning FMLA and/or DC FMLA leave, they should contact Human Resources.

I. Eligibility

FMLA leave is available to "FMLA eligible employees." To be an "FMLA eligible employee," the employee must: 1) have been employed by the Company for at least 12 months (which need not be consecutive); 2) have been employed by the Company for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave; and 3) be employed at a worksite where fifty (50) or more employees are located within 75 miles of the worksite.

Special hours of service eligibility requirements apply to airline flight crew employees.

DC FMLA leave is available to "DC FMLA eligible employees." To be a "DC FMLA eligible employee," the employee must: 1) have been employed by the Company for at least twelve (12) consecutive or non-consecutive months in the seven (7) years immediately preceding the date on which the period of family or medical leave is to commence; 2) have worked at least 1,000 hours during the 12- month period; and 3) be employed by an employer with 20 or more employees in D.C.

When the employee requests FMLA and/or DC FMLA leave, or when the Company learns that the employee's leave may be for a FMLA/DC FMLA-qualifying reason, the Company will notify the employee within five (5) business days (unless there are extenuating circumstances) whether the employee is eligible to take FMLA and/or DC FMLA leave, as explained below.

II. Entitlements

As described below, the FMLA and/or DC FMLA provides eligible employees with a right to leave, health insurance benefits and, with some limited exceptions, job restoration.

A. Basic FMLA and DCFMLA Leave Entitlement

The FMLA provides eligible employees up to twelve (12) workweeks of unpaid leave for certain family and medical reasons during a twelve- (12-) month period. The DC FMLA provides eligible employees up to 16 workweeks of unpaid leave for certain family reasons during a twenty-four- (24-) month period. In addition, the DC FMLA provides eligible employees up to sixteen (16) workweeks of unpaid leave in a twenty-four-

(24-) month period for the employee's own serious health condition that makes the employee unable to perform the functions of the position. The 12- or 24-month period is determined based on a rolling 12-month period measured backward from the date the employee uses their FMLA leave. The total leave may not exceed twelve (12) weeks in any 12-month period (FMLA) or thirty-two (32) weeks in any 24-month period (DC FMLA) except for leave to care for an injured servicemember which shall not exceed twenty-six (26) weeks of leave during a single 12-month period as described in more detail below. Where both laws apply, the leave provided by each will run concurrently. It is the Company's policy to provide the greater leave benefit provided under the FMLA or DC FMLA and to run leave concurrently under the FMLA and DC FMLA whenever possible.

Leave may be taken for any one, or for a combination, of the following reasons:

- the birth of the employee's child and to care for the employee's newborn child (counts towards FMLA and DC FMLA);
- the placement of a child with the employee for adoption or foster care and to care for the employee's newly placed child (counts towards FMLA and DC FMLA);
- the placement of a child for whom the employee permanently assumes and discharges parental responsibility (counts toward DC FMLA leave entitlements only);
- for the employee's own **serious health condition** (including pregnancy, prenatal medical care or childbirth) that makes the employee unable to perform one or more of the employee's essential job functions (counts towards FMLA and DC FMLA);
- to care for a "family member" with a **serious health condition**, which includes the employee's spouse, child, parent (counts toward FMLA and DC FMLA) or a person to whom the employee is related by blood, legal custody or marriage (counts towards DC FMLA only); a child who resides with the employee and for whom the employee permanently assumes and discharges parental responsibility (counts towards DC FMLA only); or a person with whom the employee shares or has shared within the last year a mutual residence and maintains a committed relationship (counts towards DC FMLA only); and/or
- because of any **qualifying exigency** arising out of the fact that the employee's spouse, son, daughter or parent is a military member on covered active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty) in the Reserve component of the Armed Forces for deployment to a foreign country in support of contingency operation or Regular Armed Forces for deployment to a foreign country (counts towards FMLA only).

A **serious health condition** is an illness, injury, impairment or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) consecutive calendar days combined with at least two (2) visits to a health care provider or one (1) visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, caring for the parents of the military member on covered active duty and attending post-deployment reintegration briefings.

B. Additional Military Family Leave Entitlement (Injured Servicemember Leave) (FMLA Only)

In addition to the basic FMLA leave entitlement discussed above, an eligible employee who is the spouse, son, daughter, parent or next of kin of a **covered servicemember** is entitled to take up to 26 weeks of leave during a single 12-month period to care for the servicemember with a serious injury or illness. Leave to care for a servicemember shall only be available during a single 12-month period and, when combined with other FMLA-qualifying leave, may not exceed 26 weeks during the single 12-month period. The single 12-month period begins on the first day an eligible employee takes leave to care for the injured servicemember.

A **"covered servicemember"** is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is on the temporary retired list for a serious injury or illness. Covered servicemembers also include a veteran who is discharged or released from military service under conditions other than dishonorable at any time during the five (5)-year period preceding the date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation or therapy for a serious injury or illness.

The FMLA definitions of a "serious injury or illness" for current Armed Forces members and covered veterans are distinct from the FMLA definition of "serious health condition" applicable to FMLA leave to care for a covered family member.

C. Intermittent Leave and Reduced Leave Schedules

FMLA and/or DC FMLA leave usually will be taken for a period of consecutive days, weeks or months. However, employees also are entitled to take FMLA and/or DC FMLA leave intermittently or on a reduced leave schedule when medically necessary due to a serious health condition of the employee or covered family member or the serious injury or illness of a covered servicemember (FMLA only). Leave due to qualifying exigencies may also be taken on an intermittent or reduced schedule basis (FMLA only). Unless agreed to by the Company, employees may not take family leave that only qualifies under the DC FMLA for a period of more than twenty-four (24) months.

D. No Work While on Leave

The taking of another job while on FMLA and/or DC FMLA leave or any other authorized leave of absence is grounds for immediate discharge, to the extent permitted by applicable law.

E. Protection of Group Health Insurance Benefits

During FMLA and/or DC FMLA leave, eligible employees are entitled to receive group health plan coverage on the same terms and conditions as if they had continued to work.

F. Restoration of Employment and Benefits

At the end of FMLA leave, subject to some exceptions including situations where job restoration of "key employees" will cause the Company substantial and grievous economic injury, employees generally have

a right to return to the same or equivalent positions with equivalent pay, benefits and other employment terms. The Company will notify employees if they qualify as "key employees," if it intends to deny reinstatement, and their rights in such instances.

As with FMLA leave, at the end of DC FMLA leave, subject to some exceptions, employees generally have the right to return to the same or equivalent position with equivalent pay, benefits and other terms. Under the DC FMLA, key employees may be denied job restoration if the employee is among the five (5) highest paid employees of an employer of fewer than fifty (50) persons or among the highest ten percent (10%) of employees of an employer with fifty (50) or more employees and the following conditions are met: (1) denial of restoration is necessary to prevent substantial economic injury to the Company's operations and the injury is not directly related to the leave that the employee took; and (2) the Company notifies the employee of the intent to deny restoration of employment and the basis for the decision at the time the Company determines denial of restoration of employment is necessary.

Use of FMLA and/or DC FMLA leave will not result in the loss of any employment benefit that accrued prior to the start of an eligible employee's FMLA and/or DC FMLA leave.

G. Notice of Eligibility for, and Designation of, FMLA and DC FMLA Leave

Employees requesting FMLA and/or DC FMLA leave are entitled to receive written notice from the Company telling them whether they are eligible for FMLA and/or DC FMLA leave and, if not eligible, the reasons why they are not eligible. When eligible for FMLA and/or DC FMLA leave, employees are entitled to receive written notice of: 1) their rights and responsibilities in connection with such leave; 2) the Company's designation of leave as FMLA and/or DC FMLA-qualifying or non-qualifying, and if not FMLA and/or DC FMLA-qualifying, the reasons why; and 3) the amount of leave, if known, that will be counted against the employee's leave entitlement.

The Company may retroactively designate leave as FMLA and/or DC FMLA leave with appropriate written notice to employees provided the Company's failure to designate leave as FMLA and/or DC FMLA - qualifying at an earlier date did not cause harm or injury to the employee. In all cases where leaves qualify for FMLA and/or DC FMLA protection, the Company and employee can mutually agree that leave be retroactively designated as FMLA and/or DC FMLA leave.

III. Employee FMLA and DC FMLA Leave Obligations

A. Provide Notice of the Need for Leave

Employees who wish to take FMLA and/or DC FMLA leave must timely notify the Company of their need for FMLA and/or DC FMLA leave. The following describes the content and timing of such employee notices.

1. Content of Employee Notice

To trigger FMLA and/or DC FMLA leave protections, employees must inform Human Resources of the need for FMLA/DC FMLA-qualifying leave and the anticipated timing and duration of the leave, if known. Employees may do this by either requesting FMLA and/or DC FMLA leave specifically, or explaining the

reasons for leave so as to allow the Company to determine that the leave is FMLA/DC FMLA-qualifying. For example, employees might explain that:

- a medical condition renders them unable to perform the functions of their job;
- they are pregnant;
- they have been hospitalized overnight;
- they or a covered family member are under the continuing care of a health care provider;
- they require surgery and a subsequent period of recuperation; or
- they have a chronic medical condition that requires them to be absent from work intermittently.

Calling in "sick," without providing the reasons for the needed leave, will not be considered sufficient notice for FMLA and/or DC FMLA leave under this policy. Employees must respond to the Company's questions to determine if absences are potentially FMLA and/or DC FMLA-qualifying.

If employees fail to explain the reasons for FMLA and/or DC FMLA leave, the leave may be denied. When employees seek leave due to FMLA and/or DC FMLA-qualifying reasons for which the Company has previously provided FMLA and/or DC FMLA-protected leave, they must specifically reference the qualifying reason for the leave or the need for FMLA and/or DC FMLA leave.

2. Timing of Employee Notice

Employees must provide thirty (30) days' advance notice of the need to take FMLA and/or DC FMLA leave when the need is foreseeable. When thirty (30) days' notice is not possible, or the approximate timing of the need for leave is not foreseeable, employees must provide the Company notice of the need for leave as soon as practicable under the facts and circumstances of the particular case. Employees who fail to give thirty (30) days' notice for foreseeable leave without a reasonable excuse for the delay, or otherwise fail to satisfy FMLA and/or DC FMLA notice obligations, may have FMLA and/or DC FMLA leave delayed or denied.

B. Cooperate in the Scheduling of Planned Medical Treatment (Including Accepting Transfers to Alternative Positions) and Intermittent Leave or Reduced Leave Schedules

When planning medical treatment, employees must consult with the Company and make a reasonable effort to schedule treatment so as not to unduly disrupt the Company's operations, subject to the approval of the employee's health care provider. Employees must consult with the Company prior to the scheduling of treatment to work out a treatment schedule that best suits the needs of both the Company and the employees, subject to the approval of the employee's health care provider. If employees providing notice of the need to take FMLA and/or DC FMLA leave on an intermittent basis for planned medical treatment neglect to fulfill this obligation, the Company may require employees to attempt to make such arrangements, subject to the approval of the employee's health care provider.

When employees take intermittent or reduced work schedule leave for foreseeable planned medical treatment for the employee or a family member, including during a period of recovery from a serious health condition or to care for a covered servicemember, the Company may temporarily transfer employees, during the period that the intermittent or reduced leave schedules are required, to alternative positions with equivalent pay and benefits for which the employees are qualified and which better accommodate recurring periods of leave.

When employees seek intermittent leave or a reduced leave schedule for reasons unrelated to the planning of medical treatment, upon request, employees must advise the Company of the reason why such leave is medically necessary. In such instances, the Company and employee shall attempt to work out a leave schedule that meets the employee's needs without unduly disrupting the Company's operations, subject to the approval of the employee's health care provider.

C. Submit Medical Certifications Supporting Need for FMLA and/or DC FMLA Leave (Unrelated to Requests for Military Family Leave)

Depending on the nature of FMLA and/or DC FMLA leave sought, employees may be required to submit medical certifications supporting their need for FMLA-qualifying leave. As described below, there generally are three types of FMLA medical certifications: an **initial certification**, a **recertification** and a **return to work/fitness for duty certification.**

It is the employee's responsibility to provide the Company with timely, complete and sufficient medical certifications. Whenever the Company requests employees to provide FMLA and/or DC FMLA medical certifications, employees must provide the requested certifications within fifteen (15) calendar days after the Company's request, unless it is not practicable to do so despite the employee's diligent, good faith efforts. The Company will inform employees if submitted medical certifications are incomplete or insufficient and provide employees at least seven (7) calendar days to cure deficiencies. The Company will deny FMLA and/or DC FMLA leave to employees who fail to timely cure deficiencies or otherwise fail to timely submit requested medical certifications, to the extent permitted by applicable law.

With the employee's permission, the Company (through individuals other than the employee's direct supervisor) may contact the employee's health care provider to authenticate or clarify completed and sufficient medical certifications. If employees choose not to provide the Company with authorization allowing it to clarify or authenticate certifications with health care providers, the Company may deny FMLA leave if certifications are unclear, to the extent permitted by applicable law.

Whenever the Company deems it appropriate to do so, it may waive its right to receive timely, complete and/or sufficient FMLA and/or DC FMLA medical certifications.

1. Initial Medical Certifications

Employees requesting leave because of their own, or a covered relation's, serious health condition, or to care for a covered servicemember, must supply medical certification supporting the need for such leave from their health care provider or, if applicable, the health care provider of their covered family or service member. If employees provide at least 30 days' notice of medical leave, they should submit the medical certification before leave begins. A new initial medical certification will be required on an annual basis for serious medical conditions lasting beyond a single leave year.

If the Company has reason to doubt initial medical certifications, it may require employees to obtain a second opinion at the Company's expense. If the opinions of the initial and second health care providers differ, the Company may, at its expense, require employees to obtain a third, final and binding certification from a health care provider designated or approved jointly by the Company and the employee.

2. Medical Recertifications

Depending on the circumstances and duration of FMLA and/or DC FMLA leave, the Company may require employees to provide recertification of medical conditions giving rise to the need for leave. The Company will notify employees if recertification is required and will give employees at least fifteen (15) calendar days to provide medical recertification.

3. Return to Work/Fitness for Duty Medical Certifications

Unless notified that providing such certifications is not necessary, employees returning to work from FMLA and/or DC FMLA leaves that were taken because of their own serious health conditions that made them unable to perform their jobs must provide the Company medical certification confirming they are able to return to work and the employees' ability to perform the essential functions of the employees' position, with or without reasonable accommodation. The Company may delay and/or deny job restoration until employees provide return to work/fitness for duty certifications.

D. Submit Certifications Supporting Need for FMLA Military Family Leave

Upon request, the first time employees seek leave due to qualifying exigencies arising out of the covered active duty or call to covered active duty status of a military member, the Company may require employees to provide: 1) a copy of the military member's active duty orders or other documentation issued by the military indicating the military member is on covered active duty or call to covered active duty status and the dates of the military member's covered active duty service; and 2) a certification from the employee setting forth information concerning the nature of the qualifying exigency for which leave is requested. Employees shall provide a copy of new active duty orders or other documentation issued by the military for leaves arising out of qualifying exigencies arising out of a different covered active duty or call to covered active duty status of the same or a different covered military member.

When leave is taken to care for a covered servicemember with a serious injury or illness, the Company may require employees to obtain certifications completed by an authorized health care provider of the covered servicemember. In addition, and in accordance with the FMLA regulations, the Company may request that the certification submitted by employees set forth additional information provided by the employee and/or the covered servicemember confirming entitlement to such leave.

E. Substitute Paid Leave for Unpaid FMLA and/or DC FMLA Leave

Employees must use any accrued paid time while taking unpaid FMLA leave. If leave is covered by the DC FMLA, Employees may elect to "substitute" appropriate accrued paid time off (vacation, sick days, etc.) for unpaid DC FMLA leave, but are not required to do so. The substitution of paid time for unpaid FMLA and/or DC FMLA leave time does not extend the length of FMLA and/or DC FMLA leave and the paid time will run concurrently with the employee's FMLA and/or DC FMLA entitlement.

Leaves of absence taken in connection with a disability leave plan or workers' compensation injury/illness or under the DC Universal Paid Leave Act will run concurrently with any FMLA and/or DC FMLA leave entitlement.

Upon written request, the Company will allow employees to use accrued paid time to supplement any paid disability benefits.

F. Pay Employee's Share of Health Insurance Premiums

During FMLA and/or DC FMLA leave, employees are entitled to continued group health plan coverage under the same conditions as if they had continued to work. Unless the Company notifies employees of other arrangements, whenever employees are receiving pay from the Company during FMLA and/or DC FMLA leave, the Company will deduct the employee portion of the group health plan premium from the employee's paycheck in the same manner as if the employee was actively working.

If FMLA and/or DC FMLA leave is unpaid, employees must pay their portion of the group health premium using a method determined by the Company upon leave.

The Company's obligation to maintain health care coverage ceases if the employee's premium payment is more than thirty (30) days late. If the employee's payment is more than fifteen (15) days late, the Company will send a letter notifying the employee that coverage will be dropped on a specified date unless the co-payment is received before that date. If employees do not return to work within thirty (30) calendar days at the end of the leave period (unless employees cannot return to work because of a serious health condition or other circumstances beyond their control), they will be required to reimburse the Company for the cost of the premiums the Company paid for maintaining coverage during their unpaid FMLA and/or DC FMLA leave.

IV. Coordination of FMLA and/or DC FMLA Leave with Other Leave Policies

The FMLA and DC FMLA do not affect any federal, state or local law prohibiting discrimination, or supersede any State or local law that provides greater family or medical leave rights. However, whenever permissible by law, the Company will run FMLA and/or DC FMLA leave concurrently with any other leave provided under state or local law. For additional information concerning leave entitlements and obligations that might arise when FMLA and/or DC FMLA leave is either not available or exhausted, please consult the Company's other leave policies in this handbook or contact Human Resources.

V. Questions and/or Complaints about FMLA and DC FMLA Leave

If employees have questions regarding this FMLA and DC FMLA policy, they should contact Human Resources. The Company is committed to complying with the FMLA and DC FMLA and, whenever necessary, will interpret and apply this policy in a manner consistent with the FMLA and DC FMLA.

The FMLA and the DC FMLA makes it unlawful for employers to: 1) interfere with, restrain or deny the exercise of any right provided under the FMLA and DC FMLA; or 2) discharge or discriminate against any person for opposing any practice made unlawful by the FMLA and DC FMLA or involvement in any proceeding under or relating to the FMLA and DC FMLA. If employees believe their FMLA or DC FMLA rights have been violated, they should contact Human Resources immediately. The Company will investigate any FMLA and DC FMLA complaints and take prompt and appropriate remedial action to address and/or remedy any FMLA or DC FMLA violation. Employees also may file FMLA complaints with the United States Department of Labor or may bring private lawsuits alleging FMLA violations.

DC Paid Family And Medical Leave Benefits

Employees may be eligible for paid leave benefits for covered events pursuant to the District of Columbia Universal Paid Leave Amendment Act (UPLA). The UPLA is a paid leave benefit administered by the Office of Paid Family Leave (OPFL) at the District of Columbia Department of Employment Services. Benefits are funded through an employer payroll tax, not deducted from employees' pay. The District of Columbia (the "District") is solely responsible for determining eligibility for paid leave benefits under the UPLA.

Eligibility

To be eligible for paid leave benefits, employees must have been a covered employee during some or all of the 52 calendar weeks immediately preceding the qualifying event for which paid leave is being taken. A covered employee is someone who either spends more than 50% of their work time for Chestnut Health Systems working in the District; or whose employment for Chestnut Health Systems is based in the District, who regularly spends a substantial amount of the work time in the District, and who does not spend more than 50% of their work time for Chestnut Health Systems in another jurisdiction.

Covered Events

Paid leave benefits are available for the following covered events:

- family leave to care for a family member with a serious health condition;
- medical leave for the employee's own serious health condition (including the occurrence of a stillbirth and the medical care related to a miscarriage);
- parental leave to bond with the employee's child after the child's birth, placement of a child for adoption or foster care, or placement of a child with the employee who will legally assume and discharge parental responsibility ("parental leave event"); and
- prenatal leave for covered prenatal medical care following the diagnosis of pregnancy by a health care provider and prior to the occurrence of a parental leave event.

Parental leave benefits must be used within 52 calendar weeks of the qualifying parental leave event.

Family Member Definitions

For purposes of paid leave benefits, a family member includes the employee's:

- biological, adopted or foster child, a stepchild, a legal ward, a child of a domestic partner, or a person to whom the employee stands in loco parentis;
- biological, foster or adoptive parent, a parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to when the employee was a child;
- a person to whom the employee is related by domestic partnership or marriage;
- grandparent, which means the biological, foster, adoptive or stepparent of the employee's biological, foster, adoptive or stepparent; or
- a sibling, which means the biological, half-, step-, adopted-, or foster-sibling or sibling-in-law of the employee.

Benefit Amounts

The amount of paid leave benefits that may be payable varies depending on the covered event and the date of filing for paid leave benefits, as follows.

For claims filed before October 1, 2022:

- family leave benefit is up to six (6) workweeks within a 52-calendar week period;
- medical leave benefit is up to six (6) workweeks within a 52-calendar week period;
- parental leave benefit is up to eight (8) workweeks within a 52-calendar week period; and
- prenatal leave benefit is up to two (2) workweeks within a 52-calendar week period

For claims filed on or after October 1, 2022:

- family leave benefit is up to twelve (12) workweeks within a 52-calendar week period
- medical leave benefit is up to twelve (12) workweeks within a 52-calendar week period
- parental leave benefit is up to twelve (12) workweeks within a 52-calendar week period; and
- prenatal leave benefit is up to two (2) workweeks within a 52-calendar week period.

For claims filed before October 1, 2022, the aggregate maximum amount of paid leave benefits that may be received within a 52-calendar week period for family, medical or parental leave is eight (8) workweeks. However, employees may take up to a total of ten (10) workweeks in a 52-calendar week period when parental leave and prenatal leave are combined although they may not receive any combination of prenatal leave and medical leave for more than six (6) weeks in a 52-calendar week period.

For claims filed on or after October 1, 2022, the aggregate maximum amount of paid leave benefits that may be received within a 52-calendar week period for family, medical or parental leave is twelve (12) workweeks. However, employees may take up to a total of fourteen (14) workweeks in a 52-calendar week period when parental leave and prenatal leave are combined, although they may not receive any combination of prenatal leave and medical leave for more than twelve (12) weeks in a 52-calendar week period.

The amount of benefits will be calculated by the District and will depend in part on the employee's average weekly wage as reported by the Company to the Department of Employment Services, subject to a maximum weekly benefit amount.

Employees may elect to receive paid leave benefits either intermittently or continuously in increments of no less than one (1) day.

Employees who have experienced an event that may qualify for paid leave benefits may contact Human Resources for information about the District's paid leave benefits program and how to apply for benefits. Employees also can learn more about applying for benefits with the OPFL: dcpaidfamilyleave.dc.gov

Notice and Documentation

Employees must, to the extent practicable, provide written notice of their need to use paid leave benefits to Human Resources before taking leave. If the need is foreseeable, written notice must be given at least ten (10) business days in advance. If the need is not foreseeable, notice must be provided in writing, or orally in exigent circumstances, before the start of the work shift for which the individual intends to first take time

off for a covered event. In the case of an emergency that prevents the employee from providing notice before the start of the work shift, the eligible employee, or another individual, must notify the Company in writing, or orally in exigent circumstances, within forty-eight (48) hours after the emergency occurs. The eligible employee, or someone on their behalf, must supplement oral notice with written notice as soon as practicable.

The written or oral notice should include:

- the type of covered event;
- the expected duration of the time off work for the covered event;
- the expected start and end dates of the time off work for the covered event; and
- whether the paid leave benefits sought will initially be used continuously or intermittently.

Job Protection

The UPLA does not provide job protection to employees when they take time off work and receive paid leave benefits unless they qualify for such reinstatement under federal or D.C. family and medical leave laws. Any time off for events that qualify for paid leave benefits will run concurrently with other leaves of absence, such as Family and Medical Leave and D.C. Family and Medical Leave, if applicable. Please see the Family and Medical Leave and D.C. Family and Medical Leave policies for eligibility requirements.

Retaliation

The Company prohibits retaliation against employees for requesting or using paid leave benefits or otherwise exercising or attempting to exercise any right provided in this policy or the UPLA.

Employees with questions regarding these benefits can contact Human Resources.

DC Time Off For School-Related Activities

Chestnut Health Systems will grant employees who are parents, guardians, aunts, uncles, grandparents or stepparents of school-age children up to twenty-four (24) hours of unpaid leave during any twelve- (12-) month period to attend or participate in a school-related event in which the employee's child is a participant or a subject. School-related events include those sponsored by either the school or an associated organization, such as a parent-teacher association. Examples of school-related events include a concert, play or rehearsal, a sporting event or a meeting with a teacher or counselor.

When possible, employees should provide ten (10) days' advance notice to Human Resources. Employees may use accrued paid time off for the otherwise unpaid leave. Leave may be denied if it would unduly disrupt the Company's business and make the achievement of production or service delivery unusually difficult.

CHESTNUT
HEALTH SYSTEMS

DISTRICT OF COLUMBIA SUPPLEMENT ACKNOWLEDGMENT

This District of Columbia Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

> **I have received and read a copy of Chestnut Health Systems District of Columbia Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.**
>
> **I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.**
>
> **I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.**
>
> **I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.**

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as "protected characteristics"). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone's way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

13. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
14. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
15. obscene or vulgar gestures, posters or comments;
16. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;
17. propositions or suggestive or insulting comments of a sexual nature;
18. derogatory cartoons, posters and drawings;
19. sexually-explicit e-mails, text messages or voicemails;
20. uninvited touching of a sexual nature;
21. unwelcome sexually-related comments;
22. conversation about one's own or someone else's sex life;
23. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
24. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

CHESTNUT HEALTH SYSTEMS

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

ADDENDUM – Florida Supplement – 2024



Chestnut Health Systems

Personnel Policies

Florida Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Florida Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Florida employees will receive the Company's Personnel Policies and the Florida Supplement to the Personnel Policies ("Florida Supplement) (together the "Employee Handbook").

The Florida Supplement applies only to Florida employees. It is intended as a resource containing specific provisions derived under Florida law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Florida Supplement are different from or more generous than those in the National Handbook, the policies in the Florida Supplement will apply.

The Florida Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

TIME OFF AND LEAVES OF ABSENCE

Florida Domestic Violence Leave

Employees who have worked for the Company for at least three (3) months may be granted up to three (3) days of unpaid leave in any twelve- (12-) month period if the employee or a family or household member of the employee is the victim of domestic violence.

Leave may be used to:

- seek an injunction for protection against domestic violence or an injunction for protection in cases of repeat violence, dating violence or sexual violence;
- obtain medical care or mental health counseling, or both, for the employee or a family or household member to address physical or psychological injuries resulting from the act of domestic violence;
- obtain services from a victim-services organization, including, but not limited to, a domestic violence shelter or program or a rape crisis center as a result of the act of domestic violence;
- make their home secure from the perpetrator of the domestic violence or to seek new housing to escape the perpetrator; or
- seek legal assistance in addressing issues arising from the act of domestic violence.

“Family or household member” means spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a family, and persons who are parents of a child in common regardless of whether they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit.

Except in cases of imminent danger to the health or safety of the employees or their family or household member, one (1) day advance notice of the need for leave is required. Sufficient documentation of the act of domestic violence, such as a restraining order, police report or order to appear in court, is also required. Requests for leave and documents in connection with this leave will be kept confidential to the extent permitted by law.

All paid time off available must be exhausted before receiving this leave.

CHESTNUT
HEALTH SYSTEMS

FLORIDA SUPPLEMENT ACKNOWLEDGMENT

This Florida Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

> **I have received and read a copy of Chestnut Health Systems Florida Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.**
>
> **I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.**
>
> **I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.**
>
> **I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.**

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as "protected characteristics"). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone's way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

25. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
26. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
27. obscene or vulgar gestures, posters or comments;
28. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;
29. propositions or suggestive or insulting comments of a sexual nature;
30. derogatory cartoons, posters and drawings;
31. sexually-explicit e-mails, text messages or voicemails;
32. uninvited touching of a sexual nature;
33. unwelcome sexually-related comments;
34. conversation about one's own or someone else's sex life;
35. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
36. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

CHESTNUT HEALTH SYSTEMS

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

ADDENDUM – Georgia Supplement – 2024



Chestnut Health Systems

Personnel Policies

Georgia Supplement
2024

CHESTNUT HEALTH SYSTEMS

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Georgia Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Georgia employees will receive the Company's Personnel Policies and the Georgia Supplement to the Personnel Policies ("Georgia Supplement) (together the "Employee Handbook").

The Georgia Supplement applies only to Georgia employees. It is intended as a resource containing specific provisions derived under Georgia law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Georgia Supplement are different from or more generous than those in the National Handbook, the policies in the Georgia Supplement will apply.

The Georgia Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

PAY PRACTICES

Georgia Lactation Accommodations

Chestnut Health Systems supports the legal right and necessity of employees who choose to express milk in the workplace. The Company promotes a breastfeeding-friendly work environment and supports lactating employees.

The Company will provide break time of reasonable duration to employees who wish to express breast milk at the worksite during working hours. Any break time provided under the law will be paid at the employee's regular rate of compensation.

The Company will provide the use of a private location, other than a restroom, for the employee to express milk in private at the worksite.

Employees can contact Human Resources with questions regarding this policy.

CHESTNUT
HEALTH SYSTEMS

GEORGIA SUPPLEMENT ACKNOWLEDGMENT

This Georgia Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Georgia Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

37. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
38. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
39. obscene or vulgar gestures, posters or comments;
40. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;
41. propositions or suggestive or insulting comments of a sexual nature;
42. derogatory cartoons, posters and drawings;
43. sexually-explicit e-mails, text messages or voicemails;
44. uninvited touching of a sexual nature;
45. unwelcome sexually-related comments;
46. conversation about one's own or someone else's sex life;
47. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
48. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

ADDENDUM – Indiana Supplement – 2024



Chestnut Health Systems

Personnel Policies

Indiana Supplement

2024

CHESTNUT HEALTH SYSTEMS

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Indiana Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Indiana employees will receive the Company's Personnel Policies and the Indiana Supplement to the Personnel Policies ("Indiana Supplement) (together the "Employee Handbook").

The Indiana Supplement applies only to Indiana employees. It is intended as a resource containing specific provisions derived under Indiana law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Indiana Supplement are different from or more generous than those in the National Handbook, the policies in the Indiana Supplement will apply.

The Indiana Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

TIME OFF AND LEAVES OF ABSENCE

Indiana Family Military Leave

Employees who have been employed by Chestnut Health Systems for at least twelve (12) months, have worked at least 1,500 hours during the twelve- (12-) month period immediately preceding the day the leave begins, and are the spouse, parent, grandparent, child or sibling of an individual ordered to active duty, are eligible for an unpaid leave of absence for up to ten (10) days each calendar year.

Leave may be taken during any of the following periods:

- during the thirty (30) days before active-duty orders are in effect;
- during a period in which the military family member ordered to active duty is on leave while on active-duty orders are in effect;

- during the thirty (30)days after the active duty orders are terminated.

Employees may elect to substitute any accrued paid time off (except for paid medical or sick leave) for leave provided under this policy. If applicable, health care benefits will be continued at the employee's expense during the period of leave.

Employees must provide written notice to the Company at least thirty (30) days in advance; notice must include a copy of the active-duty orders (if available) and an indication of the date the leave will begin. If the active-duty orders are issued less than thirty (30) days before the date the requested leave is to begin, written notice must be provided as soon as possible under such circumstances. The Company reserves the right to require verification of eligibility for this leave. Failure to provide such verification within a reasonable time after it was requested may result in the absence from employment being considered unexcused.

Upon returning from leave, in most cases the employee will be restored to the position they held before the leave began or to an equivalent position.

CHESTNUT
HEALTH SYSTEMS

INDIANA SUPPLEMENT ACKNOWLEDGMENT

This Indiana Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Indiana Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

49. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
50. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
51. obscene or vulgar gestures, posters or comments;
52. sexual jokes or comments about a person’s body, sexual prowess or sexual deficiencies;
53. propositions or suggestive or insulting comments of a sexual nature;
54. derogatory cartoons, posters and drawings;
55. sexually-explicit e-mails, text messages or voicemails;
56. uninvited touching of a sexual nature;
57. unwelcome sexually-related comments;
58. conversation about one’s own or someone else’s sex life;
59. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
60. teasing or other conduct directed toward a person because of the person’s gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

ADDENDUM – Kentucky Supplement – 2024



Chestnut Health Systems

Personnel Policies

Kentucky Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Kentucky Supplement

Chestnut Health Systems (“Chestnut” or “the Company”) is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Kentucky employees will receive the Company’s Personnel Policies and the Kentucky Supplement to the Personnel Policies (“Kentucky Supplement) (together the “Employee Handbook”).

The Kentucky Supplement applies only to Kentucky employees. It is intended as a resource containing specific provisions derived under Kentucky law that apply to the employee’s employment. It should be read together with the National Handbook and, to the extent that the policies in the Kentucky Supplement are different from or more generous than those in the National Handbook, the policies in the Kentucky Supplement will apply.

The Kentucky Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person’s authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

TIME OFF AND LEAVES OF ABSENCE

Kentucky Adoption Leave

Subject to limited exceptions and consistent with Kentucky law, Employees are entitled to an unpaid leave of absence of up to six (6) weeks for the purposes of adopting a child under the age of ten. Advance written notice is required. The Company may require verification of adoption. Leave runs concurrently with any other leave provided by the Company.

Employees may use accrued time off for this purpose.

CHESTNUT
HEALTH SYSTEMS

KENTUCKY SUPPLEMENT ACKNOWLEDGMENT

This Kentucky Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Kentucky Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

61. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
62. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
63. obscene or vulgar gestures, posters or comments;
64. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;
65. propositions or suggestive or insulting comments of a sexual nature;
66. derogatory cartoons, posters and drawings;
67. sexually-explicit e-mails, text messages or voicemails;
68. uninvited touching of a sexual nature;
69. unwelcome sexually-related comments;
70. conversation about one's own or someone else's sex life;
71. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
72. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

ADDENDUM – Massachusetts Supplement – 2024



Chestnut Health Systems

Personnel Policies

Massachusetts Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Massachusetts Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Massachusetts employees will receive the Company's Personnel Policies and the Massachusetts Supplement to the Personnel Policies ("Massachusetts Supplement) (together the "Employee Handbook").

The Massachusetts Supplement applies only to Massachusetts employees. It is intended as a resource containing specific provisions derived under Massachusetts law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Massachusetts Supplement are different from or more generous than those in the National Handbook, the policies in the Massachusetts Supplement will apply.

The Massachusetts Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

Massachusetts Non-Harassment

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as "protected characteristics"). Such conduct will not be tolerated by Chestnut.

The purpose of this policy is not to regulate employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion toward an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone's way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

1. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
2. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
3. obscene or vulgar gestures, posters or comments;
4. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;
5. propositions, or suggestive or insulting comments of a sexual nature;

6. derogatory cartoons, posters and drawings;
7. sexually-explicit e-mails, text messages or voicemails;
8. uninvited touching of a sexual nature;
9. unwelcome sexually-related comments;
10. conversation about one's own or someone else's sex life;
11. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
12. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If employees have been subjected to or witnessed conduct which violates this policy, they should immediately report the matter to the Employee's Supervisor. If they are unable for any reason to contact this person, or if they have not received an initial response within five (5) business days after reporting any incident of what they perceive to be harassment, they should contact Human Resources at 50 Northgate Industrial Dr. Granite City, IL 62040 or 618.877.4420. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If employees feel they have been subjected to any such retaliation, they should report it in the same manner in which they would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

Although employees are encouraged to report claims internally, if they believe they have been subjected to sexual harassment or other harassment in violation of state law, they may file a formal complaint with the government agency or agencies set forth below. Using the Company's complaint process does not prohibit the employee from filing a complaint with these agencies.

- The United States Equal Employment Opportunity Commission (EEOC) JFK Federal Building, Room 475 Boston, Massachusetts 02203, (617) 565-3200
- The Massachusetts Commission Against Discrimination (MCAD) Boston Office: One Ashburton Place, Room 601, Boston, MA 02108, (617) 994-6000

- Springfield Office: 436 Dwight Street, Room 220, Springfield, MA 01103, (413) 739-2145
- New Bedford Office: 128 Union Street, Suite 206, New Bedford, MA 02740, (774) 510-5801
- Worcester Office: 484 Main Street, Room 320, Worcester, MA 01608, (508) 453-9630

PAY PRACTICES

Massachusetts Pregnancy Accommodations

Under the Massachusetts Pregnant Workers Fairness Act, employees have the right to be free from discrimination in relation to pregnancy or a condition related to the employee's pregnancy including, but not limited to, lactation or the need to express breast milk for a nursing child, including the right to reasonable accommodations for conditions related to pregnancy.

Reasonable Accommodations

Chestnut Health Systems will provide a reasonable accommodation for the employee's pregnancy or any condition related to the employee's pregnancy including, but not limited to, lactation or the need to express breast milk for a nursing child if the employee requests such an accommodation. However, the Company may deny such an accommodation if the accommodation would impose an undue hardship on the Company's program, enterprise or business.

Reasonable accommodations may include, but are not limited to:

1. more frequent or longer paid or unpaid breaks;
2. time off to attend to a pregnancy complication or recover from childbirth with or without pay;
3. acquisition or modification of equipment or seating;
4. temporary transfer to a less strenuous or less hazardous position;
5. job restructuring;
6. light duty;
7. private non-bathroom space for expressing breast milk;
8. assistance with manual labor; or
9. a modified work schedule; provided, however, that the Company is not required to discharge or transfer the employee with more seniority or promote the employee who is not able to perform the essential functions of the job with or without a reasonable accommodation.

Notice and Documentation

Upon receiving a request for an accommodation from the employee or prospective employee capable of performing the essential functions of the position involved, the Company will engage in a timely, good faith and interactive process with the employee or prospective employee to determine an effective, reasonable accommodation to enable the employee or prospective employee to perform the essential functions of the

employee's job or the position to which the prospective employee has applied. The Company may require the employee or prospective employee to provide documentation from an appropriate health care or rehabilitation professional about the need for a reasonable accommodation; however, the Company will not require documentation for the following accommodations:

1. more frequent restroom, food or water breaks;
2. seating;
3. limits on lifting more than twenty (20) pounds; and
4. private non-bathroom space for expressing breast milk.

The Company also may require documentation for an extension of the accommodation beyond the originally agreed to accommodation.

The employee who notifies the Company of a pregnancy or of a condition related to the employee's pregnancy including, but not limited to, lactation or the need to express breast milk for a nursing child will receive an additional copy of this notice not more than ten (10) days after the notification.

Enforcement and Retaliation

The Company will not:

1. take adverse action against the employee who requests or uses a reasonable accommodation in terms, conditions or privileges of employment including, but not limited to, failing to reinstate the employee to the original employment status or to an equivalent position with equivalent pay and accumulated seniority, retirement, fringe benefits and other applicable service credits when the need for a reasonable accommodation ceases;
2. deny an employment opportunity to the employee if the denial is based on the need to make a reasonable accommodation to the known conditions related to the employee's pregnancy including, but not limited to, lactation or the need to express breast milk for a nursing child;
3. require the employee affected by pregnancy or a condition related to the pregnancy, including, but not limited to, lactation or the need to express breast milk for a nursing child, to accept an accommodation that the employee chooses not to accept, if that accommodation is unnecessary to enable the employee to perform the essential functions of the job;
4. require the employee to take a leave if another reasonable accommodation may be provided for the known conditions related to the employee's pregnancy, including, but not limited to, lactation or the need to express breast milk for a nursing child, without undue hardship on the Company's program, enterprise or business;
5. refuse to hire a person who is pregnant because of the pregnancy or because of a condition related to the person's pregnancy, including, but not limited to, lactation or the need to express breast milk for a nursing child; provided, however, that the person is capable of performing the essential functions of the position with a reasonable accommodation and that reasonable accommodation would not impose an undue hardship, demonstrated by the Company, on the Company's program, enterprise or business.

If employees have any questions about or would like to request a reasonable accommodation pursuant to this policy, they should contact Human Resources.

Massachusetts Paid Family and Medical Leave Benefits

Eligibility Requirements

All employees working in Massachusetts are eligible for Paid Family and Medical Leave Benefits under the Massachusetts Paid Family and Medical Leave Act (PFMLA), provided they are eligible for unemployment compensation in Massachusetts and receive wages from a Massachusetts employer. Former employees also may be eligible for paid benefits, to the extent they have been separated from the Company for not more than twenty-six (26) weeks at the start of their leave and have not found subsequent employment at the time their leave begins.

Entitlement

Eligible employees may take up to twenty-six (26) weeks of job-protected Paid Family and Medical Leave for certain family and medical reasons during the course of a benefit year.

The benefit year is calculated prospectively looking at the fifty-two- (52-) week period beginning on the Sunday *immediately preceding* the first day of job-protected leave for the employee. Paid Family and Medical Leave may be taken for any one (1), or for a combination, of the following reasons:

- *Up to* twelve (12) weeks of family leave:
    - To bond with a child during the first twelve (12) months after the child's birth, adoption, or foster care placement;
    - For a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces; or
    - To care for a covered family member, who has a serious health condition.
- *Up to* twenty-six (26) weeks of family leave to care for a family member who is a covered service member with a serious health condition;
- *Up to* twenty (20) weeks of medical leave for their own serious health condition that makes them unable to perform one (1) or more of the essential functions of their job.

For purposes of this policy, a **covered family member** includes the employee's spouse, domestic partner, child, parent, parent of a spouse or domestic partner, a person who stood *in loco parentis* when the employee was a minor child, grandchild, grandparent, or sibling.

For purposes of this policy, a **serious health condition** is an illness, injury, impairment, or physical or mental condition that involves: inpatient care in a hospital, hospice, or residential medical facility, or continuing treatment by a health care provider.

For purposes of this policy, **qualifying exigencies** may include caring for a military member's child or other family member of the military member on covered active duty, making financial or legal arrangements for the military member, attending counseling, attending military events or ceremonies, spending time with the

military member during a rest and recuperation leave or following return from deployment, or making arrangements following the death of the military member.

For purposes of this policy, **a covered servicemember** is either:

- A member of the Armed Forces, including a member of the National Guard or Reserves, who is: undergoing medical treatment, recuperation, or therapy; otherwise in outpatient status; or is otherwise on the temporary disability retired list for a serious injury or illness that was incurred by the member in the line of duty on active duty in the Armed Forces, or a serious injury or illness that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces; or

- A former member of the Armed Forces, including a former member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy for a serious injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces, or a serious injury or illness that existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces and manifested before or after the member was discharged or released from service.

Leave and benefits are administered by the Massachusetts Department of Family and Medical Leave (the Department). Although the Company provides wage income verification to the Department, all benefits determinations are made exclusively by the Department. The Department calculates weekly benefits as follows:

- The portion of the employee's average weekly wage that is equal to or less than 50% of the state average weekly wage shall be replaced at a rate of 80%; and

- The portion of the employee's average weekly wage that is more than 50% of the state average weekly wage shall be replaced at a rate of 50%, up to the applicable weekly benefit limits.

The first seven (7) calendar days of leave are unpaid by the Department, except for family leave following a medical leave for pregnancy or childbirth, in which case the seven- (7-) day waiting period for the family leave will be waived. During any unpaid waiting period, employees may elect to use earned sick time (provided the need for leave is covered under the earned sick time policy), PTO/vacation, and/or other paid time off time to replace their regular income. Typically, employees will start receiving benefits from the Department not less than fourteen (14) days after the Department approves the leave and receipt of benefits, unless the Department approves benefits more than fourteen (14) days before the onset of eligibility to take leave.

Supplementation of Department Benefits with Company Benefits

Employees may supplement the Department's benefits with accrued vacation, PTO, personal, sick time, extended illness bank, etc. (assuming the reason for taking Paid Family and Medical Leave is covered under the sick time policy) provided the total amount of Paid Family and Medical Leave Benefits and paid time off does not exceed the employee's regular income. Receipt of such benefits does not extend Paid Family and Medical Leave entitlements, which will run concurrently with any Company-provided benefits. Employees also may supplement benefits for their own serious health condition with short- and/or long-term disability benefits if available.

Use of Leave

Paid Family and Medical Leave is usually taken for a period of consecutive days, weeks or months. However, employees also are entitled to take Paid Family and Medical Leave intermittently or on a reduced leave schedule when medically necessary due to a serious health condition of the employee or family member. Qualifying exigency leave also may be taken on an intermittent or reduced leave schedule.

Intermittent leave may be taken in increments of fifteen (15) minutes. Please note that the Department will not pay Paid Family and Medical Leave benefits in increments of less than 15 minutes. In addition, the Department only permits employees to apply for payment of benefits associated with intermittent leave once they have eight (8) hours of accumulated leave time, except where more than thirty (30) calendar days has lapsed since the employee initially took such leave.

Employees are required to work with the Company to create an agreed-upon intermittent or reduced leave schedule. Failure to comply with the agreed-upon schedule may result in discipline.

The use of intermittent leave will result in the proportional reduction of the employee's available allotment of leave. For example, if the employee normally works forty (40) hours per week and takes intermittent leave for twenty (20) hours each week, then it will be counted as half a week of leave to be counted against the employee's leave entitlement.

Notice

To trigger Paid Family and Medical Leave protections, employees must inform the Human Resources Department of the need for leave and the anticipated timing and duration of the leave, if known. The notice must state:

- The anticipated start date of the leave;
- The anticipated length of the leave; and
- The expected return date.

Employees must provide the Company at least thirty (30) days' advance notice of the need to take Paid Family and Medical Leave when the need is foreseeable. Such notice must be provided before employees apply to the Department. When thirty (30) days' notice is not possible, or the approximate timing of the need for leave is not foreseeable, employees must provide the Company notice of the need for leave as soon as practicable.

When planning medical treatment, employees must consult with the Company and make a reasonable effort to schedule treatment so as not to unduly disrupt Company operations. Employees must consult with the Company prior to scheduling treatment to work out a treatment schedule which best suits the needs of both the Company and the employee.

The Department may deny or delay leave and benefits for employees who: fail to give the Company at least thirty (30) days' notice for foreseeable leave without a reasonable excuse for the delay; apply to the Department before notifying the Company; or otherwise fail to satisfy PFMLA notice obligations.

Application to the Department

After providing notice to the Company (unless the need for leave is unforeseeable), employees should apply directly to the Department for leave and benefits. Employees are required to use the forms provided by the Department, and their application for benefits may not be processed unless the application for benefits includes *all* information necessary for the Department's review and processing. The Department requires the following information:

1. Identifying information, such as Social Security Number or Individual Taxpayer Identification Number;
2. Nature of the leave, whether family leave or medical leave;
3. Starting date and expected duration of the leave;
4. Whether the leave will be continuous or intermittent;
5. Employer’s name and identification number;
6. Evidence that notice was provided to the employer in advance of the application for benefits, including the date notice was provided to the employer;
7. Any denied, granted or pending requests for leave for a qualifying reason from the employer during the last 12 months;
8. Attestation regarding the family relationship in the form specified by the Department if the leave involves an application for family leave benefits; and
9. Completed certification based on the type of leave in the form specified by the Department.

Employees may be required to provide additional specific information requested by the Department where reasonably necessary to review and process an application for benefits including but not limited to whether the employee will be receiving any other wage replacement. It is the employee's responsibility to provide the Department with timely, complete, and sufficient information, certifications or other documents supporting the need for leave.

Amendment or Extension of Leave Period and Paid Leave Benefits

If there is a change in relevant circumstances that would justify an extension, reduction or other modification of the period of leave, the employee and the Company must notify the Department within seven (7) calendar days of said change using the forms required by the Department. For extensions, specifically, the employee must make a request for extension at least fourteen (14) calendar days prior to the expiration of the original approved leave. The Department may consider late filed requests upon a showing of good cause by the employee. The request for extension must include:

- The reason for the extension;
- The requested duration of the extended leave;
- The date on which the covered individual provided notice for the request for extension to the employer; and
- A newly completed or updated health care certification supporting the need for leave.

Job Benefits and Protection

During Paid Family and Medical Leave, the Company will maintain health coverage under any employment-related health insurance on the same terms and conditions as if the employee had continued to work. If Company-provided benefits are used as a substitute for the Department's benefits, the Company will deduct the employee's portion of any applicable health plan premium as a regular payroll deduction. If the employee is not receiving any Company-benefits during the leave, the employee must make arrangements with the Human Resources Department prior to taking leave to pay their portion of any applicable health insurance premiums each month.

Unless otherwise provided by applicable law, employees returning from PFMLA leave will be restored to their previous or equivalent positions with equivalent status, pay, benefits, length-of-service credit, and seniority as of the date of the leave.

Return to Work/Fitness for Duty Medical Certifications

Unless notified otherwise, employees returning to work from PFMLA Leave taken for their own serious health conditions must provide the Company with a medical certification confirming they are able to return to work and perform the essential functions of their positions, with or without reasonable accommodation. The Company may delay and/or deny job restoration until employees provide return to work/fitness for duty certifications.

Interaction with Other Leave Policies

Leave taken pursuant to the PFMLA will run concurrently with leave taken under other applicable state and federal leave laws, including without limitation the Massachusetts Parental Leave Act and the federal Family and Medical Leave Act of 1993, when the leave is for a qualified reason under those laws.

Right to an Appeal

Employees who are denied leave pursuant to the PFMLA may submit an appeal to the Department. The appeal must be filed within ten (10) calendar days of receipt of the denial. The deadline may be extended by the Department upon a showing of circumstances beyond the employee's control. In addition, the employee is required to provide a complete copy of the request for appeal to the Company. Employees may request a hearing with the Department and a final decision will be issued by the Department affirming, modifying, or revoking the initial determination made by the Company.

Employees aggrieved by the Department's final decision may further appeal by filing a complaint in district court for the county in the Commonwealth where the individual resides or was last employed. The complaint must be filed within thirty (30) calendar days of the date the Department's final decision is received by the individual.

Questions and/or Complaints about PFMLA Leave

Questions regarding this PFMLA policy, should be directed to the Human Resources Department. For questions about determinations by the Department on leave eligibility, entitlement, and/or benefits, contact the Department directly. The Company is committed to complying with the PFMLA and, whenever necessary, shall interpret and apply this policy in a manner consistent with the PFMLA.

The PFMLA makes it unlawful for employers to discriminate, retaliate, threaten to retaliate, or interfere with the exercise of any rights provided under the PFMLA. In addition, employers may not retaliate or threaten to retaliate against any person who has filed a complaint, has caused a complaint to be filed, has or will participate or testify in a proceeding relating to a violation of the PFMLA, or has given or is about to give information connected to a proceeding relating to a violation of the PFMLA. If employees believe their PFMLA rights have been violated, they should contact the Human Resources Department immediately. The Company will investigate any PFMLA complaints and take prompt and appropriate remedial action to address and/or remedy any PFMLA violation. Employees also may file PFMLA complaints with the Department alleging PFMLA violations.

TIME OFF AND LEAVES OF ABSENCE

Massachusetts Earned Sick Time

Eligibility

Chestnut Health Systems provides earned sick time to employees whose primary place of work is in Massachusetts. For employees whose primary place of work is in Massachusetts who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave ordinance.

Accrual

Employees begin accruing earned sick time at the start of employment. Eligible employees will accrue one (1) hour of earned sick time for every thirty (30) hours worked, up to a maximum accrual of 40 hours each calendar year.

Exempt employees are assumed to work forty (40) hours in each workweek unless their normal workweek is less than forty (40) hours, in which case, sick time accrues based on that normal workweek.

For purposes of this policy, the calendar year is the consecutive twelve- (12-) month period beginning January 1 and ending on December 31.

Usage

Employees may begin using accrued earned sick time on the 90th day of employment. The smallest amount of earned sick time employees can use is one (1) hour. For uses beyond one (1) hour, employees may use earned sick time in hourly increments or in the smallest increment the payroll system uses to account for absences or use of other time. Employees may not use more than forty (40) hours of earned sick time in any calendar year.

Employees may use earned sick time for the following reasons:

1. to care for their child (which includes a biological child, an adopted or a foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis); their spouse (as defined by the marriage laws of Massachusetts, which include a partner in a same-sex marriage); or their parent or the parent of a spouse who is suffering from a physical or mental illness, injury, or medical condition that requires home care, a professional medical diagnosis or care, or preventive medical care;

2. to care for their own physical or mental illness, injury, or medical condition that requires home care, a professional medical diagnosis or care, or preventive medical care;

3. to attend their routine medical appointment or a routine medical appointment for their child, their spouse, their parent, or the parent of a spouse;

4. for travel to and from an appointment, a pharmacy, or another location related to the purpose for which earned sick time was taken; or

5. to address the psychological, physical, or legal effects of domestic violence.

Earned sick time may not be used as an excuse to be late for work if the lateness is not related to one of the reasons described above. Additionally, employees may not accept a specific shift assignment with the intention of calling out sick for all or part of the shift.

Use of earned sick time will run concurrently with time off provided under Family and Medical Leave, Massachusetts Parental Leave, Massachusetts Domestic Violence Leave, Massachusetts Small Necessities Leave or time off pursuant to any other applicable law, if applicable to and to the extent permitted by applicable law.

Notice and Documentation

Employees must comply with the attendance and call-in policy when providing notice. Employees must make a good-faith effort to provide notice of this need to use earned sick time if the need is foreseeable. Specifically, if the need for the use of earned sick time is due to a prescheduled or foreseeable absence, seven (7) days' advance notice to the employee's supervisor is required. If the employees anticipate a multiday absence from work, they must provide notification of the expected duration of the leave or, if unknown, provide notification daily, unless the circumstances make such notice unreasonable. If the need for the use of earned sick time is unforeseeable, notice must be provided as soon as practicable under the circumstances.

When providing notice or reporting an absence for a covered purpose, employees are not required to explicitly reference earned sick time, but the Company may, in accordance with applicable laws regarding privacy and confidentiality of medical information, review with employees the covered purposes for which earned sick time may be used.

For any earned sick time used, employees must verify in writing that they have used the time for a covered reason, but they will not be required to explain the nature of the illness or the details of the domestic violence.

The Company will also require supporting documentation if the employee's use of earned sick time:

- covers more than twenty-four (24) consecutively scheduled work hours or three (3) consecutive scheduled workdays;

- occurs within two (2) weeks before the employee's final scheduled day of work before termination of employment, except in the case of a temporary employee; and

- occurs after four (4) unforeseeable and undocumented absences within a three- (3-) month period for all other employees.

Documentation signed by a healthcare provider indicating the need for earned sick time taken constitutes acceptable certification for sick time taken for reasons #1 through #4 above; but, for employees who do not have health care covered through a private insurer, the MA Healthcare Connector and related insurers may provide a signed written statement evidencing the need for using earned sick time, without being required to explain the nature of the illness, in lieu of documentation by a healthcare provider.

Acceptable documentation for earned sick time taken for reason #5 can include:

- a restraining order or other documentation of equitable relief issued by a court of competent jurisdiction;
- a police record documenting the abuse;
- documentation that the perpetrator of the abuse has been convicted of one (1) or more offenses when the victim was a family or household member;
- medical documentation of the abuse;
- a statement provided by a counselor, a social worker, a health worker, a member of the clergy, a shelter worker, a legal advocate, or another professional who has assisted the individual in addressing the effects of the abuse on the individual or the individual's family; or
- a sworn statement from the individual attesting to the abuse.

The documentation does not need to explain the nature of the illness or the details of the domestic violence. Documentation can be submitted in person or by another reasonable method, including e-mail.

Documentation must be provided within seven (7) days of taking earned sick time, unless, for good cause shown or as otherwise permitted, the employee requires more time to provide such documentation. Failure to comply with the reasonable documentation requirements, without a reasonable justification, may result in the Company recouping the amount paid for earned sick time from future pay, as an overpayment or otherwise taking appropriate action, to the extent permitted by applicable law.

Employees may be asked to provide a fitness-for-duty certification, a work release, or other documentation from a medical provider before returning to work after an absence during which earned sick time was used.

Payment

Earned sick time will be paid at the same hourly rate as the employee earns from their employment at the time they use such time. Use of sick time is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Up to forty (40) hours of accrued, unused earned sick time under this policy can be carried over to the following calendar year, but employees are subject to an accrual cap of forty (40) hours. Once the accrual cap is reached, earned sick time will stop accruing until some earned sick time is used, at which point, accrual will resume, subject to the maximum annual accrual of forty (40) hours and the accrual cap of forty (40) hours.

Accrued but unused earned sick time under this policy will not be paid at separation.

Enforcement and Retaliation

Employees may be subject to disciplinary action for misuse of earned sick time if they are engaging in fraud or abuse of benefits available under this policy.

The Company will not tolerate retaliation against employees who oppose practices that they believe to be in violation of earned sick time law or because the employees support the exercise of rights of another employee under the earned sick time law. Employees may file an action in court to enforce their earned sick time rights.

Employees with questions regarding this policy should contact Human Resources.

Massachusetts Jury Duty Leave

Chestnut Health Systems realizes that it is the obligation of all U.S. citizens to serve on a jury when summoned to do so. All employees will be allowed time off to perform such civic service as required by law. Employees are expected, however, to provide proper notice of any request to perform jury duty and verification of their service, including fees received for jury duty service.

Employees also are expected to keep management informed of the expected length of jury duty service and to report to work for the major portion of the day if excused by the court. If the required absence presents a serious conflict for management, employees may be asked to try to postpone jury duty.

The Company will pay regularly employed jurors their regular wages for the first three (3) days of jury service. Courts may excuse employers from the duty to compensate juror-employees in cases of extreme financial hardship. In such cases, the court will award the juror reasonable compensation in lieu of wages, up to $50 a day, for the first three (3) days of juror service. Alternate jurors will receive the same payments and reimbursements from their employers and the commonwealth as jurors.

Exempt employees will be paid their full salary less jury duty fees for any week in which they performed work for the Company and missed work solely due to jury service.

Massachusetts Domestic Abuse Leave

Employees are entitled to up to fifteen (15) days of unpaid leave from work in any twelve- (12-) month period if, as defined by applicable law: (i) the employee, or a family member of the employee, is a victim of abusive behavior; (ii) the employee is using the leave from work to: seek or obtain medical attention, counseling, victim services or legal assistance; secure housing; obtain a protective order from a court; appear in court or before a grand jury; meet with a district attorney or other law enforcement official; or attend child custody proceedings or address other issues directly related to the abusive behavior against the employee or family member of the employee; and (iii) the employee is not the perpetrator of the abusive behavior against such employee's family member.

Except in cases of imminent danger to the health or safety, the employee seeking leave from work under this policy must provide to the Company appropriate advance notice of the leave. If there is a threat of imminent danger to the health or safety of the employee or the employee's family member, the employee is not required to provide advanced notice of leave; provided, however, that the employee must notify the Company within three (3) workdays that the leave was taken or is being taken pursuant to this policy.

Such notification may be communicated by the employee, a family member of the employee or employee's counselor, social worker, health care worker, member of the clergy, shelter worker, legal advocate or other professional who has assisted the employee in addressing the effects of the abusive behavior on the employee or the employee's family member.

If an unscheduled absence occurs, no negative action will be taken against the employee if the employee provides any of the documentation described in (1) to (7) below within thirty (30) days from the unauthorized absence or within thirty (30) days from the last unauthorized absence in the instance of consecutive days of unauthorized absences.

Employees must provide documentation that the employee or employee's family member has been a victim of abusive behavior and that the leave taken is consistent with this policy. However, the employee will not be required to show evidence of an arrest, conviction or other law enforcement documentation for such abusive behavior. Employees must provide such documentation within a reasonable period after the Company requests documentation relative to the employee's absence. The employee may satisfy this documentation requirement by providing any of the following documents:

1. A protective order, order of equitable relief or other documentation issued by a court of competent jurisdiction as a result of abusive behavior against the employee or employee's family member.

2. A document under the letterhead of the court, provider or public agency which the employee attended for the purposes of acquiring assistance as it relates to the abusive behavior against the employee or the employee's family member.

3. A police report or statement of a victim or witness provided to police, including a police incident report, documenting the abusive behavior complained of by the employee or the employee's family member.

4. Documentation that the perpetrator of the abusive behavior against the employee or family member of the employee has: admitted to sufficient facts to support a finding of guilt of abusive behavior; or has been convicted of, or has been adjudicated a juvenile delinquent by reason of, any offense constituting abusive behavior and which is related to the abusive behavior that necessitated the leave under this section.

5. Medical documentation of treatment as a result of the abusive behavior complained of by the employee or employee's family member.

6. A sworn statement, signed under the penalties of perjury, provided by a counselor, social worker, health care worker, member of the clergy, shelter worker, legal advocate or other professional who has assisted the employee or the employee's family member in addressing the effects of the abusive behavior.

7. A sworn statement, signed under the penalties of perjury, from the employee attesting that the employee has been the victim of abusive behavior or is the family member of a victim of abusive behavior.

Information related to the employee's leave under this policy will be kept confidential and will not be disclosed, except to the extent that disclosure is: (i) requested or consented to, in writing, by the employee; (ii) ordered to be released by a court of competent jurisdiction; (iii) otherwise required by applicable federal

or state law; (iv) required in the course of an investigation authorized by law enforcement, including, but not limited to, an investigation by the attorney general; or (v) necessary to protect the safety of the employee or others employed at the workplace.

The employee seeking leave under this policy must exhaust all annual or vacation leave, personal leave and sick leave available to the employee, prior to requesting or taking leave under this policy, unless otherwise provided by the Company.

The Company will not coerce, interfere with, restrain or deny the exercise of, or any attempt to exercise, any rights provided under this policy or to make leave requested or taken hereunder contingent upon whether or not the victim maintains contact with the alleged abuser. The Company will not discharge or in any other manner discriminate against the employee for exercising the employee's rights under this policy. The taking of leave under this policy will not result in the loss of any employment benefit accrued prior to the date on which the leave taken under this policy commenced. Upon the employee's return from such leave, to the extent required by applicable law, the employee will be entitled to restoration to the employee's original job or to an equivalent position.

Massachusetts Parental Leave

The employee who has completed three (3) consecutive months of full-time employment may be entitled to eight (8) weeks of parental leave for the purpose of giving birth or for the placement of a child under the age of eighteen (18), or under the age of twenty-three (23) if the child is mentally or physically disabled, for adoption with the employee who is adopting or intending to adopt the child or for the placement of a child with the employee pursuant to a court order. The employee who either has multiple births or adopts more than one (1) child at the same time is entitled to eight (8) weeks of leave for each child. If two (2) employees seek to take parental leave in connection with the same child, then they are entitled to a total of eight (8) weeks of parental leave in the aggregate for the birth or adoption of that child.

To be eligible for this leave, the employee must give notice of the anticipated date of departure and intention to return to work to Human Resources at least two (2) weeks in advance, or as soon as practicable if the delay is for reasons beyond the employee's control.

Parental leave will be without pay, except that if the employee has accrued unused paid time off, the employee may choose to use such time concurrently with all or part of the leave. Thus, if the employee is eligible for both leave under the Family and Medical Leave Act (FMLA) and parental leave under this policy, the employee may (but is not required to) use accrued paid time off for the period of leave covered by this policy.

At the conclusion of a parental leave, employees will be reinstated to their previous position or a similar position with the same rate of pay they received at the commencement of the leave. The Company, however, may not reinstate the employee on parental leave to the previous position or a similar position if other employees of equal seniority or status in the same or similar position(s) have been laid off due to economic conditions or have been otherwise affected by changes in employment conditions during the period of leave. Although parental leave may be extended, unless otherwise provided by applicable law, reinstatement may not be guaranteed at the conclusion of a parental leave that is more than eight (8) weeks in duration.

A parental leave will not affect the employee's ability to receive paid time off, bonuses, advancement, seniority, or other benefits for which the employee was eligible on the date leave began, however, the leave

period will not be included in the computation of such benefits. Parental leave runs concurrently with leave provided under any other applicable policy in the handbook including, without limitation, leave under the FMLA and/or MPFL policy, if applicable. Parental leave also runs concurrently with any time period qualifying the employee for receipt of monetary benefits, including benefits received under any short-term disability policy. The receipt of such monetary benefits or use of paid time off during any period of parental leave does not extend the length of the leave.

Employees with questions or concerns regarding this policy can contact Human Resources.

Massachusetts Small Necessities Leave

Chestnut Health Systems will grant employees who have worked for the Company for at least twelve (12) months and have provided at least 1,250 hours of service in the preceding twelve- (12-) month period with up to twenty-four (24) hours of unpaid leave during any twelve- (12-) month period, in addition to any FMLA leave, to participate in various activities. These include: attending a parent-teacher conference, accompanying a son or daughter to routine medical appointments or accompanying an elderly relative, related by blood or marriage, to routine medical or dental appointments or appointments for other professional services related to the relative's care, such as interviewing at nursing homes. Employees must provide seven (7) days' advance notice of their need for leave. If the need was not foreseeable, the employee must provide the Company with as much notice as possible. An eligible employee first must substitute any accrued paid time off for this leave.

CHESTNUT
HEALTH SYSTEMS

MASSACHUSETTS SUPPLEMENT ACKNOWLEDGMENT

This Massachusetts Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Massachusetts Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT HEALTH SYSTEMS

RECEIPT OF MASSACHUSETTS NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut.

The purpose of this policy is not to regulate employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion toward an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

1. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
2. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
3. obscene or vulgar gestures, posters or comments;
4. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;
5. propositions, or suggestive or insulting comments of a sexual nature;
6. derogatory cartoons, posters and drawings;
7. sexually-explicit e-mails, text messages or voicemails;
8. uninvited touching of a sexual nature;
9. unwelcome sexually-related comments;
10. conversation about one's own or someone else's sex life;
11. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
12. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If employees have been subjected to or witnessed conduct which violates this policy, they should immediately report the matter to the Employee's Supervisor at 102 4th Street Hillsboro, MO 63050 or 636.638.2617. If they are unable for any reason to contact this person, or if they have not received an initial response within five (5) business days after reporting any incident of what they perceive to be harassment, they should contact Human Resources at 50 Northgate Industrial Dr. Granite City, IL 62040 or 618.877.4420. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If employees feel they have been subjected to any such retaliation, they should report it in the same manner in which they would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

Although employees are encouraged to report claims internally, if they believe they have been subjected to sexual harassment or other harassment in violation of state law, they may file a formal complaint with the government agency or agencies set forth below. Using the Company's complaint process does not prohibit the employee from filing a complaint with these agencies.

- The United States Equal Employment Opportunity Commission (EEOC) JFK Federal Building, Room 475 Boston, Massachusetts 02203, (617) 565-3200
- The Massachusetts Commission Against Discrimination (MCAD) Boston Office: One Ashburton Place, Room 601, Boston, MA 02108, (617) 994-6000
- Springfield Office: 436 Dwight Street, Room 220, Springfield, MA 01103, (413) 739-2145
- New Bedford Office: 128 Union Street, Suite 206, New Bedford, MA 02740, (774) 510-5801
- Worcester Office: 484 Main Street, Room 320, Worcester, MA 01608, (508) 453-9630

I have read and I understand Chestnut Health Systems Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

ADDENDUM – Michigan Supplement – 2024



Chestnut Health Systems

Personnel Policies

Michigan Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Michigan Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Michigan employees will receive the Company's Personnel Policies and the Michigan Supplement to the Personnel Policies ("Michigan Supplement) (together the "Employee Handbook").

The Michigan Supplement applies only to Michigan employees. It is intended as a resource containing specific provisions derived under Michigan law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Michigan Supplement are different from or more generous than those in the National Handbook, the policies in the Michigan Supplement will apply.

The Michigan Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

Michigan Social Security Number Privacy Act

It is the policy of Chestnut Health Systems to ensure to the extent practicable the confidentiality of employees' Social Security Numbers in accordance with Michigan law.

The Company will not intentionally do any of the following acts which result in a prohibited disclosure of employees' Social Security Numbers. Violation of this policy will result in discipline up to and including discharge.

1. Publicly display more than four (4) sequential digits of a Social Security Number

2. Use more than four (4) sequential digits of a Social Security Number as a primary account number or use more than four (4) sequential digits of a Social Security Number on any identification badge or card, membership card, permit or license, except where permitted by law.

3. Require employees to use or transmit more than four (4) sequential digits of their Social Security Numbers over the internet or on a computer system or network or to gain access to the internet, computer system or network unless the connection is secure or the transmission is encrypted. Similarly, the Company will not require employees to use or transmit more than four (4) sequential digits of their Social Security Numbers to gain access to the internet or a computer system unless the connection is secure, the transmission is encrypted, or a password or other unique personal identification or authentication device is also required.

4. Include more than four (4) sequential digits of Social Security Numbers on the outside of envelopes or packages or visible internal areas.

5. Include more than four (4) sequential digits of Social Security Numbers in documents or information mailed to individuals, except as permitted by law.

The Company limits access to Social Security Numbers to those employees and outside consultants whose job duties require that they use this information in connection with Company business. The individuals who have access to Social Security Numbers are those who work in the following areas:

- Human Resources
- Benefits Administration
- Computer and Information Technology
- Executive Management
- Legal Department
- Individuals who, though not employed by the Company provide legal, tax, benefits, management or other consulting services for the Company.

The Company will properly dispose of documents containing Social Security Numbers by ensuring that all such materials are shredded or otherwise destroyed prior to discarding such information. Data stored in electronic format will be rendered irretrievable before computers are discarded or destroyed.

PAY PRACTICES

Michigan Paid Medical Leave

Eligibility

Chestnut Health Systems provides Paid Medical Leave (PML) to eligible non-exempt employees who work in Michigan. For employees who work in Michigan who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing PML pursuant to this policy at the start of employment. Eligible employees will accrue one (1) hour of PML for every thirty-five (35) hours worked, up to a maximum accrual of one (1) hour of PML in a calendar week and forty (40) hours each benefit year. For purposes of this policy, the benefit year is the consecutive twelve- (12-) month period beginning January 1 and ending on December 31.

Usage

Employees may begin using accrued PML after the 90th calendar day of employment. PML must be used in one (1) hour increments. Employees may not use more than forty (40) hours of PML in any benefit year.

Eligible employees may use PML for the following:

1. their mental or physical illness, injury or health condition; medical diagnosis, care or treatment of their mental or physical illness, injury or health condition; or preventative medical care;

2. their family member's mental or physical illness, injury or health condition; medical diagnosis, care or treatment of the family member's mental or physical illness, injury or health condition; or preventative medical care for a family member;

3. if they or their family members are a victim of domestic violence or sexual assault: the medical care or psychological or other counseling for physical or psychological injury or disability; to obtain services from a victim services organization; to relocate due to domestic violence or sexual assault; to obtain legal services; or to participate in any civil or criminal proceedings related to or resulting from the domestic violence or sexual assault; or

4. for closure of their primary workplace by order of a public official due to a public health emergency; for their need to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency; or if it has been determined by the health authorities having jurisdiction or by a health care provider that employees or their family members' presence in the community would jeopardize the health of others because of exposure to a communicable disease, whether or not eligible employees or their family members have actually contracted the communicable disease.

For purposes of this policy, family member means: biological, adopted or foster child, stepchild or legal ward or a child to whom employees stand in loco parentis; biological parent, foster parent, stepparent or adoptive parent or employees' legal guardian or the legal guardian of the employee's spouse or an individual who stood in loco parentis when the employee was a minor child; individual to whom the employee is legally married under the laws of any state; grandparent; grandchild; or a biological, foster, or adopted sibling.

Unless advised otherwise, Chestnut Health Systems will assume, subject to applicable law, that employees want to use available PML for absences for reasons set forth above and they will be paid for such absences to the extent they have PML available.

Notice and Documentation

When requesting to use PML, employees must comply with the usual and customary notice, procedural, and documentation requirements for requesting leave as outlined in the Punctuality and Attendance policy.

Where documentation is requested, employees will have at least three (3) days, upon request, to provide documentation. Those who fail to comply with notice and documentation requirements may be subject to discipline, up to and including discharge.

Employees using PML for reason #3 above may be required to provide documentation that the PML has been used for that purpose. The following types of documentation are:

- a police report indicating that employees or their family members were victims of domestic violence or sexual assault;
- a signed statement from a victim and witness advocate affirming that employees or their family members are receiving services from a victim services organization; or
- a court document indicating that employees or their family member are involved in legal action related to domestic violence or sexual assault.

The documentation should not explain the details of the violence or disclose details relating to domestic violence or sexual assault or the details of any medical condition.

Payment

PML will be paid at a pay rate equal to the greater of either normal hourly wage or base wage or the applicable minimum wage. Use of PML is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Employees may carry over up to forty (40) hours of accrued, unused PML to the following year.

Unused PML under this policy will not be paid at separation.

Questions

Employees with questions concerning this policy should contact Human Resources.

TIME OFF AND LEAVES OF ABSENCE

Michigan Victims of Crime Leave

Employees who are a victim or victim's representative, called to serve as a witness in a judicial proceeding, must notify their supervisor as soon as possible.

Employees will not be compensated for time away from work to participate in a court case, but may use available vacation and personal time to cover the period of absence.

Employees testifying as the victim or representative of a victim in a judicial proceeding will not be disciplined for their absence.

MICHIGAN SUPPLEMENT ACKNOWLEDGMENT

This Michigan Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Michigan Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

73. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
74. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
75. obscene or vulgar gestures, posters or comments;
76. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;
77. propositions or suggestive or insulting comments of a sexual nature;
78. derogatory cartoons, posters and drawings;
79. sexually-explicit e-mails, text messages or voicemails;
80. uninvited touching of a sexual nature;
81. unwelcome sexually-related comments;
82. conversation about one's own or someone else's sex life;
83. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
84. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

ADDENDUM – Minnesota Supplement – 2024



Chestnut Health Systems

Personnel Policies

Minnesota Supplement

2024

CHESTNUT HEALTH SYSTEMS

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Minnesota Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Minnesota employees will receive the Company's Personnel Policies and the Minnesota Supplement to the Personnel Policies ("Minnesota Supplement) (together the "Employee Handbook").

The Minnesota Supplement applies only to Minnesota employees. It is intended as a resource containing specific provisions derived under Minnesota law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Minnesota Supplement are different from or more generous than those in the National Handbook, the policies in the Minnesota Supplement will apply.

The Minnesota Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

Minnesota Equal Employment Opportunity

Chestnut Health Systems is an Equal Opportunity Employer that does not discriminate on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, familial status, military service and veteran status, physical or mental disability, genetic information, public assistance, local human rights commission activity, or any other characteristic protected by applicable federal, state, or local laws and ordinances. Chestnut Health Systems management team is dedicated to this policy with respect to recruitment, hiring, placement, promotion, transfer, training, compensation, benefits, employee activities, access to facilities and programs, and general treatment during employment.

The Company will endeavor to make a reasonable accommodation of an otherwise qualified applicant or employee related to an individual's: physical or mental disability; sincerely held religious beliefs and practices; and/or any other reason required by applicable law, unless doing so would impose an undue hardship upon the Company's business operations. Any applicant or employee who needs an accommodation to perform the essential functions of the job should contact the CEO to request such an accommodation. The individual should specify what accommodation is needed to perform the job and submit supporting documentation explaining the basis for the requested accommodation, to the extent permitted and in accordance with applicable law. The Company then will review and analyze the request, including engaging in an interactive process with the individual, to identify if such an accommodation can be made. The Company will evaluate requested accommodations, and as appropriate identify other possible accommodations, if any. The individual will be notified of The Company's decision regarding the request within a reasonable period. The Company treats all medical information submitted as part of the accommodation process in a confidential manner.

Any employees with questions or concerns about equal employment opportunities in the workplace are encouraged to bring these issues to the attention of the CEO. The Company will not allow any form of retaliation against individuals who raise issues of equal employment opportunity. If employees feel they have been subjected to any such retaliation, they should contact the CEO. To ensure the workplace is free of artificial barriers, violation of this policy including any improper retaliatory conduct will lead to discipline, up to and including discharge. All employees must cooperate with all investigations conducted pursuant to this policy.

Minnesota Right to Review Personnel Records

Under Minnesota law, active employees have the right to review their personnel record once every six (6) months. Employees who leave Chestnut Health Systems may review their personnel record once every year as long as the Company maintains the personnel record.

To review their personnel record, employees must make a good faith request in writing to Human Resources. Employees may also request a copy of the record at the time they review it. The copy will be made available to the employee at no cost.

The Company will provide employees an opportunity to review their personnel record within seven (7) working days of the written request or within fourteen (14) working days of the written request if the personnel record is physically located outside of Minnesota.

What is contained in the personnel record is carefully defined under Minnesota law. The law does not require employee access to information that is not contained in the personnel record.

If employees dispute information contained in their personnel record, they may request that it be removed from the record. However, if the Company does not agree the information should be removed, the employee may submit a written response to the denial (not to exceed five (5) pages).

No action can be taken against employees who appropriately ask to review their personnel records.

If employees are improperly denied their rights as provided by this law, the law provides certain remedies.

This notice only describes some of the employee's rights under the law. For more information, the Minnesota statutes detailing employee rights can be found at Minnesota Statutes. § 181.960 through

Minnesota Statutes §181.965. These laws can be found on the internet at https://www.revisor.mn.gov/pubs/ or in public libraries throughout the state.

Minnesota Wage Disclosure Protections

Under Minnesota law, an employer may not:

1. require nondisclosure by employees of their wages as a condition of employment;
2. require employees to sign a waiver or other document which purports to deny them the right to disclose their wages; or
3. take any adverse employment action against employees for disclosing their own wages or discussing another employee's wages which have been disclosed voluntarily.

Nonetheless, this policy should not be construed to:

1. create an obligation on Chestnut Health Systems or on employees to disclose wages;
2. permit employees, without the written consent of the Company, to disclose proprietary information, trade secret information or information that is otherwise subject to legal privilege or protected by law;
3. diminish any existing rights under the National Labor Relations Act; or
4. permit employees to disclose wage information of other employees to a competitor of Chestnut Health Systems.

An employer may not retaliate against the employee for asserting rights or remedies set forth in this policy.

Employees may bring a civil action against the Company for a violation of this policy. If a court finds that the Company has violated this policy, the court may order reinstatement, back pay, restoration of lost service credits, if appropriate, and the expungement of any related adverse records of the employee who was the subject of the violation.

PAY PRACTICES

Minnesota Nursing Mothers, Lactating Employees, and Pregnancy Accommodations

Minnesota's Nursing Mothers, Lactating Employees, and Pregnancy Accommodations law, Minn. Stat. § 181.939, gives pregnant and lactating employees certain legal rights.

Pregnant employees have the right to request and receive reasonable accommodations, which may include, but are not limited to, more frequent or longer breaks, seating, limits to heavy lifting, temporary transfer to another position, temporary leave of absence, or modification in work schedule or tasks. Employers cannot require employees to take a leave or accept an accommodation.

Lactating employees have the right to reasonable paid break times to express milk at work unless they are expressing milk during a break that is not usually paid, such as a meal break. Employers should provide a clean, private, and secure room that is not a bathroom near the work area that includes access to an electrical outlet for employees to express milk.

It is against the law for an employer to retaliate or to take negative action against a pregnant or lactating employee for exercising their rights under this law.

Employees who believe their rights have been violated under this law can contact the Minnesota Department of Labor and Industry's Labor Standards Division at dli.laborstandards@state.mn.us or 651-284-5075 for help. Employees also have the right to file a civil lawsuit for relief. For more information about this law, visit dli.mn.gov/newparents.

TIME OFF AND LEAVES OF ABSENCE

Minnesota Sick and Safe Time

Eligibility

Chestnut Health Systems provides sick and safe time (SST) to employees who perform work within Minnesota for at least eighty (80) hours in a year. For employees who work in Minnesota and are eligible for sick and safe time under the general policy, this policy applies solely to the extent it provides greater benefits/rights on any specific issues.

Accrual

Employees begin to accrue SST at the start of employment. Employees accrue one (1) hour for every thirty (30) hours worked, up to a maximum annual accrual of forty-eight (48) hours each year. Additionally, employees' total SST accrual balance may not exceed eighty (80) hours at any time ("overall accrual cap"). Exempt employees will be presumed to work forty (40) hours in each workweek for accrual purposes unless their normal workweek is less than forty (40) hours, in which case accrual will be based on that normal workweek. For purposes of this policy, the year is the twelve- (12-) month period beginning January 1 and ending on December 31.

Usage

Employees can begin to use granted or accrued SST immediately. SST may be used in the smallest increment of time tracked by the Company's payroll system.

Employees may use SST for the following reasons:

1. The employee's own mental or physical illness, injury, or health condition to accommodate the employee's need for medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition or the employee's need for preventive medical care;

2. Care of a family member with a mental or physical illness, injury, or health condition who needs medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition or care for a family member who needs preventive medical care;

3. Absences due to domestic abuse, sexual assault, or stalking of the employee or employee's family member, provided the absence is for medical attention related to physical or psychological injury or disability caused by domestic abuse, sexual assault, or stalking; to obtain services from a victim services organization; to obtain psychological or other counseling; to relocate or take steps to secure an existing home due to domestic abuse, sexual assault, or stalking; or to seek legal advice

or take legal action, including preparing for or participating in any civil or criminal proceedings related to or resulting from domestic abuse, sexual assault, or stalking;

4. The closure of the employee's place of business due to weather or other public emergency;

5. To accommodate the employee's need to care for a family member whose school or place of care has been closed due to weather or other public emergency;

6. The employee's inability to work or telework because the employee is:

    i. Prohibited from working by the Company due to health concerns related to the potential transmission of a communicable illness related to a public emergency; or

    ii. Seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, a communicable disease related to a public emergency and such employee has been exposed to a communicable disease or the Company has requested a test or diagnosis; and

7. When it has been determined by the health authorities having jurisdiction or by a health care professional that the presence of the employee or family member of the employee in the community would jeopardize the health of others because of the exposure of the employee or family member of the employee to a communicable disease, whether or not the employee or family member has actually contracted the communicable disease.

For purposes of this policy, "family member" means a child (including child-in-law), spouse or registered domestic partner, sibling (including a sibling-in-law), parent, grandchild, grandparent, a child of a sibling, a sibling of the parents of the employee or the employee's spouse or registered domestic partner, any other individual related by blood or whose close association with the employee is the equivalent of a family relationship, or one individual annually designated by the employee. The family members listed above are not limited to biological family members, but also include step-, foster, adoptive, half-relations, and those who stand in *loco parentis* and legal guardians.

Unless the employee advises the Company. otherwise, the Company. will assume, subject to applicable law, that employees want to use available SST for absences for reasons set forth above and employees will be paid for such absences to the extent they have SST available.

Employees will be provided with SST balance and usage information on their pay statement.

Notice and Documentation

When the need to use SST is foreseeable, employees must provide seven (7) days advance notice to their Supervisor. When the need to use SST is not foreseeable, employees must provide notice to their Supervisor as soon as practicable. For SST of more than three (3) consecutive workdays, employees may also be required to provide reasonable documentation that SST was taken for a covered reason. For example, for SST used for reasons (1), (2), (6), or (7) above, documentation signed by a licensed health care provider indicating the need for the amount of SST taken and that SST was used for a covered reason under this policy and/or applicable law will be considered reasonable documentation, and such documentation need not specify the nature of the employee's or the employee's family member's injury, illness, or condition, except as required by law. Supporting documentation will not be required for the above purposes if it would result in an unreasonable expense on the employee or where the employee did not

receive services from a health care professional. In this event, reasonable documentation may include a written statement from the employee. For example, for SST used for reason (3) above, documentation signed by the employee or volunteer of a victim services organization, an attorney, a police officer, or an antiviolence counselor will be considered reasonable documentation, and such documentation need not specify the details of the domestic abuse, sexual assault, or stalking.

Payment

SST is paid at the same hourly rate as the employee's rate of pay for the hours the employee was scheduled to work during the time SST is used, unless otherwise required by applicable law. Use of SST is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued, unused SST may be carried over to the following year, but as indicated above, there is an overall accrual cap of eighty (80) hours. Once the overall accrual cap is reached, SST will stop accruing until some SST is used.

Accrued, unused SST will not be paid upon separation.

Enforcement and Retaliation

Employees may be subject to discipline for using SST for a reason other than the covered reasons above, to the maximum extent permitted by applicable law. Retaliation against employees who request or use earned SST is prohibited.

Employees have the right to file a complaint with the Minnesota Department of Labor and Industry or bring a civil action if they believe they have been denied SST, retaliated against, or that their rights to SST has been otherwise interfered with or restrained.

Employees with questions regarding this policy can contact Human Resources.

Minneapolis Sick and Safe Time

Eligibility

Chestnut Health Systems provides Sick and Safe Time (SST) to employees who perform work within the City of Minneapolis for at least 80 hours in a year. For employees who work in Minneapolis who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin to accrue SST at the start of employment. Employees accrue one (1) hour for every thirty (30) hours worked, up to a maximum annual accrual of forty-eight (48) hours. Additionally, the employee's total SST accrual balance may not exceed 80 hours at any time ("overall accrual cap"). Exempt employees will be presumed to work forty (40) hours in each workweek for accrual purposes unless their normal workweek is less than forty (40) hours, in which case accrual will be based on that normal workweek. For

purposes of this policy, the year is the twelve- (12-) month period beginning January 1 and ending on December 31.

Usage

Employees can begin to use accrued SST immediately. SST may be used in the smallest increment of time tracked by the Company's payroll system.

The employee may use SST for the following reasons:

1. The medical diagnosis, treatment, recuperation, or preventative care for a mental or physical illness, injury, or health condition of the employee or family member;

2. Absences due to domestic violence, sexual assault, or stalking of the employee or employee's family member, provided the absence is for medical attention related to physical or psychological injury or disability caused by domestic abuse, sexual assault, or stalking; to obtain services from a victim services organization; to obtain psychological or other counseling; to relocate due to domestic violence or take steps to secure an existing home, sexual assault, or stalking; or to take legal action, including preparing for or participating in any civil or criminal proceedings related to or resulting from domestic violence, sexual assault, or stalking;

3. The closure of the employee's place of business due to weather or other public emergency or by order of a public official to limit exposure to an infectious agent, biological toxin, or hazardous material, or other public health emergency;

4. To accommodate the employee's need to care for a family member whose school or place of care has been closed due to weather or other public emergency or by order of a public official to limit exposure to an infectious agent, biological toxin, or hazardous material, or other public health emergency; or

5. To accommodate the employee's need to care for a family member whose school or place of care has been closed due to inclement weather; loss of power, heating, or water; other public emergency; or other unexpected closure.

6. The employee's inability to work or telework because the employee is:

    i. Prohibited from working by the Company due to health concerns related to the potential transmission of a communicable illness related to a public emergency; or

    ii. Seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, a communicable disease related to a public emergency and such employee has been exposed to a communicable disease or the Company has requested a test or diagnosis; or

7. When it has been determined by the health authorities having jurisdiction or by a health care professional that the presence of the employee or family member of the employee in the community would jeopardize the health of others because of the exposure of the employee or family member of the employee to a communicable disease, whether or not the employee or family member has actually contracted the communicable disease.

For purposes of this policy, family member means a child (including child-in-law), spouse or registered domestic partner, sibling (including a sibling-in-law), parent, grandchild, grandparent, a child of a sibling, a sibling of the parents of the employee or the employee's spouse of registered domestic partner, guardian, ward, or a person who currently resides in the employee's home, any other individual related by blood or whose close association with the employee is the equivalent of a family relationship; or one (1) individual annually designated by the employee. The family members listed above are not limited to biological family members but also include step, foster, adoptive, half-relations, and those who stand in *loco parentis* and legal guardians.

Unless advised otherwise by the employee, the Company will assume, subject to applicable law, that employees want to use available SST for absences for reasons set forth above and employees will be paid for such absences to the extent they have SST available.

Upon request of the employee, the Company will provide information (in writing or electronically) regarding the employee's accrued and available SST and used SST. Employees also will be provided information on SST in their regular pay statement.

Notice and Documentation

When the need to use SST is foreseeable, employees must provide seven (7) days advance notice to their Supervisor. When the need to use SST is not foreseeable, employees must provide notice to their Supervisor as soon as practicable. Employees who know that their absence will exceed one (1) day should also indicate the day that they expect to return to work.

Employees may be required to confirm, either verbally or in writing, that they used SST for a reason covered under this policy, to the extent permitted by applicable law. For SST of more than three (3) consecutive work days, employees also may be required to provide reasonable documentation that SST was taken for a covered reason. For example, for SST used for reasons (1), (6), or (7) above, documentation signed by a licensed health care provider indicating the need for the amount of SST taken and that SST was used for a covered reason under this policy and/or applicable law will be considered reasonable documentation, and such documentation need not specify the nature of the employee's or the employee's family member's injury, illness, or condition, except as required by law. Supporting documentation will not be required for the above purposes if it would result in an unreasonable expense on the employee or where the employee did not receive services from a health care professional. In this event, reasonable documentation may include a written statement from the employee. For example, for SST used for reason (2) above, documentation signed by an employee or volunteer of a victim services organization, an attorney, a police officer, or an antiviolence counselor will be considered reasonable documentation, and such documentation need not specify the details of the domestic abuse, sexual assault, or stalking.

Payment

SST is paid at the same hourly rate as employee's regular rate of pay (including shift differentials, if applicable, but not including overtime payments or any special forms of compensation such as lost tips, incentives, commissions, premium payments or bonuses) for the hours the employee was scheduled to work during the time SST is used, unless otherwise required by applicable law. Use of SST is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued, unused SST may be carried over, but as indicated above, there is an overall accrual cap of eighty (80) hours. Once the overall accrual cap is reached, SST will stop accruing until some SST is used. Accrued, unused SST will not be paid upon separation.

Enforcement and Retaliation

Retaliation against employees who request or use earned SST is prohibited. Employees have the right to file a complaint with the City of Minneapolis Labor Standards Enforcement Division if they believe they have been denied SST, retaliated against, or that their rights to SST have been otherwise interfered with or restrained. Employees also have the right to file a complaint with the Minnesota Department of Labor and Industry or bring a civil action if they believe they have been denied SST, retaliated against, or that their rights to SST has been otherwise interfered with or restrained.

Employees with questions regarding this policy can contact Human Resources.

St. Paul Earned Sick and Safe Time

Eligibility

The Company provides Earned Sick and Safe Time (ESST) to employees who perform work within the City of St. Paul for at least eighty (80) hours in a year. For employees who work in St. Paul who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin to accrue ESST at the start of employment, whichever is later. Employees accrue one (1) hour of ESST for every thirty (30) hours worked, up to a maximum annual accrual of forty-eight (48) hours. Additionally, the employee's total ESST accrual balance may not exceed 80 hours at any time ("overall accrual cap"). Exempt employees will be presumed to work forty (40) hours in each workweek for accrual purposes unless their normal workweek is less than forty (40) hours, in which case accrual will be based on that normal workweek. For purposes of this policy, the year is the twelve- (12-) month period beginning January 1 and ending on December 31.

Usage

Employees can begin to use accrued ESST immediately. ESST may be used in the smallest increment of time tracked by the Company's payroll system.

The employee may use ESST for the following reasons:

1. The employee's mental or physical illness, injury, or health condition, need for medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition, or need for preventive medical care;

2. Care of a family member with a mental or physical illness, injury, or health condition, who needs medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition or who needs preventive medical care;

3. Absences due to domestic violence, sexual assault, or stalking of the employee or employee's family member, provided the absence is for medical attention related to physical or psychological injury or disability caused by domestic abuse, sexual assault, or stalking; to obtain services from a victim services organization; to obtain psychological or other counseling; to relocate or take steps to secure an existing home due to domestic violence, sexual assault, or stalking; or to take legal action, including preparing for or participating in any civil or criminal proceedings related to or resulting from domestic violence, sexual assault, or stalking;

4. The closure of the employee's place of business due to weather or other public emergency;

5. To accommodate the employee's need to care for a family member whose school or place of care has been closed due to weather or other public emergency;

6. The employee's inability to work or telework because the employee is:

    a. Prohibited from working by the Company due to health concerns related to the potential transmission of a communicable illness related to a public emergency; or

    b. Seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of a communicable disease related to a public emergency, and such employee has been exposed to a communicable disease or the Company has requested a test or diagnosis; or

7. When it has been determined by the health authorities having jurisdiction or by a health care professional that the presence of the employee or family member of the employee in the community would jeopardize the health of others because of the exposure of the employee or family member of the employee to a communicable disease, whether or not the employee or family member has actually contracted the communicable disease.

For purposes of this policy, family member means a child (including child-in-law), spouse or registered domestic partner, sibling (including a sibling-in-law), parent, grandchild, grandparent, a child of a sibling, a sibling of the parents of the employee or the employee's spouse of registered domestic partner, guardian, ward, or a person who currently resides in the employee's home, any other individual related by blood or whose close association with the employee is the equivalent of a family relationship; or one (1) individual annually designated by the employee. The family members listed above are not limited to biological family members but also include step, foster, adoptive, half-relations, and those who stand *in loco parentis* and legal guardians.

Unless the employee advises the Company otherwise, the Company will assume, subject to applicable law, that employees want to use available ESST for absences for reasons set forth above and employees will be paid for such absences to the extent they have ESST available.

Upon request of the employee, the Company will provide information (in writing or electronically) regarding both the employee's accrued and available ESST and used ESST.

Notice and Documentation

When the need to use ESST is foreseeable, employees must provide seven (7) days advance notice to the employee's supervisor. When the need to use ESST is not foreseeable, employees must provide notice to the employee's supervisor as soon as practicable.

For ESST of more than three (3) consecutive work days, employees may be required to provide reasonable documentation that ESST was taken for a covered reason. For example, for SST used for reasons (1), (6), or (7) above, documentation signed by a licensed health care provider indicating the need for the amount of ESST taken and that ESST was used for a covered reason under this policy and/or applicable law will be considered reasonable documentation, and such documentation need not specify the nature of the employee's or the employee's family member's injury, illness, or condition, except as required by law. Supporting documentation will not be required for the above purposes if it would result in an unreasonable expense on the employee or where the employee did not receive services from a health care professional. In this event, reasonable documentation may include a written statement from the employee. For example, for ESST used for reason (2) above, documentation signed by an employee or volunteer of a victim services organization, an attorney, a police officer, or an antiviolence counselor will be considered reasonable documentation, and such documentation need not specify the details of the domestic abuse, sexual assault, or stalking.

Payment

ESST is paid at the same hourly rate as the employee's regular rate of pay for the hours the employee was scheduled to work during the time ESST is used, unless otherwise required by applicable law. Use of ESST is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued, unused ESST may be carried over, but as indicated above, there is an overall accrual cap of eighty (80) hours. Once the overall accrual cap is reached, ESST will stop accruing and until some ESST is used.

Accrued, unused ESST will not be paid upon separation.

Enforcement and Retaliation

Employees may be subject to discipline for using ESST under this policy for purposes other than those provided under this policy, to the maximum extent permitted by applicable law. Retaliation against employees who request or use ESST is prohibited. Employees have the right to file a complaint with the City of St. Paul Department of Human Rights and Equal Economic Opportunity if they believe they have been denied ESST, retaliated against, or that their rights to ESST have been otherwise interfered with or restrained; or may bring a civil action in the event of retaliation. Employees also have the right to file a complaint with the Minnesota Department of Labor and Industry or bring a civil action if they believe they have been denied ESST, retaliated against, or that their rights to ESST have been otherwise interfered with or restrained.

Employees with questions regarding this policy can contact Human Resources.



Bloomington Sick and Safe Time

Eligibility

The Company provides sick and safe time (SST) to employees who perform work within the City of Bloomington for at least eighty (80) hours in a year. For employees who work in Bloomington who are eligible for SST under the general Sick Days policy, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy.

Accrual

Employees begin to accrue SST at the start of employment. Employees accrue one (1) hour of SST for every thirty (30) hours worked, up to a maximum annual accrual of forty-eight (48) hours each year. Additionally, an employee's total SST accrual balance may not exceed eighty (80) hours at any time (overall accrual cap). Exempt employees will be presumed to work forty (40) hours in each workweek for accrual purposes unless their normal workweek is less than forty (40) hours, in which case accrual will be based on that normal workweek. For purposes of this policy, the year is the twelve- (12-) month period January 1st and ending on December 31st.

Usage

Employees can begin to use accrued SST immediately. SST may be taken in the smallest increment of time tracked by the Company's payroll system.

An employee may use SST for the following reasons:

1. The employee's mental or physical illness; injury; health condition; need for medical diagnosis; care, including prenatal care; treatment of a mental or physical illness, injury, or health condition; or need for preventive medical or health care.

2. The care of a family member with a mental or physical illness, injury, or health condition; care of a family member who needs medical diagnosis, care including prenatal care; or treatment of a mental or physical illness, injury, or health condition; or care for a family member who needs preventive medical or health care.

3. An absence due to domestic abuse, sexual assault, or stalking of the employee or employee's family member, provided the absence is to:

    a. Seek medical attention or psychological or other counseling services related to physical or psychological injury or disability caused by domestic abuse, sexual assault, or stalking;

    b. Obtain services from a victim services organization;

    c. Seek relocation or take steps to secure an existing home due to domestic abuse, sexual assault, or stalking; or

    d. Seek legal advice or take legal action, including preparing for or participating in any civil or criminal legal proceeding related to or resulting from domestic abuse, sexual assault, or stalking.

4. The closure of the employee's place of business due to weather or other public emergency.

5. To accommodate the employee's need to care for a family member whose school or place of care has been closed due to weather or other public health emergency.

6. The employee's inability to work or telework because the employee is:

    i. Prohibited from working by the Company due to health concerns related to the potential transmission of a communicable illness related to a public emergency; or

    ii. Seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, a communicable disease related to a public emergency and such employee has been exposed to a communicable disease or the employee's employer has requested a test or diagnosis; and

7. When it has been determined by the health authorities having jurisdiction or by a health care professional that the presence of the employee or family member of the employee in the community would jeopardize the health of others because of the exposure of the employee or family member of the employee to a communicable disease, whether or not the employee or family member has actually contracted the communicable disease.

For purposes of this policy, family member means a child (including child-in-law), spouse or registered domestic partner, sibling (including a sibling-in-law), parent, grandchild, grandparent, a child of a sibling, a sibling of the parents of the employee or the employee's spouse or registered domestic partner, guardian, ward, other member of the employee's household, any other individual related by blood or whose close association with the employee is the equivalent of a family relationship; or one individual annually

designated by the employee. The family members listed above are not limited to biological family members but also include step, foster, adoptive, half-relations, and those who stand *in loco parentis* and legal guardians.

Unless the employee advises the Company otherwise, it will assume, subject to applicable law, that the employee wants to use available SST for absences for reasons set forth above, and the employee will be paid for such absences to the extent they have SST available.

Employees will be provided with their accrued and available SST and used SST on the employee's pay statement.

Notice & Documentation

When the need to use SST is foreseeable, employees must provide seven (7) days advance notice to the employee's Supervisor. When the need to use SST is not foreseeable, employees must provide notice to the employee's Supervisor as soon as practicable.

For SST of more than three (3) consecutive workdays taken for reasons one (1) to three (3) above, employees may also be required to provide reasonable documentation that SST was taken for a covered reason. For example, for SST used for reasons (1), (2), (6), or (7) above, documentation signed by a licensed health care provider indicating the need for the amount of SST taken and that SST was used for a covered reason under this policy and/or applicable law will be considered reasonable documentation, and such documentation need not specify the nature of the employee's or the employee's family member's injury, illness, or condition, except as required by law. Supporting documentation will not be required for the above purposes where the employee or employee's family member did not receive services from a health care professional or if documentation cannot be obtained from a health care professional in a reasonable time or without added expense. In this event, reasonable documentation may include a written statement from the employee indicating that the employee is using or used earned sick and safe time for a qualifying purpose pursuant to reasons (1), (2), (6) or (7).

For example, for SST used for reason (3) above, documentation signed by an employee or volunteer of a victim services organization, an attorney, a police officer, or an antiviolence counselor will be considered reasonable documentation, and such documentation need not specify the details of the domestic abuse, sexual assault, or stalking. For example, for SST used for reason (4) above, a written statement from the employee indicating that the employee is using or used earned sick and safe time for a qualifying purpose will be considered reasonable documentation.

Payment

SST is paid at the same hourly rate as employee's regular rate of pay (including shift differentials, if applicable, but not including overtime payments or any special forms of compensation such as lost tips, incentives, commissions, premium payments, or bonuses) for the hours the employee was scheduled to work during the time SST is used, unless otherwise required by applicable law. Use of SST is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Accrued, unused SST may be carried over, but as indicated above, there is an overall accrual cap of eighty (80) hours. Once the overall accrual cap is reached, SST will stop accruing until some SST is used.

Accrued, unused SST will not be paid upon separation.

Enforcement and Retaliation

Employees may be subject to discipline for using SST for a reason other than the covered reasons above, to the maximum extent permitted by applicable law. Retaliation against employees who request or use earned SST is prohibited. Employees have the right to file a complaint with the City of Bloomington's City Attorney's Office if they believe they have been denied SST, retaliated against, or that their rights to SST have been otherwise interfered with or restrained. Employees also have the right to file a complaint with the Minnesota Department of Labor and Industry or bring a civil action if they believe they have been denied SST, retaliated against, or that their rights to SST have been otherwise interfered with or restrained.

Employees with questions regarding this policy can contact Human Resources.



Minnesota Crime Victims Leave

Employees who are victims of a violent crime and are subpoenaed or requested by the prosecutor to attend court for the purpose of giving testimony may be granted reasonable time off from work without pay to attend criminal proceedings related to the victim's case. Employees who are a victim's spouse or immediate family member may be granted reasonable time off from work without pay to attend criminal proceedings related to the victim's case.

Employees must give 48 hours' advance notice of the request for time off pursuant to this policy, unless impracticable or an emergency prevents the employee from doing so.

Upon request, the employee must provide verification that supports the employee's reason for being absent from the workplace. All information related to the employee's leave pursuant to this section shall be kept confidential by the Company.

Minnesota Family Military Leave

Any employee who is the grandparent, parent, legal guardian, sibling, child, grandchild, spouse, fiancé or fiancée of a member of the United States armed forces who has been ordered into active service in support of a war or other national emergency ("mobilized service member") is eligible for an unpaid leave of absence of up to one (1) day per calendar year to attend a send-off or homecoming ceremony for the mobilized service member. Employees are asked to give Chestnut Health Systems as much notice of their intent to take this leave as is practicable under the circumstances.

Additionally, any employee who is the parent, child, grandparent, sibling or spouse of a member of the United States armed forces who has been injured or killed while engaged in active service is eligible for an unpaid leave of absence for up to 10 days. The employee must give the Company as much notice of intent to take this leave as is practicable. Any accrued paid time off which is used during this period will run concurrently with leave under this policy and will not extend the length of leave.

Minnesota Family and Medical Leave for Employers Covered by the FMLA

Employees may be entitled to a leave of absence under the Family and Medical Leave Act (FMLA) and/or the Minnesota Pregnancy & Parental Leave Act (MPPLA). This policy provides employees with information concerning FMLA and/or MPPLA entitlements and obligations employees may have during such leaves. If employees have any questions concerning FMLA and/or MPPLA leave, they should contact Human Resources.

I. Eligibility

FMLA leave is available to "FMLA eligible employees." To be an "FMLA eligible employee," the employee must: 1) have been employed by the Company for at least twelve (12) months (which need not be consecutive); 2) have been employed by the Company for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave; and 3) be employed at a worksite where fifty (50) or more employees are located within seventy-five (75) miles of the worksite.

Special hours of service eligibility requirements apply to airline flight crew employees.

All employees who work in Minnesota are "MPPLA eligible employees."

II. Entitlements

The FMLA and MPPLA provide eligible employees with a right to leave, health insurance benefits, and, with some limited exceptions, job restoration.

A. Basic FMLA and MPPLA Leave Entitlement

The FMLA provides eligible employees up to twelve (12) workweeks of unpaid leave for certain family and medical reasons during a twelve- (12-) month period. The twelve- (12-) month period is determined based on a rolling 12-month period measured backward from the date the employee uses their FMLA leave. The MPPLA provides eligible employees up to twelve (12) workweeks of unpaid leave for:

1. The birth or placement for adoption of a child; or

2. For a female employee's prenatal care, or incapacity due to pregnancy, childbirth, or related health conditions.

MPPLA leave for the birth or adoption of a child may begin not more than twelve (12) months after the birth or adoption, except that where the child must remain in the hospital longer than the childbearing parent, the leave may not begin more than twelve (12) months after the child leaves the hospital. It is the Company's policy to provide the greater leave benefit provided under the FMLA or MPPLA and to run leave concurrently under the FMLA and MPPLA whenever possible. Leave may be taken for any one (1), or for a combination, of the following reasons:

- To care for the employee's child after birth, or placement for adoption (or foster care—FMLA only);

- To care for the employee's spouse, son, daughter, or parent (but not in-law) who has a serious health condition (FMLA only);

- For the employee's own serious health condition (including any period of incapacity due to pregnancy, prenatal medical care, childbirth, or related health condition) that makes the employee unable to perform one (1) or more of the essential functions of the employee's job (FMLA only, except under the MPPLA, for a employee's own prenatal care, or incapacity due to pregnancy, childbirth, or related health conditions); and/or

- Because of any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a military member on covered active duty or called to covered active-duty status (or has been notified of an impending call or order to covered active duty) in the Reserve component of the Armed Forces for deployment to a foreign country in support of contingency operations or Regular Armed Forces for deployment to a foreign country (FMLA only).

A "serious health condition" is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) consecutive calendar days combined with at least two (2) visits to a health care provider or one (1) visit and a regimen of continuing treatment, incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

"Qualifying exigencies" may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, caring for the parents of the military member on covered active duty, and attending post-deployment reintegration briefings.

B. Additional Military Family Leave Entitlement (Injured Servicemember Leave) (FMLA Only)

In addition to the basic FMLA leave entitlement discussed above, an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember is entitled to take up to twenty-six (26) weeks of leave during a single twelve- (12-) month period to care for the servicemember with a serious injury or illness. Leave to care for a servicemember shall only be available during a single 12-month period

and, when combined with other FMLA-qualifying leave, may not exceed twenty-six (26) weeks during the single 12-month period. The single 12-month period begins on the first day an eligible employee takes leave to care for the injured servicemember.

A "covered servicemember" is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is on the temporary retired list, for a serious injury or illness. These individuals are referred to in this policy as "current members of the Armed Forces." "Covered servicemembers" also include a veteran who is discharged or released from military service under conditions other than dishonorable at any time during the five- (5-)year period preceding the date the eligible employee takes FMLA leave to care for the covered veteran, and who is who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. These individuals are referred to in this policy as "covered veterans."

The FMLA definitions of a "serious injury or illness" for current Armed Forces members and covered veterans are distinct from the FMLA definition of "serious health condition" applicable to FMLA leave to care for a covered family member.

C. Intermittent Leave and Reduced Leave Schedules

FMLA leave usually will be taken for a period of consecutive days, weeks, or months. However, employees also are entitled to take FMLA leave intermittently or on a reduced leave schedule when medically necessary due to a serious health condition of the employee or covered family member, or the serious injury or illness of a covered servicemember. Leave due to qualifying exigencies may also be taken on an intermittent or reduced schedule basis.

D. No Work While on Leave

The taking of another job while on FMLA/MPPLA leave or any other authorized leave of absence is grounds for immediate discharge, to the extent permitted by applicable law.

E. Protection of Group Health Insurance Benefits

During FMLA/MPPLA leave, eligible employees are entitled to receive group health plan coverage on the same terms and conditions as if they had continued to work. However, if leave is solely pursuant to MPPLA, the employee may be required to pay the full health insurance premium during leave.

F. Restoration of Employment and Benefits

At the end of FMLA/MPPLA leave, subject to some exceptions, employees generally have a right to return to the same or equivalent positions with equivalent pay, benefits, and other employment terms. Under the FMLA only, reinstatement also may be denied where job restoration of "key employees" will cause the Company substantial and grievous economic injury. The Company will notify employees if they qualify as "key employees," if it intends to deny reinstatement and of their rights in such instances. Use of FMLA/MPPLA leave will not result in the loss of any employment benefit that accrued prior to the start of an eligible employee's FMLA/MPPLA leave.

G. Notice of Eligibility for, and Designation of, FMLA Leave

Employees requesting FMLA leave are entitled to receive written notice from the Company telling them whether they are eligible for FMLA leave and, if not eligible, the reasons why they are not eligible. When eligible for FMLA leave, employees are entitled to receive written notice of:

1. Their rights and responsibilities in connection with such leave;
2. The Company's designation of leave as FMLA-qualifying or non-qualifying, and if not FMLA-qualifying, the reasons why; and
3. The amount of leave, if known, that will be counted against the employee's leave entitlement.

The Company may retroactively designate leave as FMLA leave with appropriate written notice to employees provided the Company's failure to designate leave as FMLA-qualifying at an earlier date did not cause harm or injury to the employee. In all cases where leaves qualify for FMLA protection, the Company and employee can mutually agree that leave be retroactively designated as FMLA leave.

III. Employee FMLA/MPPLA Leave Obligations

A. Provide Notice of the Need for Leave

Employees who wish to take FMLA/MPPLA leave must timely notify the Company of their need for FMLA/MPPLA leave. The following describes the content and timing of such employee notices.

1. Content of Employee Notice

To trigger FMLA leave protections, employees must inform Human Resources of the need for FMLA-qualifying leave and the anticipated timing and duration of the leave, if known. Employees may do this by either requesting FMLA leave specifically, or explaining the reasons for leave so as to allow the Company to determine that the leave is FMLA-qualifying. For example, employees might explain that:

- A medical condition renders them unable to perform the functions of their job;
- They are pregnant or have been hospitalized overnight;
- They or a covered family member are under the continuing care of a health care provider;
- The leave is due to a qualifying exigency caused by a military member being on covered active duty or called to covered active-duty status to a foreign country; or
- If the leave is for a family member, that the condition renders the family member unable to perform daily activities or that the family member is a covered servicemember with a serious injury or illness.

Calling in "sick," without providing the reasons for the needed leave, will not be considered sufficient notice for FMLA leave under this policy. Employees must respond to the Company's questions to determine if absences are potentially FMLA-qualifying.

If employees fail to explain the reasons for FMLA leave, the leave may be denied. When employees seek leave due to FMLA-qualifying reasons for which the Company has previously provided FMLA-protected leave, they must specifically reference the qualifying reason for the leave or the need for FMLA leave.

For MPPLA, the notice of the need for leave should include the date the leave will commence and the estimated duration of the leave.

2. Timing of Employee Notice

Employees must provide 30 days' advance notice of the need to take FMLA/MPPLA leave when the need is foreseeable. When 30 days' notice is not possible, or the approximate timing of the need for leave is not foreseeable, employees must provide the Company notice of the need for leave as soon as practicable under the facts and circumstances of the particular case. Employees who fail to give 30 days' notice for foreseeable leave without a reasonable excuse for the delay, or otherwise fail to satisfy FMLA notice obligations, may have FMLA leave delayed or denied.

Employees returning from MPPLA leave longer than one (1) month also must provide notice of their return from leave to Human Resources at least two (2) weeks in advance.

B. Cooperate in the Scheduling of Planned Medical Treatment (Including Accepting Transfers to Alternative Positions) and Intermittent Leave or Reduced Leave Schedules

When planning medical treatment, employees must consult with the Company and make a reasonable effort to schedule treatment so as not to unduly disrupt the Company's operations, subject to the approval of the employee's health care provider. Employees must consult with the Company prior to the scheduling of treatment to work out a treatment schedule that best suits the needs of both the Company and the employees, subject to the approval of the employee's health care provider. If employees providing notice of the need to take FMLA leave on an intermittent basis for planned medical treatment neglect to fulfill this obligation, the Company may require employees to attempt to make such arrangements, subject to the approval of the employee's health care provider.

When employees take intermittent or reduced work schedule leave for foreseeable planned medical treatment for the employee or a family member, including during a period of recovery from a serious health condition or to care for a covered servicemember, the Company may temporarily transfer employees, during the period that the intermittent or reduced leave schedules are required, to alternative positions with equivalent pay and benefits for which the employees are qualified and which better accommodate recurring periods of leave.

When employees seek intermittent leave or a reduced leave schedule for reasons unrelated to the planning of medical treatment, upon request, employees must advise the Company of the reasons why such leave is medically necessary. In such instances, the Company and employee shall attempt to work out a leave schedule that meets the employee's needs without unduly disrupting the Company's operations, subject to the approval of the employee's health care provider.

C. Submit Medical Certifications Supporting Need for FMLA Leave (Unrelated to Requests for Military Family Leave)

Depending on the nature of the FMLA leave sought, employees may be required to submit medical certifications supporting their need for FMLA-qualifying leave. As described below, there generally are three (3) types of FMLA medical certifications: an initial certification, a recertification, and a return to work/fitness for duty certification.

It is the employee's responsibility to provide the Company with timely, complete, and sufficient medical certifications. Whenever the Company requests employees to provide FMLA medical certifications, employees must provide the requested certifications within fifteen (15) calendar days after the Company's request, unless it is not practicable to do so despite the employee's diligent, good-faith efforts. The Company will inform employees if submitted medical certifications are incomplete or insufficient and provide employees at least seven (7) calendar days to cure deficiencies. The Company will deny FMLA leave to employees who fail to timely cure deficiencies or otherwise fail to timely submit requested medical certifications.

With the employee's permission, the Company (through individuals other than the employee's direct supervisor) may contact the employee's health care provider to authenticate or clarify completed and sufficient medical certifications. If employees choose not to provide the Company with authorization allowing it to clarify or authenticate certifications with health care providers, the Company may deny FMLA leave if certifications are unclear.

Whenever the Company deems it appropriate to do so, it may waive its right to receive timely, complete, and/or sufficient FMLA medical certifications.

1. Initial Medical Certifications

Employees requesting leave because of their own, or a covered relation's, serious health condition, or to care for a covered servicemember, must supply medical certification supporting the need for such leave from their health care provider or, if applicable, the health care provider of their covered family or servicemember. If employees can provide at least 30 days' notice of medical leave, they should submit the medical certification before leave begins. A new initial medical certification will be required on an annual basis for serious medical conditions lasting beyond a single leave year.

If the Company has reason to doubt initial medical certifications, it may require employees to obtain a second opinion at the Company's expense. If the opinions of the initial and second health care providers differ, the Company may, at its expense, require employees to obtain a third, final, and binding certification from a health care provider designated or approved jointly by the Company and the employee.

2. Medical Recertifications

Depending on the circumstances and duration of FMLA leave, the Company may require employees to provide recertification of medical conditions giving rise to the need for leave. The Company will notify employees if recertification is required and will give employees at least fifteen (15) calendar days to provide medical recertification.

3. Return to Work/Fitness for Duty Medical Certifications

Unless notified that providing such certifications is not necessary, employees returning to work from FMLA leaves that were taken because of their own serious health conditions that made them unable to perform their jobs must provide the Company medical certification confirming they are able to return to work and the employees' ability to perform the essential functions of the employees' position, with or without reasonable accommodation. The Company may delay and/or deny job restoration until employees provide return to work/fitness for duty certifications.

D. Submit Certifications Supporting Need for Military Family Leave

Upon request, the first-time employees seek leave due to qualifying exigencies arising out of the covered active duty or call to covered active-duty status of a military member, the Company may require employees to provide:

1. A copy of the military member's active-duty orders or other documentation issued by the military indicating the military member is on active duty or call to covered active-duty status and the dates of the military member's covered active-duty service; and

2. A certification from the employee setting forth information concerning the nature of the qualifying exigency for which leave is requested. Employees shall provide a copy of new active-duty orders or other documentation issued by the military for leaves arising out of qualifying exigencies arising out of a different covered active duty or call to covered active-duty status of the same or a different military member.

When leave is taken to care for a covered servicemember with a serious injury or illness, the Company may require employees to obtain certifications completed by an authorized health care provider of the covered servicemember. In addition, and in accordance with the FMLA regulations, the Company may request that the certification submitted by employees set forth additional information provided by the employee and/or the covered servicemember confirming entitlement to such leave.

E. Substitute Paid Leave for Unpaid FMLA and MPPLA Leave

Employees must use any accrued paid time while taking unpaid FMLA and/or MPPLA leave.

The substitution of paid time for unpaid FMLA and/or MPPLA leave time does not extend the length of FMLA leave and the paid time will run concurrently with the employee's FMLA/MPPLA entitlement.

Leaves of absence taken in connection with a disability leave plan or workers' compensation injury/illness shall run concurrently with any FMLA leave entitlement. Upon written request, the Company will allow employees to use accrued paid time to supplement any paid disability benefits.

F. Pay Employee's Share of Health Insurance Premiums

During FMLA/MPPLA leave, employees are entitled to continued group health plan coverage under the same conditions as if they had continued to work. However, if leave is solely pursuant to MPPLA, the employee may be required to pay the full health insurance premium during leave. Unless the Company notifies employees of other arrangements, whenever employees are receiving pay from the Company during FMLA/MPPLA leave, the Company will deduct the employee's portion of the group health plan premium from the employee's paycheck in the same manner as if the employee was actively working.

If FMLA/MPPLA leave is unpaid, employees must pay their portion of the group health premium through a method determined by the Company upon leave.

The Company's obligation to maintain health care coverage ceases if the employee's premium payment is more than thirty (30) days late. If the employee's payment is more than fifteen (15) days late, the Company will send a letter notifying the employee that coverage will be dropped on a specified date unless the co-payment is received before that date. If employees do not return to work within thirty (30) calendar days at the end of the leave period (unless employees cannot return to work because of a serious health condition or other circumstances beyond their control), they will be required to reimburse the Company for the cost of the premiums the Company paid for maintaining coverage during their unpaid FMLA leave.

IV. Coordination of FMLA/MPPLA Leave with Other Leave Policies

The FMLA and MPPLA do not affect any federal, state, or local law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights. However, whenever permissible by law, FMLA leave will run concurrently with MPPLA and any other leave provided under state or local law. For additional information concerning leave entitlements and obligations that might arise when FMLA/MPPLA leave is either not available or exhausted, please consult the Company's other leave policies in this handbook or contact Human Resources.

V. Questions and/or Complaints about FMLA/MPPLA Leave

If employees have questions regarding this FMLA/MPPLA policy, they should contact Human Resources. The Company is committed to complying with the FMLA/MPPLA and, whenever necessary, shall interpret and apply this policy in a manner consistent with the FMLA/MPPLA.

The FMLA makes it unlawful for employers to:

1. Interfere with, restrain, or deny the exercise of any right provided under FMLA; or

2. Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or involvement in any proceeding under or relating to FMLA. If employees believe their FMLA rights have been violated, they should contact Human Resources immediately. The Company will investigate any FMLA complaints and take prompt and appropriate remedial action to address and/or remedy any FMLA violation. Employees also may file FMLA complaints with the U.S. Department of Labor or may bring private lawsuits alleging FMLA violations.

Minnesota Domestic Abuse or Harassment Leave

Employees are entitled to reasonable unpaid time off to obtain or attempt to obtain an order of protection and/or other relief from a court related to domestic abuse or harassment.

The employee who is absent from the workplace shall give forty-eight (48) hours' advance notice to the Company except in cases of imminent danger to the health or safety of the employee or the employee's child, or unless impracticable.

Upon request, the employee must provide verification that supports the employee's reason for being absent from the workplace. All information related to the employee's leave pursuant to this section shall be kept confidential by the Company.

Minnesota School Conference and Activities Leave

Chestnut Health Systems will provide employees with up to sixteen (16) hours of leave during any twelve-(12-) month period to attend school conferences or school-related activities related to the employee’s child (including conferences related to a pre-kindergarten program or child care services), provided the conferences or school-related activities cannot be scheduled during nonwork hours.

When leave cannot be scheduled during non-work hours and the need for leave is foreseeable, the employee must provide reasonable prior notice of the leave and make a reasonable effort to schedule the leave so as not to unduly disrupt the Company's operations. Leave under this policy is unpaid. However, the employee may substitute accrued paid time off for leave under this policy.

CHESTNUT
HEALTH SYSTEMS

MINNESOTA SUPPLEMENT ACKNOWLEDGMENT

This Minnesota Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Minnesota Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

85. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;
86. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;
87. obscene or vulgar gestures, posters or comments;
88. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;
89. propositions or suggestive or insulting comments of a sexual nature;
90. derogatory cartoons, posters and drawings;
91. sexually-explicit e-mails, text messages or voicemails;
92. uninvited touching of a sexual nature;
93. unwelcome sexually-related comments;
94. conversation about one's own or someone else's sex life;
95. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and
96. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

ADDENDUM – Montana Supplement – 2024



Chestnut Health Systems

Personnel Policies

Montana Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Montana Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Montana employees will receive the Company's Personnel Policies and the Montana Supplement to the Personnel Policies ("Montana Supplement) (together the "Employee Handbook").

The Montana Supplement applies only to Montana employees. It is intended as a resource containing specific provisions derived under Montana law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Montana Supplement are different from or more generous than those in the National Handbook, the policies in the Montana Supplement will apply.

The Montana Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

About the Montana Handbook/Disclaimer

Chestnut Health Systems prepared this handbook to assist employees in finding the answers to many questions they may have regarding their employment. Employees should take the necessary time to read it.

Chestnut Health Systems does not expect this handbook to answer all questions. Human Resources also will be a major source of information.

Neither this supplement/handbook, nor any other verbal or written communication by a management representative, is, nor should it be considered to be, an agreement, contract of employment, express or

implied, or a promise of treatment in any particular manner in any given situation nor does it confer any contractual rights whatsoever.

Chestnut Health Systems fully complies with all provisions of the Montana Wrongful Discharge from Employment Act which allows termination of employees only for good cause, except to the extent any employee is subject to the 12-month introductory period. During the introductory period, employment is at-will and may be terminated at any time and for any lawful reason by the Employee or the Company (unless modified by a writing signed by CEO). Chestnut Health Systems also may extend the introductory period as allowed by law.

Many matters covered by this handbook, such as benefit plan descriptions, are also described in separate Company documents. These documents are always controlling over any statement made in this handbook or by any member of management.

This handbook states only general Company guidelines. The Company may, at any time, in its sole discretion, modify or vary from anything stated in this handbook, with or without notice, subject to applicable law.

This handbook supersedes all prior handbooks.

TIME OFF AND LEAVES OF ABSENCE

Montana Pregnancy Leave

Chestnut Health Systems will not discriminate against an applicant or employee because of pregnancy, childbirth or related medical condition. The Company will not treat employees disabled due to pregnancy less favorably than any employee with a temporary disability under any health, medical temporary disability or sick leave plan maintained by the Company. All benefits provided to temporarily disabled employees pursuant to such a plan will be provided to pregnant employees.

The Company will provide employees a reasonable leave of absence for the temporary disabilities associated with pregnancy, childbirth, delivery and related medical conditions and will not place restrictions on the leave which would not apply to leaves of absence for any other valid medical reason. As a condition of leave provided for pregnancy, the Company may require the employee to provide medical verification that the employee is unable to perform the employee's job duties.

A pregnant employee is entitled to use any disability benefits, sick leave, vacation time, annual leave or compensatory time accrued pursuant to plans maintained by the Company for pregnancy leave. If the Company maintains no such plans or benefits or such benefits have been exhausted, the pregnancy leave will be without pay.

Any employee who has signified the intent to return at the end of a reasonable leave of absence for pregnancy will be reinstated to the employee's original job or to an equivalent position with equivalent pay and accumulated seniority, retirement, fringe benefits and other service credits, except when the Company's circumstances have changed so much that it is impossible or unreasonable to do so.

If employees have any questions concerning this policy, they should contact Human Resources.

CHESTNUT
HEALTH SYSTEMS

MONTANA SUPPLEMENT ACKNOWLEDGMENT

This Montana Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Montana Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

97. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;

98. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;

99. obscene or vulgar gestures, posters or comments;

100. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;

101. propositions or suggestive or insulting comments of a sexual nature;

102. derogatory cartoons, posters and drawings;

103. sexually-explicit e-mails, text messages or voicemails;

104. uninvited touching of a sexual nature;

105. unwelcome sexually-related comments;

106. conversation about one's own or someone else's sex life;

107. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and

108. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

ADDENDUM – New Jersey Supplement – 2024



Chestnut Health Systems

Personnel Policies

New Jersey Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This New Jersey Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, New Jersey employees will receive the Company's Personnel Policies and the New Jersey Supplement to the Personnel Policies ("New Jersey Supplement) (together the "Employee Handbook").

The New Jersey Supplement applies only to New Jersey employees. It is intended as a resource containing specific provisions derived under New Jersey law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the New Jersey Supplement are different from or more generous than those in the National Handbook, the policies in the New Jersey Supplement will apply.

The New Jersey Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

New Jersey Equal Employment Opportunity

Chestnut Health Systems is an Equal Opportunity Employer that does not discriminate on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, domestic partnership or civil union status, military service or veteran status, physical or mental disability, atypical hereditary cellular or blood trait, genetic information, or any other characteristic protected by applicable federal, state or local laws. Chestnut Health Systems management team is dedicated to this policy with respect to recruitment, hiring, placement, promotion, transfer, training, compensation, benefits, employee activities, access to facilities and programs, and general treatment during employment.

The Company will endeavor to make a reasonable accommodation of an otherwise qualified applicant or employee related to an individual’s physical or mental disability; sincerely held religious beliefs and practices; and/or any other reason required by applicable law, unless doing so would impose an undue hardship upon the Company's business operations. Any applicant or employee who needs an accommodation in order to perform the essential functions of the job should contact the CEO to request such an accommodation. The individual should specify what accommodation is needed to perform the job and submit supporting documentation explaining the basis for the requested accommodation, to the extent permitted and in accordance with applicable law. The Company then will review and analyze the request, including engaging in an interactive process with the individual, to identify if such an accommodation can be made. The Company will evaluate requested accommodations, and as appropriate identify other possible accommodations, if any. The individual will be notified of The Company's decision regarding the request within a reasonable period. The Company treats all medical information submitted as part of the accommodation process in a confidential manner.

Any employees with questions or concerns about equal employment opportunities in the workplace are encouraged to bring these issues to the attention of the CEO. The Company will not allow any form of retaliation against individuals who raise issues of equal employment opportunity. If employees feel they have been subjected to any such retaliation, they should contact the CEO. To ensure the workplace is free of artificial barriers, violation of this policy including any improper retaliatory conduct will lead to discipline, up to and including discharge. All employees must cooperate with all investigations conducted pursuant to this policy.

New Jersey Pregnancy Accommodations

Pursuant to New Jersey law, Chestnut Health Systems prohibits unlawful discrimination on the basis of pregnancy or breastfeeding. The Company will endeavor to reasonably accommodate the needs of employees' pregnancy, childbirth, breastfeeding or expressing milk for breastfeeding or related medical condition, including recovery from childbirth, provided that the pregnancy, childbirth or related medical condition is known or should have been known by the Company, and the proposed accommodation does not impose an undue hardship on the business operations of the Company.

Reasonable accommodations may include, but are not limited to:

1. bathroom breaks;
2. breaks for increased water intake;
3. periodic rest;
4. assistance with manual labor;
5. job restructuring or modified work schedules;
6. temporary transfers to less strenuous or hazardous work; or
7. reasonable break time each day to express breast milk.

For purposes of expressing breast milk, the Company will provide a suitable room or other location with privacy, other than a toilet stall, in close proximity to the work area.

Any employee who needs to request an accommodation due to pregnancy, childbirth or a related medical condition or who has questions regarding the policy should contact Human Resources.

PAY PRACTICES

New Jersey Statutory Short-Term Disability Benefits

Chestnut Health Systems also provides statutory short-term disability insurance.

This is solely a monetary benefit and not a leave of absence. Employees who will be out of work must also request a formal leave of absence. See the Leave of Absence sections of this handbook for more information.

New Jersey Pre-Tax Transportation Fringe Benefit

All New Jersey employees are eligible to receive a pre-tax transportation fringe benefit. This benefit allows commuter highway vehicle and transit benefits to be deducted from employees' gross income. The transportation benefits must be consistent with IRS provisions and limits at the maximum benefit levels allowable under federal law.

Employees should contact Human Resources for further information about the program or to sign up for benefits.

New Jersey Family Leave Insurance Benefits

If employees need to take time off work for the reasons listed below, they may be eligible to receive family leave benefits through the state of New Jersey. Leave, in this instance, is administered by the Division of Temporary Disability Insurance, the New Jersey Department of Labor and Workforce Development. Reasons are as follows:

- care for a family member with a serious health condition;
- bond with a child during the first twelve (12) months after birth or placement of the child for adoption or as a foster child;
- engage in activities for which unpaid leave may be taken pursuant to the New Jersey Security and Financial Empowerment Act (NJ SAFE Act), on the employee's own behalf, if a victim of an incident of domestic violence or a sexually violent offense, or to assist a family member of the individual who has been a victim of an incident of domestic violence or a sexually violent offense (except for any time for which the employee receives disability benefits for a disability caused by the violence or offense);
- in the event of a state of emergency declared by the Governor, or when indicated to be needed by the Commissioner of Health or other public health authority, an epidemic of a communicable disease, a known or suspected exposure to the communicable disease, or efforts to prevent spread of the communicable disease, provide in-home care or treatment of the family member of the employee required due to:

1. the issuance by a healthcare provider or the commissioner or other public health authority of a determination that the presence in the community of the family member may jeopardize the health of others; and

2. the recommendation, direction, or order of the provider or authority that the family member be isolated or quarantined as a result of suspected exposure to a communicable disease,

For purposes of this policy, family member includes the employee's child, parent, spouse, domestic partner, civil union partner, parent-in-law, sibling, grandparent, grandchild or any other individual related by blood to the employee, and any other individual with whom the employee has a close association equivalent to a family relationship.

These benefits are financed solely through employee contributions to the state. The state is responsible for determining if employees are eligible for such benefits.

Employees should advise their immediate supervisor or Human Resources if they need to take time for these purposes. Employees will be given information about the state's family leave benefits program and how to apply for benefits. Employees also may contact the Division of Temporary Disability Insurance for further information.

Employees should maintain regular contact with their immediate supervisor during the time off work so Chestnut Health Systems may monitor their return-to-work status. In addition, employees should contact their immediate supervisor or Human Resources when they are ready to return to work so the Company may determine what positions, if any, are open.

Job Reinstatement Not Guaranteed

Please note: employees taking time off for these purposes are not guaranteed job reinstatement unless they qualify for such reinstatement under federal and/or state leave laws. Any time off for family leave purposes will run concurrently with other leaves of absence, such as Family and Medical Leave Act and the New Jersey Family Leave Act and/or the NJ SAFE Act, if applicable. Please see the "Family and Medical Leave" and/or the NJ SAFE Act policies for eligibility requirements.

Retaliation

Employees will not be discharged, harassed, threatened or otherwise discriminated or retaliated against because they have requested or taken any family leave benefits pursuant to this policy.

TIME OFF AND LEAVES OF ABSENCE

New Jersey Earned Sick and Safe Leave

Eligibility

Chestnut Health Systems provides paid Earned Sick and Safe Leave (ESSL) to employees who work in New Jersey. For employees who work in New Jersey who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing ESSL at the start of employment. Eligible employees will accrue one (1) hour of ESSL for every thirty (30) hours worked, up to a maximum accrual of forty (40) hours each benefit year.

Exempt employees are assumed to work forty (40) hours in each workweek unless their normal workweek is less than forty (40) hours, in which case ESSL accrues based upon that normal workweek. For purposes of this policy, the benefit year is the consecutive twelve- (12-) month period beginning January 1 and ending on December 31.

Usage

Employees may begin using accrued ESSL on the 120th calendar day of employment. ESSL may be used in one- (1-) hour increments, except to the extent such increment is greater than the number of hours the employee was scheduled to work during that shift. The employee may not use more than forty (40) hours of ESSL in any benefit year.

Employees may use ESSL for the following reasons:

1. diagnosis, care or treatment of, or recovery from, the employee's mental or physical illness, injury or other adverse health condition or for preventive medical care for the employee;

2. diagnosis, care or treatment of, or recovery from, a family member's mental or physical illness, injury or other adverse health condition or for preventive medical care for the family member;

3. circumstances resulting from the employee, or a family member of the employee, being a victim of domestic or sexual violence, if the leave is to allow the employee to obtain for the employee or the family member:

    - medical attention needed to recover from physical or psychological injury or disability caused by domestic or sexual violence;

    - services from a designated domestic violence agency or other victim services organization;

    - psychological or other counseling;

    - relocation; or

    - legal services, including obtaining a restraining order or preparing for, or participating in, any civil or criminal legal proceeding related to domestic or sexual violence.

4. time during which the employee is not able to work because of:

    - a closure of the employee's workplace, or the school or place of care of a child of the employee by order of a public official or because of a state of emergency declared by the Governor, due to an epidemic or other public health emergency;

    - the declaration of a state of emergency by the Governor, or the issuance by a health care provider or the Commissioner of Health or other public health authority of a determination that the presence in the community of the employee, or a member of the employee's family in need of care by the employee would jeopardize the health of others;

- during a state of emergency declared by the Governor, or upon the recommendation, direction or order of a healthcare provider or the Commissioner of Health or other authorized public official, the employee undergoes isolation or quarantine or cares for a family member in quarantine as a result of suspected exposure to a communicable disease and a finding by the provider or authority that the presence in the community of the employee or family member would jeopardize the health of others.

5. time needed by the employee in connection with a child of the employee to attend a school-related conference, meeting, function or other event requested or required by a school administrator, teacher or other professional staff member responsible for the child's education; or to attend a meeting regarding care provided to the child in connection with the child's health conditions or disability.

For purposes of this policy, a family member includes a child, grandchild, sibling, spouse, domestic partner, civil union partner, parent or grandparent of the employee; or a spouse, domestic partner, or civil union partner of a parent or grandparent of the employee; or a sibling of a spouse, domestic partner or civil union partner of the employee; or any other individual related by blood to the employee or whose close association with the employee is the equivalent of a family relationship.

Unless the employee advises the Company otherwise, we will assume, subject to applicable law, that employees want to use available ESSL for absences for reasons set forth above and employees will be paid for such absences to the extent they have ESSL available.

Notice and Documentation

If the employee's need to use ESSL is foreseeable, employees must give seven (7) calendar days advance notice, prior to the date the leave is to begin, of their intention to use the leave and its expected duration. If the reason for the leave is not foreseeable, employees must give notice of the intention to use ESSL as soon as practicable. The Company may prohibit employees from using foreseeable ESSL on certain dates or require reasonable documentation if ESSL that is not foreseeable is used during such dates.

The Company will require reasonable documentation if the employee uses ESSL for three (3) or more consecutive work days.

If ESSL is taken for reasons #1 or #2 above, documentation signed by a health care professional, who is treating the employee or the family member of the employee, indicating the need for the leave and, if possible, number of days of leave, will be considered reasonable documentation.

If ESSL is taken for reason #3 above, any of the following will be considered reasonable documentation of the domestic or sexual violence:

- medical documentation;
- a law enforcement agency record or report;
- a court order;
- documentation that the perpetrator of the domestic or sexual violence has been convicted of a domestic or sexual violence offense;

- certification from a certified Domestic Violence Specialist or a representative of a designated domestic violence agency or other victim services organization; or

- other documentation or certification provided by a social worker, counselor, member of the clergy, shelter worker, health care professional, attorney or other professional who has assisted the employee or family member in dealing with the domestic or sexual violence.

If ESSL is taken for reason #4 above, a copy of the order of the public official or the determination by the health authority will be considered reasonable documentation.

If ESSL is taken for reason #5 above, the following will be considered reasonable documentation: tangible proof of the school-related conference, meeting, function or other event requested or required by a school administrator, teacher or other professional staff member responsible for the education of the employee's child; or tangible proof of the meeting regarding care provided to the child of the employee in connection with the child's health conditions or disability.

Payment

ESSL will be paid at the same rate of pay with the same benefits as the employee normally earns, but no less than the state minimum wage. Use of ESSL will not be counted as hours worked for purposes of calculating overtime.

Carryover and Payout

The employee may carry over up to forty (40) hours of accrued, unused ESSL under this policy to the following benefit year. Accrued but unused ESSL under this policy will not be paid at separation.

Enforcement and Retaliation

Employees have the right to request and use ESSL and may file a complaint for alleged violations of their rights with the New Jersey Department of Labor and Workforce Development. The Company prohibits retaliation or the threat of retaliation against the employee for exercising or attempting to exercise any right provided in this policy or under applicable law.

Employees with questions regarding this policy can contact Human Resources.

New Jersey Family and Medical Leave

Employees may be entitled to a leave of absence under the Family and Medical Leave Act (FMLA) and/or the New Jersey Family Leave Act (NJFLA). This policy provides employees with information concerning FMLA and/or NJFLA entitlements and obligations employees may have during such leaves. If employees have any questions concerning FMLA and/or NJFLA leave, they should contact Human Resources.

I. Eligibility

"FMLA leave is available to "FMLA eligible employees." To be an "FMLA eligible employee," the employee must: 1) have been employed by the Company for at least twelve (12) months (which need not be consecutive); 2) have been employed by the Company for at least 1,250 hours of service during the twelve-(12-)month period immediately preceding the commencement of the leave; and 3) be employed at a worksite where fifty (50) or more employees are located within 75 miles of the worksite.

Special hours of service eligibility requirements apply to airline flight crew.

NJFLA leave is available to "eligible employees." To be an "NJFLA eligible employee," the employee must: 1) have been employed by the Company for at least twelve (12) months; 2) have worked at least 1,000 base hours during the twelve- (12-) month period preceding the leave; and 3) be employed by an employer that has thirty (30) or more employees. "Base hours" mean the hours of work for which the employee receives compensation including overtime hours and hours for which the employee receives workers' compensation benefits.

II. Employee Entitlements for FMLA and NJFLA Leave

As described below, the FMLA and NJFLA provide eligible employees with a right to leave, health insurance benefits (FMLA only), and, with some limited exceptions, job restoration.

A. Basic FMLA and NJFLA Leave Entitlement

The FMLA provides eligible employees up to twelve (12) workweeks of unpaid leave for certain family and medical reasons during a twelve- (12-) month period. The NJFLA provides eligible employees up to twelve (12) workweeks of unpaid leave for certain family reasons during a twenty-four- (24-) month period. The 12- or 24-month period is determined on a rolling 12-month period measured backward from the date the employee uses their FMLA leave.

It is the Company's policy to provide the greater leave benefit provided under the FMLA or NJFLA and to run leave concurrently under the FMLA and NJFLA whenever possible.

Leave may be taken for any one (1), or for a combination, of the following reasons:

- To care for the employee's child after birth or placement for adoption or foster care;
- To care for the employee's spouse (domestic partner or partner in a civil union—NJFLA only), child or parent (or parent-in-law, sibling, grandparent, grandchild, any individual related by blood, or any other individual with a close association equivalent to a family relationship—NJFLA only) who has a **serious health condition**;
- In the event of a state of emergency declared by the Governor or when indicated to be needed by the Commissioner of Health or other public health authority, an epidemic of a communicable disease, a known or suspected exposure to the communicable disease, or efforts to prevent spread of a communicable disease, which:
    1. Requires in-home care or treatment of a child due to the closure of the school or place of care of the child of the employee, by order of a public official due to the epidemic or other public health emergency;
    2. Prompts the issuance by a public health authority of a determination, including by mandatory quarantine, requiring or imposing responsive or prophylactic measures as a result of illness caused by an epidemic of a communicable disease or known or suspected exposure to the communicable disease because the presence in the community of a family member in need of care by the employee would jeopardize the health of others; or

3. Results in the recommendation of a health care provider or public health authority, that a family member (child, parent, parent-in-law, sibling, grandparent, grandchild, spouse, domestic partner or one (1) partner in a civil union couple, any other individual related by blood to the employee, or any other individual with whom the employee has a close association equivalent to a family relationship) in need of care by the employee voluntarily undergo self-quarantine as a result of suspected exposure to a communicable disease because the presence in the community of that family member in need of care would jeopardize the health of others (NJFLA only);

- For the employee's own **serious health condition** (including any period of incapacity due to pregnancy, prenatal medical care, or childbirth) that makes the employee unable to perform one (1) or more of the essential functions of the employee's job (FMLA only); and/or

- Because of any **qualifying exigency** arising out of the fact that the employee's spouse, son, daughter, or parent is a military member on covered active duty or called to covered active-duty status (or has been notified of an impending call or order to covered active duty) in the Reserve component of the Armed Forces for deployment to a foreign country in support of contingency operations or Regular Armed Forces for deployment to a foreign country (FMLA only).

A **"serious health condition"** is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) consecutive calendar days combined with at least two (2) visits to a health care provider or one (1) visit and a regimen of continuing treatment or incapacity due to pregnancy or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Qualifying exigencies for FMLA leave may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, caring for the parents of the military member on covered active duty, and attending post-deployment reintegration briefings.

B. Additional Military Family Leave Entitlement (Injured Servicemember Leave) (FMLA only)

In addition to the basic FMLA leave entitlement discussed above, an eligible employee who is the spouse, son, daughter, parent, or next of kin of a **covered servicemember** is entitled to take up to twenty-six (26) weeks of leave during a single twelve- (12-) month period to care for the servicemember with a serious injury or illness. FMLA leave to care for a servicemember shall only be available during a single 12-month period and, when combined with other FMLA-qualifying leave, may not exceed twenty-six (26) weeks during the single 12-month period. The single 12-month period begins on the first day an eligible employee takes leave to care for the injured servicemember.

A **"covered servicemember"** is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is on the temporary retired list for a serious injury or illness. These individuals are referred to in this policy as "current members of the Armed Forces." **Covered servicemembers** also include a veteran who is discharged or released from military service under conditions other than

dishonorable at any time during the five- (5-) year period preceding the date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. These individuals are referred to in this policy as "covered veterans."

The FMLA definitions of a "serious injury or illness" for current Armed Forces members and covered veterans are distinct from the FMLA definition of "serious health condition" applicable to FMLA leave to care for a covered family member.

C. Intermittent Leave and Reduced Leave Schedules

FMLA and/or NJFLA leave usually will be taken for a period of consecutive days, weeks or months. However, employees also may be entitled to take leave intermittently or on a reduced leave schedule when medically necessary due to a serious health condition of the employee (FMLA only) or covered family member (both FMLA and NJFLA), to bond with a child after birth, placement for adoption or foster care (NJFLA only), the serious injury or illness of a covered servicemember (FMLA only), or in the case of leave taken due to an epidemic of a communicable disease, a known or suspected exposure to the communicable disease, or efforts to prevent spread of the communicable disease if the covered individual provides the Company with prior notice of the leave as soon as practicable; the covered individual makes a reasonable effort to schedule the leave so as not to unduly disrupt the operations of the Company and, if possible, provide the Company, prior to the commencement of the intermittent leave, with a regular schedule of the day or days of the week on which the intermittent leave will be taken (NJFLA only).

Leave due to qualifying exigencies (FMLA only) may also be taken on an intermittent or reduced schedule basis.

D. No Work While on Leave

The taking of another job while on FMLA/NJFLA or any other authorized leave of absence is grounds for immediate termination, to the extent permitted by applicable law.

E. Protection of Group Health Insurance Benefits

During FMLA leave only, eligible employees are entitled to receive group health plan coverage on the same terms and conditions as if they had continued to work.

F. Restoration of Employment and Benefits

At the end of FMLA leave, subject to some exceptions including situations where job restoration of "key employees" will cause the Company substantial and grievous economic injury, employees generally have a right to return to the same or equivalent positions with equivalent pay, benefits, and other employment terms. The Company will notify employees if they qualify as "key employees," if it intends to deny reinstatement, and of their rights in such instances. A "employee" is defined under the FMLA as the employee among the highest paid 10 percent of all employees who are employed within 75 miles of the worksite. Use of FMLA leave will not result in the loss of any employment benefit that accrued prior to the start of an eligible employee's FMLA leave.

As with FMLA leave, at the end of NJFLA leave, subject to some exceptions, employees generally have the right to return to the same or equivalent position with equivalent pay, benefits and other terms. However, unlike key employees under the FMLA who may be denied reinstatement, key employees under NJFLA may be denied NJFLA leave if: 1) the employee is a salaried employee among the highest paid 5 percent

of employees or one (1) of the seven (7) highest paid employees and 2) denial of the leave is necessary to prevent substantial and grievous economic injury to the Company's operations. The Company will notify employees if they qualify as key employees under the NJFLA and that leave is being denied. Nonetheless, the Company may not deny reinstatement when, in the event of a state of emergency declared by the Governor or when indicated to be needed by the Commissioner of Health or other public health authority, the family leave is for an epidemic of a communicable disease, a known or suspected exposure to a communicable disease, or efforts to prevent spread of a communicable disease. If the denial of the NJFLA leave occurs while the employee's leave already has begun, the employee must return to work within two (2) weeks.

G. Notice of Eligibility for, and Designation of, FMLA and NJFLA Leave

Employees requesting FMLA leave are entitled to receive written notice from the Company telling them whether they are eligible for FMLA leave and, if not eligible, the reasons why they are not eligible. When eligible for FMLA leave, employees are entitled to receive written notice of: 1) their rights and responsibilities in connection with such leave; 2) the Company's designation of leave as FMLA-qualifying or non-qualifying, and if not FMLA-qualifying, the reasons why; and 3) the amount of leave, if known, that will be counted against the employee's leave entitlement.

The Company may retroactively designate leave as FMLA and/or NJFLA leave with appropriate written notice to employees provided the Company's failure to designate leave as FMLA- or NJFLA-qualifying at an earlier date did not cause harm or injury to the employee. In all cases where leaves qualify for FMLA and/or NJFLA protection, the Company and employee can mutually agree that leave be retroactively designated as FMLA and/or NJFLA leave.

III. Employee FMLA and/or NJFLA Leave Obligations

A. Provide Notice of the Need for Leave

Employees who wish to take FMLA and/or NJFLA leave must timely notify the Company of their need for FMLA and/or NJFLA leave. The following describes the content and timing of such employee notices.

1. Content of Employee Notice

To trigger FMLA and/or NJFLA leave protections, employees must inform Human Resources of the need for FMLA/NJFLA-qualifying leave and the anticipated timing and duration of the leave, if known. Employees may do this by either requesting FMLA and/or NJFLA leave specifically, or explaining the reasons for the leave so as to allow the Company to determine that the leave is FMLA/NJFLA-qualifying. For example, employees might explain that:

- A condition renders them unable to perform the functions of their job or that they are under the continuing care of a health care provider (FMLA only);
- They are pregnant or have been hospitalized overnight (FMLA only);
- A covered family member (including partner in a civil union and parent-in-law under NJFLA) is under the continuing care of a health care provider or a condition renders the family member unable to perform daily activities;

- The leave is due to a qualifying exigency cause by a covered military member being on active duty or called to covered active-duty status to a foreign country (FMLA only); or

- A family member is a covered servicemember with a serious injury or illness (FMLA only).

Calling in "sick," without providing the reasons for the needed leave will not be considered sufficient notice for FMLA leave under this policy. Employees must respond to the Company's questions to determine if absences are potentially FMLA-qualifying.

If employees fail to explain the reasons for leave, the leave may be denied. When employees seek leave due to FMLA/NJFLA-qualifying reasons for which the Company has previously provided FMLA/NJFLA-protected leave, employees must specifically reference the qualifying reason for the leave or the need for FMLA and/or NJFLA leave.

2. Timing of Employee Notice

Employees requesting intermittent leave under the NJFLA (whether to care for a family member with a serious health condition or to bond with a newborn child or placement for adoption/foster care) must provide 15 days advance notice from the first day of the intermittent leave unless an emergency or other unforeseen circumstance precludes prior notice. Employees must make a reasonable effort to schedule the leave so as to not unduly disrupt the operations of the Company. Employees must, if possible, provide the Company the regular schedule of the days or days of the week on which intermittent leave will be taken prior to the commencement of the intermittent leave.

For all other reasons, employees must provide 30 days' advance notice of the need to take FMLA and/or NJFLA leave when the need is foreseeable. When 30 days' notice is not possible, or the approximate timing of the need for leave is not foreseeable, employees must provide the Company notice of the need for leave as soon as practicable under the facts and circumstances of the particular case. Employees who fail to give 30 days' notice for foreseeable leave without a reasonable excuse for the delay, or otherwise fail to satisfy FMLA and/or NJFLA notice obligations, may have leave delayed or denied, to the extent permitted by applicable law.

B. Cooperate in the Scheduling of Planned Medical Treatment (Including Accepting Transfers to Alternative Positions) and Intermittent Leave or Reduced Leave Schedules

When planning medical treatment, employees must consult with the Company and make a reasonable effort to schedule treatment so as not to unduly disrupt the Company's operations, subject to the approval of the employee's health care provider. Employees must consult with the Company prior to the scheduling of treatment to work out a treatment schedule that best suits the needs of both the Company and the employees, subject to the approval of the employee's health care provider. If employees providing notice of the need to take FMLA leave on an intermittent basis for planned medical treatment neglect to fulfill this obligation, the Company may require employees to attempt to make such arrangements, subject to the approval of the employee's health care provider.

When employees take intermittent or reduced work schedule leave for foreseeable planned medical treatment for the employee or a family member, including during a period of recovery from a serious health condition or to care for a covered servicemember, the Company may temporarily transfer employees, during the period that the intermittent or reduced leave schedules are required, to alternative positions with

equivalent pay and benefits for which the employees are qualified and which better accommodate recurring periods of leave.

When employees seek intermittent leave or a reduced leave schedule for reasons unrelated to the planning of medical treatment, upon request, employees must advise the Company of the reason why such leave is medically necessary. In such instances, the Company and employee shall attempt to work out a leave schedule that meets the employee's needs without unduly disrupting the Company's operations, subject to the approval of the employee's health care provider.

C. Submit Medical Certifications Supporting Need for Leave (Unrelated to Requests for Military Family Leave)

Depending on the nature of leave sought, employees may be required to submit medical certifications supporting their need for FMLA/NJFLA-qualifying leave. As described below, there generally are three (3) types of medical certifications: an **initial certification**, a **recertification,** and a **return to work/fitness for duty certification**.

It is the employee's responsibility to provide the Company with timely, complete, and sufficient medical certifications. Whenever the Company requests employees to provide medical certifications, employees must provide the requested certifications within 15 calendar days after the Company's request, unless it is not practicable to do so despite the employee's diligent, good faith efforts. The Company shall inform employees if submitted medical certifications are incomplete or insufficient and provide employees at least seven (7) calendar days to cure deficiencies. The Company will deny leave to employees who fail to timely cure deficiencies or otherwise fail to timely submit requested medical certifications.

With the employee's permission, the Company (through individuals other than the employee's direct supervisor) may contact the health care provider to authenticate or clarify completed and sufficient medical certifications. If the employee chooses not to provide the Company with authorization allowing it to clarify or authenticate the certification with the health care provider, the Company may deny leave if the medical certification is unclear.

Whenever the Company deems it appropriate to do so, it may waive its right to receive timely, complete, and/or sufficient medical certifications.

1. Initial Medical Certifications

Employees requesting leave because of their own or a family member's serious health condition, or to care for a covered servicemember, must supply medical certification supporting the need for such leave from their health care provider or, if applicable, the health care provider of their covered family or servicemember, or where the leave is for an epidemic of a communicable disease, a known or suspected exposure to a communicable disease, or efforts to prevent spread of a communicable disease, certification issued by a school, place of care for children, public health authority, public official, or health care provider, supporting the need for such leave. If employees provide at least 30 days' notice of medical leave, they should submit the medical certification before leave begins. A new initial medical certification will be required on an annual basis for serious medical conditions lasting beyond a single leave year.

If the Company has reason to doubt initial medical certifications, it may require employees to obtain a second opinion at the Company's expense. If the opinions of the initial and second health care providers

differ, the Company may, at its expense, require employees to obtain a third final and binding certification from a health care provider designated or approved jointly by the Company and the employee.

2. Medical Recertifications

Depending on the circumstances and duration of FMLA leave, the Company may require employees to provide recertification of medical conditions giving rise to the need for leave. The Company will notify employees if recertification is required and will give employees at least fifteen (15) calendar days to provide medical recertification.

3. Return to Work/Fitness for Duty Medical Certifications

Unless notified that providing such certifications is not necessary, the employees returning to work from FMLA leave that was taken because of their own serious health conditions that made them unable to perform their job must provide the Company medical certification confirming the employee is able to return to work and the employee's ability to perform the essential functions of the employee's position, with or without reasonable accommodation. The Company may delay and/or deny job restoration until the employee provides a return to work/fitness for duty certification.

D. Submit Certifications Supporting Need for Military Family Leave

Upon request, the first time employees seek leave due to qualifying exigencies arising out of the covered active duty or call to covered active duty status of a military member, the Company may require employees to provide: 1) a copy of the military member's active duty orders or other documentation issued by the military indicating the military member is on covered active duty or call to covered active duty status and the dates of the military member's covered active duty service; and 2) a certification from the employee setting forth information concerning the nature of the qualifying exigency for which leave is requested. Employees shall provide a copy of new active-duty orders or other documentation issued by the military for leaves arising out of qualifying exigencies arising out of a different covered active duty or call to covered active-duty status of the same or a different military member.

When leave is taken to care for a covered servicemember with a serious injury or illness, the Company may require employees to obtain certifications completed by an authorized health care provider of the covered servicemember. In addition, and in accordance with the FMLA regulations, the Company may request that the certification submitted by employees set forth additional information provided by the employee and/or the covered servicemember confirming entitlement to such leave.

E. Substitute Paid Leave for Unpaid FMLA and NJFLA Leave

Employees must use any accrued paid time while taking unpaid FMLA and/or NJFLA leave, except that employees will not be required to use any paid time off during any leave also covered under the New Jersey SAFE Act.

The substitution of paid time for unpaid FMLA and/or NJFLA leave time does not extend the length of FMLA and/or NJFLA leaves and the paid time will run concurrently with the employee's FMLA and/or NJFLA entitlement.

During the leave, employees may be eligible for compensation, such as temporary disability benefits, family leave benefits, or workers' compensation benefits. Any compensation or leave taken in connection with any other policy/plan shall run concurrently with any FMLA/NJFLA leave entitlement.

Upon written request, the Company will allow employees to use accrued paid time to supplement any paid disability benefits.

F. Pay Employee's Share of Health Insurance Premiums

As noted above, during FMLA leave, employees are entitled to continued group health plan coverage under the same conditions as if they had continued to work. Unless the Company notifies employees of other arrangements, whenever employees are receiving pay from the Company during FMLA leave, the Company will deduct the employee's portion of the group health plan premium from the employee's paycheck in the same manner as if the employee was actively working. If FMLA leave is unpaid, employees must pay their portion of the group health premium through a method determined by the Company upon leave.

The Company's obligation to maintain health care coverage ceases if the employee's premium payment is more than 30 days late. If the employee's payment is more than 15 days late, the Company will send a letter notifying the employee that coverage will be dropped on a specified date unless the co-payment is received before that date. If employees do not return to work within 30 calendar days at the end of the leave period (unless employees cannot return to work because of a serious health condition or other circumstances beyond their control), they will be required to reimburse the Company for the cost of the premiums the Company paid for maintaining coverage during their unpaid FMLA leave.

[Note: If the employee is taking NJFLA leave only, the continuation requirements for group health plans under the FMLA are not applicable to group health plans covered under ERISA. Therefore, the employee who is on NJFLA-only leave likely will trigger COBRA requirements due to a reduction in hours worked. If the employer's group health plan is covered under ERISA, the employer should coordinate with their insurance broker or plan to ensure appropriate steps are taken regarding COBRA notice.]

IV. Coordination of FMLA/NJFLA Leave with Other Leave Policies

The FMLA does not affect any federal, state, or local law prohibiting discrimination, or supersede any state or local law that provides greater family or medical leave rights such as the NJFLA. However, whenever permissible by law, the Company will run FMLA leave concurrently with NJFLA and any other leave provided under state or local law. For additional information concerning leave entitlements and obligations that might arise when FMLA/NJFLA leave is either not available or exhausted, please consult the Company's other leave policies in this handbook or contact Human Resources.

V. Questions and/or Complaints about FMLA/NJFLA Leave

If employees have questions regarding this FMLA/NJFLA policy, they should contact Human Resources. The Company is committed to complying with the FMLA and, whenever necessary, shall interpret and apply this policy in a manner consistent with the FMLA/NJFLA.

The FMLA makes it unlawful for employers to: 1) interfere with, restrain or deny the exercise of any right provided under FMLA; or 2) discharge or discriminate against any person for opposing any practice made unlawful by FMLA or involvement in any proceeding under or relating to FMLA. If employees believe their rights have been violated, they should contact Human Resources immediately. The Company will investigate any complaints and take prompt and appropriate remedial action to address and/or remedy any

violation. Employees also may file FMLA complaints with the United States Department of Labor or may bring private lawsuits alleging FMLA violations.

CHESTNUT HEALTH SYSTEMS

NEW JERSEY SUPPLEMENT ACKNOWLEDGMENT

This New Jersey Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems New Jersey Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

109. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;

110. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;

111. obscene or vulgar gestures, posters or comments;

112. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;

113. propositions or suggestive or insulting comments of a sexual nature;

114. derogatory cartoons, posters and drawings;

115. sexually-explicit e-mails, text messages or voicemails;

116. uninvited touching of a sexual nature;

117. unwelcome sexually-related comments;

118. conversation about one's own or someone else's sex life;

119. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and

120. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

ADDENDUM – New Mexico Supplement – 2024



Chestnut Health Systems

Personnel Policies

New Mexico Supplement

2024

CHESTNUT HEALTH SYSTEMS

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This New Mexico Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, New Mexico employees will receive the Company's Personnel Policies and the New Mexico Supplement to the Personnel Policies ("New Mexico Supplement) (together the "Employee Handbook").

The New Mexico Supplement applies only to New Mexico employees. It is intended as a resource containing specific provisions derived under New Mexico law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the New Mexico Supplement are different from or more generous than those in the National Handbook, the policies in the New Mexico Supplement will apply.

The New Mexico Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

New Mexico Pregnancy Accommodations

In compliance with New Mexico Pregnant Worker Accommodation Act, Chestnut Health Systems will not discriminate against employees or job applicants in relation to pregnancy, childbirth and related conditions and will provide reasonable accommodation for conditions related to pregnancy, childbirth or a related condition.

Reasonable Accommodations

If employees or job applicants with a known limitation arising out of pregnancy, childbirth or a related condition make a request for reasonable accommodation, the Company will endeavor to grant the request unless the accommodation constitutes an undue hardship. Reasonable accommodations may include

modification or adaptation of the work environment, work rules or job responsibilities for as long as necessary to enable employees with limitations due to pregnancy, childbirth or a related condition to perform the job that does not impose an undue hardship on the Company. The Company will not require employees to take paid or unpaid leave if another reasonable accommodation can be provided to the known limitations related to the pregnancy, childbirth or related condition.

Further, the Company will not refuse to hire, discharge, refuse to promote, demote or discriminate in matters of compensation or leave or terms, conditions or privileges of employment against any person otherwise qualified for employment on the basis of that person's pregnancy or childbirth or a related condition, including failing to treat employees or job applicants affected by pregnancy, childbirth or a related condition in the same manner as other persons similar in ability to work for all employment-related purposes, including receipt of benefits under fringe benefit programs, unless based on a bona fide occupational qualification.

Additionally, the Company will not print or circulate any statement, advertisement or publication; use any form of application for employment; or make any inquiry regarding prospective employment that expresses, directly or indirectly, any limitation, specification or discrimination as to pregnancy, childbirth or a related condition, unless based on a bona fide occupational qualification. The Company will not refuse to list, properly classify for employment or refer a person for employment in a known available job for which the person is otherwise qualified on the basis of the person's pregnancy, childbirth or related condition, unless based on a bona fide occupational qualification.

The Company reserves the right to require employees to provide medical certification concerning the need for reasonable accommodation consistent with the Company's requests for certification of other temporary disabilities.

The Company will not discharge, demote, deny promotion to or in any other way discriminate against employees in the terms or conditions of employment in retaliation for the person asserting a claim or right pursuant to the Pregnant Worker Accommodation Act, for assisting another person to assert a claim or right pursuant to the Pregnant Worker Accommodation Act, or for informing another person about employment rights or other rights provided by law. A person claiming to be aggrieved by an unlawful discriminatory practice in violation of the Pregnant Worker Accommodation Act may seek relief under the Human Rights Act.

If employees have any questions about or would like to request a reasonable accommodation pursuant to this policy, they should contact Human Resources.

TIME OFF AND LEAVES OF ABSENCE

New Mexico Sick and Safe Time

Eligibility

Chestnut Health Systems provides paid sick leave to employees who work in New Mexico in accordance with the Healthy Workplaces Act. For employees who work in New Mexico who are eligible for sick time under another policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing paid sick leave pursuant to this policy at the start of employment. Employees accrue one (1) hour of paid sick leave for every thirty (30) hours worked. Exempt employees are assumed to work forty (40) hours in each workweek unless their normal workweek is less than forty (40) hours, in which case paid sick leave accrues based upon that normal workweek. For purposes of this policy, the year is the consecutive twelve- (12-) month period beginning January 1 and ending on December 31.

Usage

Employees may use paid sick leave immediately. Paid sick leave may be used in one- (1-) hour increments. Employees may not use more than sixty-four (64) hours of paid sick leave in any year.

Employees may use paid sick leave for absences due to:

1. The employee's mental or physical illness, injury or health condition; medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; and preventive medical care;

2. Care of a family member of the employee for mental or physical illness, injury or health condition; medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; and preventive medical care;

3. Meetings at the employee's child's school or place of care related to the child's health or disability; or

4. Absences necessary due to domestic abuse, sexual assault or stalking suffered by the employee or a family member of the employee provided that the leave is for the employee to:

    a. obtain medical or psychological treatment or other counseling;

    b. relocate;

    c. prepare for or participate in legal proceedings; or

    d. obtain services or assist a family member of the employee with any of the activities set forth in subparagraphs (a) through (c).

For purposes of this policy, family member includes the employee's spouse or domestic partner or a person related to the employee or the employee's spouse or domestic partner as: (1) a biological, adopted or foster child, a stepchild or legal ward or a child to whom the employee stands in loco parentis; (2) a biological, foster, step or adoptive parent or legal guardian, or a person who stood in loco parentis when the employee was a minor child; (3) a grandparent; (4) a grandchild; (5) a biological, foster, step or adopted sibling; (6) a spouse or domestic partner of a family member; or (7) an individual whose close association with the employee or the employee's spouse or domestic partner is the equivalent of a family relationship. A domestic partner includes an individual with whom another individual maintains a household and a mutual committed relationship without a legally recognized marriage.

The employee's use of paid sick leave will not be conditioned upon searching for or finding a replacement worker.

Unless employees advise the Company otherwise, we will assume, subject to applicable law, that employees want to use available paid sick leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have paid sick leave available.

Notice and Documentation

When employees need to use paid sick leave, the employee or an individual acting on the employee's behalf must make an oral or written request to the Employee's Supervisor to use the leave. When possible, the request must include the expected duration of the sick leave absence. When the need to use paid sick leave is foreseeable, the employee must make a reasonable effort to provide advance notice before using the paid sick leave and must make a reasonable effort to schedule use of paid sick leave in a way that does not disrupt the Company's operations. When the need to use paid sick leave is not foreseeable, the employee must notify the Employee's Supervisor as soon as practicable.

Employees may be required to provide reasonable documentation for the use of paid sick leave if the employee used paid sick leave for two (2) or more consecutive workdays. Where sick leave is requested for reasons 1 or 2 above, documentation signed by a health care professional indicating the amount of sick leave taken is necessary will be considered reasonable documentation. Where sick leave is requested for reason 4 above, the employee may provide one of the following: a police report; a court-issued document; or a signed statement by a victim services organization, clergy member, attorney, advocate, the employee, a family member or any other person. The signed statement does not have to be notarized or be in any particular format. It only needs to affirm the employee took paid sick leave for one of the purposes specified by the Act. Employees are allowed up to fourteen (14) days from the date they return to work to provide the documentation. The documentation does not need to explain the nature of any medical condition or the details of the domestic abuse, sexual assault or stalking. The Company will never delay the use of paid sick leave because the employer has not yet received documentation. All information and documentation received about the employee's reasons for taking paid sick leave is confidential. The Company will not disclose the above-referenced information except with the employee's permission or as necessary for validation of disability insurance claims, accommodations consistent with the federal Americans with Disabilities Act (ADA), as required by the Healthy Workplaces Act, or by Court Order.

Payment

Paid sick leave will be paid at the same hourly rate and with the same benefits the employee normally earns during hours worked at the time the employee uses such time, but no less than the applicable minimum wage. Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Employees may carry over up to sixty-four (64) hours of accrued, unused paid sick leave to the following year. Unused paid sick leave will not be paid at separation.

Enforcement and Retaliation

Retaliation against any employee who requests or uses paid sick leave is prohibited. Employees have the right to file a complaint with the New Mexico Department of Workforce Solutions, Labor Relations Division if paid sick leave as required by law is denied or if the employee is subjected to retaliation for requesting or taking paid sick leave. The New Mexico Department of Workforce Solutions, Labor Relations Division can

be reached by calling (505) 841-4400, visiting www.dws.state.nm.us or going to a New Mexico Workforce Connections Office.

Questions about rights and responsibilities under the law can be answered by Human Resources.

CHESTNUT HEALTH SYSTEMS

NEW MEXICO SUPPLEMENT ACKNOWLEDGMENT

This New Mexico Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems New Mexico Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

121. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;

122. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;

123. obscene or vulgar gestures, posters or comments;

124. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;

125. propositions or suggestive or insulting comments of a sexual nature;

126. derogatory cartoons, posters and drawings;

127. sexually-explicit e-mails, text messages or voicemails;

128. uninvited touching of a sexual nature;

129. unwelcome sexually-related comments;

130. conversation about one's own or someone else's sex life;

131. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and

132. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

ADDENDUM – North Carolina Supplement – 2024



Chestnut Health Systems

Personnel Policies

North Carolina Supplement

2024

CHESTNUT
HEALTH SYSTEMS

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This North Carolina Supplement

Chestnut Health Systems (“Chestnut” or “the Company”) is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, North Carolina employees will receive the Company’s Personnel Policies and the North Carolina Supplement to the Personnel Policies (“North Carolina Supplement) (together the “Employee Handbook”).

The North Carolina Supplement applies only to North Carolina employees. It is intended as a resource containing specific provisions derived under North Carolina law that apply to the employee’s employment. It should be read together with the National Handbook and, to the extent that the policies in the North Carolina Supplement are different from or more generous than those in the National Handbook, the policies in the North Carolina Supplement will apply.

The North Carolina Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person’s authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

TIME OFF AND LEAVES OF ABSENCE

North Carolina School Attendance Leave

Chestnut Health Systems will grant employees who are parents or guardians of school-age children up to four (4) hours of unpaid leave during any twelve- (12-) month period to participate in activities at their children's school. Forty-eight (48) hours' written advance notice is required. The leave shall occur at a time mutually agreed upon by the employee and the Company. The Company may require verification of the employee's participation in the school activities. Employees must first use accrued paid time off for this purpose.

CHESTNUT
HEALTH SYSTEMS

NORTH CAROLINA SUPPLEMENT ACKNOWLEDGMENT

This North Carolina Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems North Carolina Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

133. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;

134. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;

135. obscene or vulgar gestures, posters or comments;

136. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;

137. propositions or suggestive or insulting comments of a sexual nature;

138. derogatory cartoons, posters and drawings;

139. sexually-explicit e-mails, text messages or voicemails;

140. uninvited touching of a sexual nature;

141. unwelcome sexually-related comments;

142. conversation about one's own or someone else's sex life;

143. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and

144. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

ADDENDUM – Oregon Supplement – 2024



Chestnut Health Systems

Personnel Policies

Oregon Supplement

2024

CHESTNUT HEALTH SYSTEMS

GENERAL INFORMATION

About This Oregon Supplement

Chestnut Health Systems ("Chestnut") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Oregon employees will receive the Company's Personnel Policies and the Oregon Supplement to the Personnel Policies ("Oregon Supplement) (together the "Employee Handbook").

The Oregon Supplement applies only to Oregon employees. It is intended as a resource containing specific provisions derived under Oregon law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Oregon Supplement are different from or more generous than those in the National Handbook, the policies in the Oregon Supplement will apply.

The Oregon Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the President of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the President of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact their Human Resources representative.

COMMITMENT TO DIVERSITY

Equal Employment Opportunity

As set forth in the National Handbook, Chestnut is committed to equal employment opportunity and to compliance with federal antidiscrimination laws. We also comply with Oregon law which prohibits discrimination and harassment against any employees, applicants for employment or interns based on race (including physical characteristics that are historically associated with race, such as natural hair, hair texture, hair type and protective hairstyles), color, religion, sex (including pregnancy, childbirth or related medical conditions), national origin or ancestry, citizenship, physical or mental disability, genetic information, age (18 and over), veteran status, uniform servicemember status, unemployment status, sexual orientation, gender identity, marital status family status, or having been a victim of sexual abuse, including domestic abuse, sexual assault or stalking. The Company will not tolerate discrimination or harassment based upon these characteristics or any other characteristic protected by applicable federal, state or local law.

Sexual and Other Prohibited Harassment

Chestnut is committed to providing a work environment free of harassment. The Company complies with Oregon law and maintains a strict policy prohibiting sexual harassment and harassment against employees, applicants for employment or interns based on employees, applicants for employment or interns based on race (including physical characteristics that are historically associated with race, such as natural hair, hair texture, hair type and protective hairstyles), color, religion, sex (including pregnancy, childbirth or related medical conditions), national origin or ancestry, citizenship, physical or mental disability, genetic information, age (18 and over), veteran status, uniform servicemember status, unemployment status, sexual orientation, gender identity, marital status family status, or having been a victim of sexual abuse, including domestic abuse, sexual assault or stalking. The Company will not tolerate discrimination or harassment based upon these characteristics or any other characteristic protected by applicable federal,

state or local law. Sexual harassment prohibited under this policy includes sexual assault, which is unwanted conduct of a sexual nature that is inflicted upon a person or compelled through the use of physical force, manipulation, threat or intimidation.

All employees are expected to comply with the Company's Sexual and Other Prohibited Harassment policy, which is included in the National Handbook. While the Sexual and Other Prohibited Harassment policy sets forth the Company's goals of promoting a workplace that is free of harassment, the policy is not designed or intended to limit the Company's authority to discipline or take remedial action for workplace conduct that we deem unacceptable, regardless of whether that conduct satisfies the definition of unlawful harassment.

Any employee who believes they have been harassed or discriminated against should provide a written or verbal report to their supervisor, another member of management, to the Director of Human Resources or Chestnut's on-line corporate compliance reporting website as soon as possible. All employees are encouraged to document any incidents involving discrimination, harassment or sexual assault as soon as possible.

Chestnut will not tolerate retaliation against any employee for raising a good faith concern, for providing information related to a concern, or for otherwise cooperating in an investigation of a reported violation of this policy. Any employee who retaliates against anyone involved in an investigation is subject to disciplinary action, up to and including dismissal.

Time Limitations

Nothing in this policy precludes any person from filing a formal grievance in accordance with the Oregon Bureau of Labor and Industries' Civil Rights Division or the Equal Employment Opportunity Commission. Note that Oregon state law requires that any legal action taken on alleged discriminatory conduct (specifically that prohibited by ORS 659A.030, 659A.082 or 659A.112) commence no later than five years after the occurrence of the violation. Other applicable laws may have a shorter time limitation on filing.

Nondisclosure and Nondisparagement Agreements

The Company will not require or coerce a current, former, or prospective employee to enter into any agreement as a condition of employment, continued employment, promotion, compensation or the receipt of benefits, that contains a nondisclosure provision, nondisparagement provision or any other provision that has the purpose or effect of preventing the individual from disclosing or discussing unlawful employment discrimination or harassment (including sexual assault). An employee claiming to be aggrieved by discrimination, harassment, or sexual assault may, however, voluntarily request to enter into a settlement, separation, or severance agreement that contains a nondisclosure, nondisparagement, or no-rehire provision (as defined below) and/or prevents the disclosure of the amount of or any fact of any settlement and will have at least seven days to revoke any such agreement.

Under this policy, a nondisclosure agreement is any agreement by which one or more parties agree not to discuss or disclose information regarding any complaint of work-related harassment, discrimination, or sexual assault. A nondisparagement agreement is any agreement by which one or more parties agree not to discredit or make negative or disparaging written or oral statements about any other party or the Company. A no-rehire provision is an agreement that prohibits an employee from seeking reemployment with the Company and allows the Company to not rehire that individual in the future.

Pregnancy Accommodation

The Company will provide employees and applicants with a reasonable accommodation for limitations related to pregnancy, childbirth or a related medical condition, including lactation, unless doing so would

impose an undue hardship on the Company's business. Reasonable accommodations may include, but are not limited to: acquisition or modification of equipment or devices; more frequent or longer break periods or periodic rest; assistance with manual labor; or modification of work schedules or job assignments.

The Company will not require a pregnant employee or applicant to accept a reasonable accommodation if the employee does not have a known pregnancy-related limitation or require reasonable accommodation to perform essential job duties, nor will the Company require a pregnant employee to take a leave of absence instead of providing a reasonable accommodation.

The Company prohibits discrimination against employees and applicants on the basis of pregnancy, childbirth or related condition. The Company will not take an adverse employment action or in any manner discriminate or retaliate against an applicant or employee because they request, inquire about or use reasonable accommodations in accordance with this policy. Employees with questions or concerns regarding this policy or who would like to request an accommodation should contact Human Resources**.**

Oregon Workplace Accommodations

Chestnut Health Systems is an equal opportunity employer and does not discriminate on the basis of race, religion, color, sex, age, national origin, disability, veteran status, sexual orientation, gender identity, gender expression or any other classification protected by law.

The Company will make reasonable accommodations for known physical or mental disabilities of an applicant or employees as well as known limitations related to pregnancy, childbirth or a related medical condition, such as lactation, unless the accommodation would cause an undue hardship.

Among other possibilities, reasonable accommodations could include:

- acquisition or modification of equipment or devices;
- more frequent or longer break periods or periodic rest;
- assistance with manual labor; or
- modification of work schedules or job assignments.

Employees and job applicants have a right to be free from unlawful discrimination and retaliation.

For this reason, the Company will not:

- deny employment opportunities on the basis of a need for reasonable accommodation;
- deny reasonable accommodation for known limitations, unless the accommodation would cause an undue hardship;
- take an adverse employment action, discriminate or retaliate because the applicant or employee has inquired about, requested or used a reasonable accommodation;
- require an applicant or employee to accept an accommodation that is unnecessary; or
- require the employee to take family leave or any other leave, if the Company can make reasonable accommodation instead.

Any employee who has questions about the policy or who would like to request an accommodation due to physical or mental disabilities, pregnancy, childbirth or a related medical condition should contact Human Resources. If that person is unavailable, please contact Human Resources or the General Counsel.

CHESTNUT HEALTH SYSTEMS

GENERAL EMPLOYMENT PRACTICES

Personal and Family Relationships

Employee's relatives and friends may be eligible for employment and, if employed, may be eligible for transfers, promotions, etc., to positions for which they are qualified. However, relatives are not entitled to preferential consideration and will not be hired or promoted into a position that creates a conflict of interest.

The term "relatives," includes but is not limited to, the following relationships: spouse, domestic partner, child, parent, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, aunt, uncle, niece, nephew, stepparent and stepchild.

PAY PRACTICES

Meal and Rest Breaks

Employees working at least six-hours will receive an unpaid meal break of 30 minutes approximately midway through the day. If the work period is at least six but less than seven hours, the meal period must be taken between the second and fifth hours worked. If the work period is more than seven hours, the meal period must be taken between the third and sixth hours worked.

An uninterrupted meal break lasting 30 minutes or more will be unpaid for nonexempt employees.

Employees may not take a shorter meal break or skip a meal break to leave early.

Employees who work at least two hours and one minute will also receive a paid 10-minute rest break and an additional rest break for every four hours worked thereafter.

Rest breaks will be in addition to any meal breaks and cannot be taken at the beginning or end of a shift or combined with a meal break.

Summary Chart

Below is a chart that generally summarizes the number of rest breaks and meal periods provided to Oregon employees.

Hours of Work	Rest Breaks	Meal Breaks
2 hours or less	0	0
2 hours 1 min - 5 hours 59 min	1	0
6 hours	1	1
6 hours 1 min - 10 hours	2	1
10 hours 1 min - 13 hours 59 min	3	1
14 hours	3	2
14 hours 1 min - 18 hours	4	2
18 hours 1 min - 21 hours 59 min	5	2
22 hours	5	3
22 hours 1 min - 24 hours	6	3

Oregon Lactation Breaks

Subject to certain exceptions where permitted by applicable law, employees who are nursing may take a reasonable rest period to express milk each time they have a need to express milk for their child who is 18 months of age or younger. The employee will, if feasible, take the rest periods to express milk at the same time as the rest periods or meal periods that are otherwise provided to the employee. Chestnut Health Systems will make reasonable efforts to provide a location, other than a public restroom or toilet stall, in close proximity to the employee's work area for the employee to express milk in private. Employees will not be retaliated against for exercising their rights under this policy.

Employees should advise management if they need break time and an area for this purpose. Employees can consult Human Resources with questions regarding this policy.

Discussion of Wages

No employee is prohibited from inquiring about, discussing or disclosing their own wages or those of another employee. The Company will not terminate, demote, suspend, or otherwise discriminate or retaliate against any employee on the basis of such a disclosure or because the employee files a complaint or charge or otherwise institutes an investigation, proceeding or hearing based on the disclosure of wage information.

This policy does not apply to disclosure of other employees' wage information by employees who have access to such information solely as part of their essential job functions and who, while acting on behalf of the company, make unauthorized disclosure of that information. Company representatives may disclose employees' wages in response to a complaint or charge, or in furtherance of an investigation, proceeding, hearing or action under state law.

TIME OFF AND LEAVES OF ABSENCE

Paid Leave Oregon (coming soon)

Paid Sick and Safe Time (Accrual Method)

Eligibility

All employees (including full-time, part-time and temporary employees) are eligible to accrue paid sick and safe time.

Annual Accrual of Paid Sick and Safe Time

Eligible employees begin to accrue paid sick and safe time on January 1, 2016, or upon their first day of employment, whichever is later.

Paid sick and safe time accrues at a rate of one hour for every 30 hours worked or 6 hours for each month of service, whichever is greater, up to a maximum accrual cap of 480 hours. Employees will not accrue paid sick and safe time during periods of paid or unpaid leave.

Salaried exempt employees will be assumed to work 40 hours in a week unless the employee's regular workweek is less than 40 hours, in which case sick time accrues based upon that regular workweek.

Eligible employees hired on or before January 1, 2016 may use paid sick and safe time as it accrues beginning on January 1, 2016. Employees hired after January 1, 2016 may use accrued paid sick and safe time beginning on their 91st calendar day of employment.

For qualifying absences, employees must use paid sick and safe time on the first day, and on each subsequent date, until all time is used. Paid sick and safe time can be used in one-hour increments.

Employees are not required to find an employee to cover their work when they take paid sick and safe time and are not required to work an alternate shift to make up for the use of such time.

Reasons Sick and Safe Time May be Used

Employees may use paid sick and safe time for the following reasons:

- For the diagnosis, care or treatment of the employee or the employee's family member's mental or physical illness, injury or health condition, including preventive medical care;

- For reasons specified in the Company's Family and Medical Leave policy and covered under the Oregon Family Leave Act, including:

    - To care for a spouse, same-gender domestic partner, child, parent, parent-in-law, grandparent, or grandchild of an employee (or of an employee's same-sex domestic partner) or a person with whom the employee is or was in a relationship of *in loco parentis* with a serious health condition;

    - For an employee's own serious health condition;

    - To care for a sick child of the employee or of a same-gender domestic partner who does not have a serious health condition but requires home care;

    - To be with or care for a child of the employee or of a same-gender domestic partner after birth, placement for adoption or foster care (or certain comparable situations). This parental leave may include any time necessary for the legal process required for adoption or foster care if the child is under age 18 or is incapable of self-care because of a physical or mental disability. (This type of leave must be completed within one year of the birth or placement for adoption);

    - For an employee's own disability due to pregnancy, childbirth or related medical condition or for absence for prenatal care. Pregnancy disability leave is available only if the employee is unable to perform any job duties that the Company is able to offer, except that leave for prenatal care is covered without regard to disability; and

    - To make arrangements necessitated by the death of a family member, to attend the family member's funeral or memorial service, and/or to grieve the death of a family member.

- For reasons related to domestic violence, harassment, sexual assault or stalking against the employee or the employee's minor child or dependent, including:

    - To seek legal or law enforcement assistance or remedies to ensure the health and safety of the employee or the employee's minor child or dependent, including preparing for and participating in protective order proceedings or other civil or criminal legal proceedings related to domestic violence, harassment, sexual assault or stalking;

    - To seek medical treatment for or to recover from injuries caused by domestic violence or sexual assault to or harassment or stalking of the employee or the employee's minor child or dependent;

  - To obtain, or to assist a minor child or dependent in obtaining, counseling from a licensed mental health professional related to an experience of domestic violence, harassment, sexual assault or stalking;

  - To obtain services from a victim services provider for the eligible employee or the employee's minor child or dependent; or

  - To relocate or take steps to secure an existing home to ensure the health and safety of the employee or the employee's minor child or dependent.

- If either the employee's place of business or the employee's child's school or day care is closed by order of a public official due to a public health emergency or if the employee is excluded from work for health reasons;

- If a family member's presence in the community jeopardizes the health of others as determined by a lawful public health authority or by a health care provider;

- If the employee is not employed as a first responder and an authorized public official issues an emergency evacuation order of level 2 (SET) or level 3 (GO) that covers the Company's place of business or the employee's home address; and

- If the employee is not employed as a first responder and an authorized public official issues a determination that the air quality index or heat index are at a level where continued exposure would jeopardize the health of the employee.

For purposes of this policy, "family members" include a:

- A spouse or domestic partner of the employee;

- A child of the employee or the child's spouse or domestic partner;

- A parent of the employee or the parent's spouse or domestic partner;

- A sibling or stepsibling of the employee or the sibling's or stepsibling's spouse

  or domestic partner;

- A grandparent of the employee or the grandparent's spouse or domestic partner;

- A grandchild of the employee or the grandchild's spouse or domestic partner; or

- Any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship

Requesting Paid Sick and Safe Time/Documentation

When the need for paid sick and safe time is foreseeable (i.e., expected or planned leave), employees must provide reasonable advance notice, including, when possible, the expected duration of the leave, and must make reasonable attempts to schedule the use of paid sick and safe time in a manner that does not unduly disrupt the company's business operations. When the need for paid sick and safe time is unforeseeable, employees must provide notice before the start of the employee's shift or, when circumstances prevent such notice, as soon as practicable. To provide notice of the need to use paid sick and safe time, employees should contact their supervisor.

Employees must inform the company of any change in the expected duration of the sick and safe time as soon as practicable.

In connection with the Company's national sick leave policy, if sick and safe time is for more than 40 consecutive hours, employees must provide supporting documentation establishing the need for and duration of sick and safe time. Examples of documentation include, but are not limited to:

- Documentation signed by a licensed health care provider; or
- Documentation for victims of domestic violence, such as a copy of a police report or protective order.

If the need for sick and safe time is foreseeable and is projected to last more than three scheduled workdays, the verification must be provided before the sick and safe time begins or as soon as otherwise practicable. If an employee begins leave without providing required prior notice, medical verification (e.g., for an employee's or family member's illness, injury or health care or preventative care) must be provided within 15 calendar days after the Company requests verification, and certification for absences relating to domestic violence, harassment, sexual assault or stalking must be provided within a reasonable time after the Company requests certification.

The Company will pay any costs associated with any out-of-pocket expenses incurred by employees (that is not paid by insurance) in obtaining required verification from a licensed health care provider.

The Company may require documentation prior to the third consecutive workday if it suspects an employee is abusing leave.

Failure to provide required medical documentation may result in the delay or denial of payment for sick and safe time.

Rate of Pay and Overtime

Sick and safe time is paid based on the employee's regular rate of pay. Sick and safe time is not considered time worked for the purpose of calculating overtime for the week in which the time was taken.

Leave Carryover

At no time will an employee have more than 480 hours of accrued sick and safe time.

The Company does not offer pay in lieu of actual sick and safe time.

Effect on Other Rights and Policies

The Company may provide other forms of leave for employees to care for medical conditions or for issues related to domestic violence under certain federal, state and municipal laws. In certain situations, leave under this policy may run at the same time as leave available under another federal, state or municipal law, provided eligibility requirements for that law are met. The Company is committed to complying with all applicable laws. Employees should contact their Human Resources representative for information about other federal, state and municipal medical or family leave rights.

Separation from Employment

Compensation for accrued and unused paid sick and safe time is not provided upon separation from employment for any reason. If an employee is rehired by the Company within 180 days of separation from employment, previously accrued but unused sick and safe time will be immediately reinstated. If separation occurs before an employee's 91st day of employment and the employee is rehired within 180 days, the

accrued sick and safe time balance will be restored and may be used once the employee has worked a combined total of 90 calendar days.

Retaliation

Employees have the right to request and use sick and safe time. The Company will not retaliate or discriminate, or tolerate retaliation or discrimination, against any employee who seeks or obtains sick and safe time under this policy, inquires about or invokes the provisions of the OSTL, or participates in an investigation, proceeding or hearing related to the OSTL.

Confidentiality and Nondisclosure

The Company will treat as confidential sick and safe time-related health information pertaining to the employee or employee's family member. Records and information concerning requests for or use of sick and safe time for reasons related to being the victim of domestic violence, harassment, sexual assault or stalking, will be treated as confidential and will not be released without the employee's express permission, unless otherwise required by law.

Family and Medical Leave of Absence

We recognize that employees may need to be absent from work for an extended period of time for family, medical or bereavement-related reasons. Accordingly, the Company will grant time off to employees in accordance with the requirements of the federal Family and Medical Leave Act (Fed-FMLA) and the Oregon Family Leave Act (OFLA). The OFLA applies to employees who work in Oregon. Where both the Fed-FMLA and the OFLA apply, the leave provided by each will count against the employee's entitlement under both laws and must be taken concurrently. An employee who is eligible for leave under only one of these laws will receive benefits in accordance with that law only.

The following policy addresses employee family and medical leave rights under the OFLA. Employees should refer to the National Handbook for additional details regarding the Fed-FMLA. Questions concerning this policy should be directed to Human Resources **[or insert name of appropriate company representative or department]**.

OFLA Eligibility

To be eligible for family leave under the OFLA, employees generally must:

- Have worked for the Company for at least 180 days immediately before the date the leave begins; and

- Have averaged at least 25 hours a week during the 180 days immediately before the date on which OFLA leave begins. The requirement of 25 hours or more a week does not apply to OFLA leave for parental leave purposes. For parental leave, eligible employees are those who have worked for the company for at least 180 days.

During a period of time covered by a public health emergency, an employee must have worked for the Company for at least 30 days immediately before the date leave begins and have averaged at least 25 hours of work per week in the 30 days immediately before the date on which OFLA leave begins.

Reasons for OFLA Leave

OFLA leave may be granted for these reasons or purposes:

- To care for a spouse, same-sex domestic partner, child, parent, parent-in-law, grandparent, or grandchild of an employee (or of an employee's same-sex domestic partner) with a serious health condition;

- For an employee's own serious health condition;

- To care for a sick child of the employee or of a same-sex domestic partner who does not have a serious health condition but requires home care, if no other family member is available to care for the child;

- To be with or care for a child of the employee or of a same-sex domestic partner after birth, placement for adoption or foster care (or certain comparable situations). This parental leave may include any time necessary for the legal process required for adoption or foster care if the child is under age 18 (or is incapable of self-care because of a physical or mental disability. (This type of leave must be completed within one year of the birth or placement for adoption);

- To care for a child of the employee or of a same-sex domestic partner whose school or child care provider has been closed in conjunction with a declared public health emergency or declared state of emergency that is related to a public health emergency ;

- For an employee's disability due to their own pregnancy, childbirth or related medical condition or for absence for prenatal care. Pregnancy disability leave is available only if the employee is unable to perform any job duties that the Company is able to offer, except that leave for prenatal care is covered without regard to disability;

- To make arrangements necessitated by the death of a family member, to attend the family member's funeral or memorial service, and/or to grieve the death of a family member (Bereavement Leave).

A "serious health condition" means:

- An illness, injury, impairment or physical or mental condition that involves an overnight stay in a hospital or similar facility;

- An illness, disease or condition that the treating health care provider believes poses an imminent danger of death, is terminal in prognosis with a reasonable possibility of death in the near future, or is a mental or physical condition requiring constant care;

- Any period of absence due to pregnancy-related disability or for prenatal care; or

- Any period of absence for the donation of a body part, organ or tissue, including preoperative or diagnostic services, surgery, post-operative treatment and recovery.

Length of Leave

Eligible employees are entitled to up to 12 workweeks (and up to an *additional* 12 weeks for any pregnancy-related disability) in any leave year. Absences due to a compensable, disabling on-the-job injury do not count against the 12 workweeks under OFLA except when the employee refuses a suitable offer of light-duty or modified work. Where applicable, OFLA leave will run concurrently with leave provided under the Oregon Military Family Leave Act. Eligible employees are entitled to two weeks of bereavement leave.

Parents who use all 12 of their workweeks for parental leave to care for a newborn, newly adopted or newly placed foster child are also entitled to take up to 12 workweeks to care for a child with an illness or an injury

that is not a serious health condition if no other family member is available to care for the child — that is, to take sick-child leave. A female employee may take up to 12 weeks of OFLA pregnancy disability leave, up to 12 weeks of parental leave, *and* up to another 12 weeks of OFLA sick child leave, for a total of up to 36 weeks of OFLA leave. Additional OFLA leave is not available in the case of birth, adoption or foster care placement of more than one child at the same time.

The applicable leave year utilized by the Company is **a** 12-month period measured forward from the start date of the employee's first OFLA leave. Under this method the leave year is measured from the date the employee first uses any OFLA leave.

If more than one qualifying family member works for the Company, two family members can only take leave at the same time if one needs to care for the other with a serious health condition, needs to care for a child with a serious health condition while another also has such a condition, both family members have a serious health condition at the same time or both family members are taking bereavement leave at the same time.

Employees will be allowed up to two weeks of unpaid bereavement leave per death of a covered family member, not to exceed 12 weeks total per year. For purposes of bereavement leave, a “family member’ includes a family member includes the employee’s spouse (including same-sex spouse), same-sex domestic partner, parent, child, parent-in-law, grandparent and the parent or child of the employee’s same-sex domestic partner. Bereavement leave must be completed within 60 days of the date the eligible employee receives notice of the family member’s death.

Pay

OFLA leave is unpaid and employees may use all accrued vacation and sick pay (if eligible to use it) before going on unpaid status.

Requesting OFLA Leave

Except in very unusual or emergency situations, employees *must* request leave as soon as is practicable after learning of the need for time away from work.

If employees do not give timely notice, the Company may deny or delay the start of an employee’s leave, and/or an employee may be subject to disciplinary action.

If an employee knows of the need for the leave 30 or more days in advance, the employee must complete the leave of absence forms at least 30 days before leave is to begin.

In unusual or emergency situations (for example, if an employee is injured in an accident, suddenly becomes ill, gives premature birth, experiences a death in their family, etc.), the employee must make an oral request to their manager for leave within 24 hours (or as soon thereafter as is practicable). All oral requests for leave must then be confirmed in writing as soon as is practicable and in no event later than three calendar days after returning to work.

In the case of Bereavement Leave, prior notice is not required, but oral notice must be provided by the employee or someone on the employee’s behalf to the Company within 24 hours of beginning leave. Written confirmation of such notice must then be provided to Human Resources and the employee’s supervisor within three days of returning to work.

In the case of leave to care for a child whose school or child care provider has been closed in conjunction with a public health emergency, the Company may require verification of the need for leave.

As long as employees are using some form of paid leave (for example, earned vacation or sick leave) to cover missed time, employees need only comply with the notice provisions of those policies.

Employees should consult with Human Resources and the employee's supervisor when scheduling intermittent or reduced leave for planned medical treatment or supervision so that time off can be scheduled to minimize disruption to the normal work schedule.

If an employee is seeking to use paid (for example, earned vacation) or unpaid leave for a purpose that may qualify for FMLA and/or OFLA leave, they must notify the Company so that the employee will receive all of the benefits to which they are entitled. Failure to provide notification of reasons for any absence, whether a partial or full day, which might qualify, could result in the absence being counted against the employee for attendance and other purposes (e.g., pay increases, promotional opportunities, etc.).

Medical Certification

For leaves due to an employee's own health condition, the employee's health care provider must review the employee's essential job functions and certify that the employee's condition prevents the employee from performing at least one of them.

If an employee's insurance or other benefit plan does not cover the cost, the Company will pay for the medical certification.

For leaves due to a family member's health condition, the Company may require written certification from the treating health care provider(s), except for an Oregon employee whose child has an illness requiring home care that does not qualify as a serious health condition (i.e., sick child leave). In the case of sick child leave, the Company will only require medical verification after an employee has taken more than three days of leave for this purpose in a one-year period. The Company will pay for the cost of the certification to the extent it is not covered by the employee's insurance or benefit plan. In appropriate situations, the Company may also require documentation of the individual's relationship to the employee.

Medical certification forms are available from the Human Resources Department and must be *fully* completed and returned prior to the start of any leave for which the employee has provided 30 days' advance notice. In other circumstances (for example, in emergencies or other unusual circumstances when it is impossible to foresee the need for leave that far in advance), employees must return the completed form as soon as is practicable but no later than within 15 calendar days of the date an employee's absence began or within 15 calendar days of our request for certification or recertification. If an employee fails to provide a timely, fully completed certification or recertification, they may be denied continuation of the leave until complete and sufficient medical verification is received.

Recertification of the medical need for continuing leave must be provided every 30 days, and more often when circumstances have changed significantly or the Company has received information casting doubt on the validity of the prior certification.

The Company may request a second (or third) medical opinion (except for an Oregon employee who has a sick child requiring home care who does not have a serious health condition) at the Company's expense. The Company may also initiate an unpaid leave of absence and/or require a medical or other professional examination at the Company's expense in circumstances in which an employee's performance, conduct or behavior, the nature of an employee's job and/or the employee's condition raises an issue as to fitness for duty or ability to safely perform regular job duties.

An employee who is absent for **7** or more calendar days in any 30-day period because of an illness, injury or other condition (other than one returning from intermittent leave) **will** be required to provide a return-to-

work release from an employee's health care provider confirming that the employee is able to return to work. We may require such a release for absences of less than **7** calendar days as well.

All medical releases must clearly explain an employee's work abilities and any limitations or restrictions. Reinstatement may be delayed until the employee has provided a release meeting these standards. An employee who does not timely provide the required release is subject to disciplinary action up to and including termination.

All medical information will be kept in the employee's confidential medical file and will not be the basis for any personnel actions or decisions other than those related to family and medical leave, reasonable accommodation, or as otherwise allowed by law.

Intermittent/Reduced Schedule Leave

The Company may transfer an employee who takes OFLA leave on an intermittent or reduced work schedule basis or who is recovering from a serious health condition to an alternative position to accommodate the leave or recovery, but will do so only if the employee agrees to the transfer voluntarily, the transfer is temporary and the alternative job has equivalent pay and benefits.

An employee will be allowed to take parental leave in two or more nonconsecutive periods only with Company approval, except in the case of parental leave to effectuate adoption or foster placement of a child. Such leave need not be taken in one uninterrupted period.

Reinstatement

Employees returning from OFLA leave will be reinstated to their former job if it exists. If the former job does not exist, reinstatement will be to a job with equivalent status, pay, benefits and other employment terms. For OFLA leave, reinstatement rights exist at the former site as well as any other location within 20 miles. If an employee is on leave due to their own health condition, they may be required to provide a return-to-work release.

Benefit Coverage

The Company will continue paying its share of the cost of an employee's health coverage while the employee is on FMLA/OFLA leave on the same terms as if the employee were working, but the employee will be responsible for continuing to make any payments normally required of them. If the employee does not pay the cost of coverage during the leave, the Company may seek to recover the employee's share of the cost of benefit coverage, in accordance with applicable law.

While an employee is on paid leave (i.e., using sick leave or vacation time), any required employee payments will continue to be deducted from their check as usual to the extent that the employee's pay is sufficient to cover the deduction.

If an employee does not return to work at the end of leave, the employee may have rights under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue health coverage by paying the full premium (plus a small administrative fee), and may also be able to obtain portability coverage under some state laws.

Reemployment and Temporary Cessation of Scheduled Hours

If an employee who separates from employment is eligible for OFLA leave at the time of separation and is subsequently reemployed by the Company within 180 days of separation, the employee will be eligible upon rehire to use OFLA leave in accordance with this policy.

If an employee is eligible for OFLA leave at the beginning of a temporary cessation of scheduled hours lasting 180 days or less and returns to work at the end of that temporary cessation of scheduled hours, the employee will be eligible upon return to use OFLA leave in accordance with this policy.

Any OFLA leave taken during a leave year continues to count against the length of leave to which the employee is entitled.

Fraudulent Use of OFLA Prohibited

Employees who fraudulently obtain leave under this policy may be subject to disciplinary action, up to and including termination.

Retaliation

The Company will not interfere, restrain or deny the exercise of any rights provided under this policy. If an employee believes that their OFLA rights have been violated in any way, they should immediately report the matter to Human Resources**.**

Domestic Violence, Harassment, Sexual Assault or Stalking Victim Leave

Employees who are the victim, or the parent or guardian of a minor child or dependent who is a victim of harassment, domestic violence, sexual assault or stalking will be allowed time off in order to:

- Seek legal or law enforcement assistance or remedies;
- Seek medical treatment for or to recover from injuries caused by harassment, domestic violence, sexual assault, or stalking;
- Obtain or assist a minor child or dependent in obtaining counseling related to an experience of harassment, domestic violence, sexual assault or stalking;
- Obtain services from a victim services provider; or
- Relocate or take steps to secure an existing home.

Time off under this policy is unpaid except that exempt employees will be paid when required under applicable law. In addition, employees are allowed, but not required, to use any accrued paid vacation leave, sick leave, personal business leave or other paid leave during a leave under this policy. Where applicable, time off under this policy will run concurrently with time off under the Oregon Family Leave Act (OFLA) and/or the federal Family and Medical Leave Act (FMLA)**.**

Employees must provide their supervisor or Human Resources Department reasonable advance notice of their intent to take leave under this policy, unless providing advance notice is not feasible. In cases of emergency, employees, or a person acting on behalf of an employee, must give notice as soon as practicable. The Company may also require certification that the employee or minor child is a victim and that the leave is being taken for a permissible purpose. Such certification may take the form of a police

report, protective order, or documentation from a health care professional, clergy, attorney or law enforcement officer.

The Company reserves the right to limit the amount of leave an eligible employee may take, if the leave creates an undue hardship on the Company's business.

Leave may be taken on an intermittent or reduced work schedule basis. The Company may transfer an employee on intermittent leave or a reduced work schedule to an alternate position that better accommodates the leave, so long as the transfer is temporary and voluntary and there is no other reasonable option available that would allow the employee to use intermittent or reduced schedule leave. Transferred employees will be returned to their former position upon providing notification of readiness to return.

While on leave, employees must periodically report their status to their supervisor, including the date they intend to return to work.

Upon request, the Company will provide reasonable safety accommodations needed because of actual or threatened domestic violence, harassment, sexual assault or stalking, unless such accommodations impose an undue hardship on the Company's business. Such safety accommodations may include, but are not limited to: transfer, reassignment, a modified schedule, a changed work telephone number, a changed work station, an installed lock or implemented safety procedures or other adjustment to a job structure, workplace facility or work requirement.

Employees who wish to request time off or an accommodation under this policy should promptly notify a supervisor or the Human Resources Department.

Confidentiality of the situation, including the employee's request for reasonable safety accommodation or time off under this policy and any documentation provided, will be maintained to the greatest extent possible.

The Company will not retaliate, or tolerate retaliation, against any employee who seeks or obtains leave or an accommodation under this policy.

Crime Victim Leave

Eligible employees will be allowed time off to attend a criminal proceeding, a juvenile proceeding or any other proceeding at which a crime victim has the right to be present.

Eligible employees are those who:

- Have worked an average of more than 25 hours per week during the 180 days immediately prior to the leave; and

- Are a victim who has suffered financial, social, psychological or physical harm as a result of a personal felony or is the spouse, domestic partner, parent, sibling, child, stepchild or grandparent of the victim.

Time off under this policy is unpaid except that exempt employees will be paid when required under applicable law. Employees will also be allowed to use available accrued vacation or other paid leave, though the Company may determine the order in which such leave must be used.

The Company reserves the right to limit the amount of leave an eligible employee may take, if the leave creates an undue hardship on the Company's business.

Employees must provide reasonable advance notice of their intent to take leave under this policy, as well as a copy of any notices of scheduled criminal proceedings provided by a law enforcement agency.

Confidentiality of the situation, including the employee's request for the time off under this policy and any documentation provided, will be maintained to the greatest extent possible.

Juvenile Court Appearance Leave

Employees will be allowed time off when compelled to attend a juvenile court proceeding involving a child of which the employee is a parent or legal guardian.

Time off under this policy will be without pay, except that exempt employees will receive pay when required by applicable law.

The Company will not discriminate or retaliate against employees who seek or obtain leave under this policy.

Legislative Leave

Regular full-time and part-time employees that have been employed by the Company for at least 90 days will be allowed time off to serve in the Oregon Legislative Assembly. Leave will be granted for any regular or special sessions or for time needed to perform official duties as a member or prospective member of the Legislative Assembly. Time off under this policy will be without pay.

Employees must provide notice of the need for leave under this policy at least 30 days before a regular session begins and as soon as possible when it is apparent that a special or emergency session will be called.

Employees must return to work within 15 days after the adjournment of the Legislative Assembly following a regular session or within five days after any other assignment is completed. Upon return from leave, employees will be reinstated to the same or similar position without loss of seniority or benefits earned before the leave commenced.

The Company reserves the right to deny reinstatement if a conflict of interest develops or if the circumstances of the Company change during the leave such that it would be impossible or unreasonable to reinstate the employee.

Bone Marrow Donation Leave

Eligible employees who undergo a medical procedure to donate bone marrow will be allowed to use already accrued paid leave to do so. Eligible employees are those who work an average of 20 or more hours per week. The leave can extend up to the amount of the employee's accrued paid leave or 40 work hours, whichever is less, unless the Company agrees otherwise.

Employees may be required to provide the Company with verification from a physician of the purpose and length of each leave. If there is a medical determination that the employee does not qualify as a bone marrow donor, the paid leave used prior to the determination is not affected.

The Company will not retaliate against any employee for requesting or taking a leave under this policy.

Military Leave

As is set forth in the National Handbook, and under state law, the Company provides leave and reemployment following leave to provide service in the uniformed service, in accordance with the federal

Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Under USERRA, the total military leave time may not exceed five years during employment, except in certain, defined circumstances. For Oregon employees, time spent performing the following types of service will be excluded when determining whether the employee has met the five-year limit on duration of military leave: time spent providing voluntary service overseas and voluntary service within the United States during or in response to an emergency or disaster declared by the local, state or federal government.

In addition to these military leave rights, Oregon employees who are members of an organized militia will be granted an unpaid leave of absence to perform active state service if the militia is called into active service. The Company will grant leave until the employee is released from state service. Employees who take leave under this policy will be restored to their prior position or to an equivalent position and will not lose seniority, vacation credits, sick leave credits, service credits under a pension plan or any other employee benefit or right that had been earned at the time of the leave of absence. Employees who take leave under this policy must return to employment within seven calendar days in order to be entitled to reinstatement.

Family Military Leave

Employees working an average of at least 20 hours per week who have a spouse or domestic partner that is a member of the military and has been notified of an impending call, order to active duty, or has been deployed during a period of military conflict, will be granted a leave of up to 14 days for each deployment. Leave may be taken intermittently, in which case the total number of hours of leave available is the amount the employee regularly works per day multiplied by 14. The leave can be taken before and during deployment, as well as when the military spouse or domestic partner is on leave from deployment.

Employees should let the Company know within five days of receiving an official notification of a call to duty if they intend to take leave, or as soon as practicable if official notice is received less than five days before the leave is to begin. An employee taking leave under this policy may be required to provide a photocopy of the service member's orders.

Leave under this policy is unpaid, but employees may elect to use accrued paid time off during the leave. For employees who are eligible for leave under the Oregon Family Leave Act (OFLA) and/or the federal Family and Medical Leave Act (FMLA) and have OFLA and/or FMLA leave time remaining, time off under this policy will be counted as part of the total amount of authorized OFLA and/or FMLA leave.

Veterans' Day Observance

The Company will provide employees who are also qualified veterans unpaid time off on Veterans' Day, provided that the employee gives at least 21 calendar days' notice of the intent to take time off on Veterans' Day, provides valid documentation showing they are a qualified veteran, and would otherwise be required to work on Veterans' Day.

Employees should contact their supervisor to make appropriate arrangements. The Company reserves the right to deny requested time off to all qualifying veterans under this policy if it determines that providing such time off would cause significant economic or operational disruption, or undue hardship.

SAFETY AND SECURITY

Smoke-Free Workplace

The Company prohibits smoking in the workplace. Employees wishing to smoke must do so outside of company facilities during scheduled work breaks and must not smoke in outside areas that will allow

circulation of smoke into the company's facilities. For example, employees must not smoke within 10 feet of the Company's facilities' ventilation intakes, windows, entrances or exits. For purposes of this policy, "smoking" includes the use of aerosolized or vaporized inhalants, such as nicotine, cannabinoids or other substances that are not FDA approved and marketed solely for a therapeutic purpose.

Employees who observe other individuals smoking in the workplace in violation of this policy have a right to object and should report the violation to their supervisor or another member of management or the Human Resources Department. Employees will not be disciplined or retaliated against for reporting smoking that violates Oregon law or this policy.

Employees who violate this policy will be subject to disciplinary action up to and including termination of employment.

Safety Committees

The Company forms safety committees to allow management and employees to work together to monitor the overall safety of our operations and to recommend changes in policies, rules and practices in order to make this a safer place for all of us to work.

Each business location has its own safety committee consisting of four members. The safety committee will be composed of an equal number of employer-selected members and employee-elected or volunteer members. If company management and employees agree, the safety committee may have more employee-elected or volunteer members.

Management will select its representatives and employee representatives shall be selected by the employees. The names of the current safety committee members will be posted on the company's bulletin board.

The safety committee will:

- Establish and/or maintain a system by which employees may make safety-related suggestions, report hazards, and present to the safety committee any pertinent information. Such suggestions, reports and information shall be reviewed at the next safety committee meeting.

- Assist in evaluating the Company's accident and illness prevention program and make written recommendations for improvement.

- Establish procedures and conduct workplace inspections and make written recommendations for improvements.

- Evaluate the Company's accountability system and make recommendations to implement supervisor and employee accountability for safety and health.

- Establish procedures for investigating all safety-related incidents including injury accidents, illnesses and deaths (the safety committee need not conduct the investigation itself).

Safety committee members may use company facilities and staff assistance for the preparation of any required reports or recommendations. Safety committee reports and recommendations shall be delivered to the Safety and Learning Manager and posted, except when posting would disclose confidential information (e.g., relating to an employee's medical condition) and copies will be available upon request from Human Resources.

CHESTNUT HEALTH SYSTEMS

ADDENDUM – Pennsylvania Supplement – 2024



Chestnut Health Systems

Personnel Policies

Pennsylvania Supplement

2024

CHESTNUT HEALTH SYSTEMS

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Pennsylvania Supplement

Chestnut Health Systems (“Chestnut” or “the Company”) is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Pennsylvania employees will receive the Company’s Personnel Policies and the Pennsylvania Supplement to the Personnel Policies (“Pennsylvania Supplement) (together the “Employee Handbook”).

The Pennsylvania Supplement applies only to Pennsylvania employees. It is intended as a resource containing specific provisions derived under Pennsylvania law that apply to the employee’s employment. It should be read together with the National Handbook and, to the extent that the policies in the Pennsylvania Supplement are different from or more generous than those in the National Handbook, the policies in the Pennsylvania Supplement will apply.

The Pennsylvania Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person’s authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

PAY PRACTICES

Philadelphia Notice Regarding Unpaid Wages

Employees who work in Philadelphia may file a wage theft complaint or bring a civil action for unpaid wages pursuant to Philadelphia's Wage Theft Ordinance (Ordinance).

A signed wage theft complaint, in which the alleged unpaid wages are equal to or greater than the minimum threshold amount of $100 and equal to or less than the maximum threshold amount of $100,000, must be filed with the wage theft coordinator in the Mayor's Office of Benefits and Wage Compliance less than three (3) years from the date the alleged wage theft occurred.

Retaliation for exercising rights provided under the Ordinance, such as filing a complaint or bringing a civil action, is prohibited.

CHESTNUT HEALTH SYSTEMS

TIME OFF AND LEAVES OF ABSENCE

Allegheny County Paid Sick Time

Eligibility

Chestnut Health Systems provides paid sick time to employees who have worked in Allegheny County for at least 35 hours in the calendar year in accordance with Article XXIV ("Paid Sick Days") of the Allegheny County Health Department Rules and Regulation (the "Ordinance"). For employees who work in Allegheny County who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing paid sick time pursuant to this policy at the start of employment. Employees accrue one (1) hour for every thirty-five (35) hours worked, up to a maximum accrual of forty (40) hours each calendar year and an overall accrual cap of forty (40) hours at any time. Exempt employees are assumed to work forty (40) hours in each workweek unless their normal workweek is less than forty (40) hours, in which case paid sick time accrues based upon that normal workweek.

For purposes of this policy, the calendar year is the consecutive 12-month period beginning January 1 and ending on December 31.

Usage

Employees may use paid sick time beginning on the 90th calendar day following commencement of employment. Paid sick time may be used in in the smaller of hourly increments or the smallest increment that the Company's payroll system uses to account for absences or use of other time. Employees may not use more than forty (40) hours of paid sick time in any calendar year.

Employees may use paid sick time:

- for their own mental or physical illness, injury or health condition; for medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; for preventive medical care;
- to care for a family member with a mental or physical illness, injury or health condition; to care of a family member who needs medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; to care of a family member who needs preventive medical care;
- for the closure of the employee's place of business by order of a public official due to a public health emergency;
- to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency; or

- to care for a family member when it has been determined by the health authorities having jurisdiction or by a health care provider that the family member's presence in the community would jeopardize the health of others because of the family member's exposure to a communicable disease, whether or not the family member has actually contracted the communicable disease.

For purposes of this policy, family member includes: a biological, adopted or foster child, stepchild or legal ward, a child of a domestic partner or a child to whom the employee stands in loco parentis; a biological, foster, adoptive, step-parent or legal guardian of the employee or the employee's spouse or domestic partner or a person who stood in loco parentis when the employee was a minor child; a person to whom the employee is legally married under the laws of any state; a grandparent or spouse or domestic partner of a grandparent; grandchild; a biological, foster or adopted sibling; a domestic partner; or any individual for whom the employee has received permission from the employer to care for at the time of the employee's request to make use of paid sick time.

Employees' use of paid sick time will not be conditioned upon searching for or finding a replacement worker.

Unless employees advise the Company otherwise, we will assume, subject to applicable law, that employees want to use available paid sick time for absences for reasons set forth above and they will be paid for such absences to the extent they have paid sick time available.

Notice and Documentation

Requests to use paid sick time may be made orally, in writing or electronically (e.g., via email), and whenever possible, the request must include the expected duration of the employee's absence. When the use of paid sick time is foreseeable, the employee is required to make a good faith effort to provide notice of the need for such time to the Employee's Supervisor seven (7) days in advance of the use of the paid sick time or as early as possible under the circumstances and make a reasonable effort to schedule the use of paid sick time in a manner that does not unduly disrupt the Company's operations. When the use of paid sick time is not foreseeable, the employee is required to provide notice to the Employee's Supervisor at least one (1) hour prior to the start of the employee's workday or as soon as possible under the circumstances.

For paid sick time of three (3) or more full consecutive days, the Company may require reasonable documentation that the paid sick time has been used for a covered purpose. Documentation signed by a health care professional indicating that sick time is necessary shall be considered reasonable documentation. Documentation provided to the Company should not explain the nature of the employee's or a family member's illness or health condition.

Payment

Paid sick time will be paid at the same base rate of pay and with the same benefits, including health care benefits, as the employee would have earned at the time of the use of the paid sick time, but no less than the applicable minimum wage, unless otherwise required by applicable law. Use of paid sick time is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Employees may carry over up to forty (40) hours of accrued, unused paid sick time to the following calendar year. Unused paid sick time will not be paid at separation.

Enforcement and Retaliation

The Company prohibits retaliation or discrimination against any employee because the employee has exercised rights protected under the Ordinance. Such rights include but are not limited to the right to use sick time pursuant to the Ordinance, the right to file a complaint with the Allegheny County Department of Administrative Services to effectuate the provisions of the Ordinance, the right to inform any person about alleged violations of the Ordinance and the right to inform any person of the employee's potential rights under the Ordinance. Employees may file a complaint if sick time is denied or if they are subjected to retaliation for requesting or taking sick time.

Questions about rights and responsibilities under the law can be answered by Human Resources.

Philadelphia Paid Sick Time

Eligibility

Chestnut Health Systems provides paid sick time to employees who work in Philadelphia for at least forty (40) hours in a year. For employees who work in Philadelphia who are eligible for sick time under another policy and/or any other applicable sick time/leave ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than any other policy and/or any other applicable sick time/leave ordinance.

Accrual

Employees begin accruing paid sick time pursuant to this policy at the start of employment. Eligible employees will accrue one (1) hour of paid sick time for every forty (40) hours worked, up to a maximum accrual of forty (40) hours each calendar year. Exempt employees will be presumed to work forty (40) hours in each workweek for accrual purposes unless their normal workweek is less than 40 hours, in which case accrual will be based on that normal workweek. For purposes of this policy, the calendar year is the consecutive 12-month period beginning January 1 and ending on December 31.

Usage

Employees may begin using paid sick time on the 90th calendar day of employment. Paid sick time may be used in minimum increments of one (1) hour. The employee may not use more than forty (40) hours of accrued paid sick time in any calendar year.

The employee may use paid sick time for the following qualifying absences:

1. the employee's mental or physical illness, injury or health condition; the employee's need for medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; the employee's need for preventive medical care;

2. the care of a family member with a mental or physical illness, injury or health condition; care of a family member who needs medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; care of a family member who needs preventive medical care; or

3. an absence necessary due to domestic abuse, sexual assault or stalking, provided the leave is to allow the employee to obtain the medical attention needed for the employee or the family member to recover from physical or psychological injury or disability caused by domestic or sexual violence

or stalking; services from a victim services organization; psychological or other counseling; relocation due to the domestic or sexual violence or stalking; or legal services or remedies, including preparing for or participating in any civil or criminal legal proceeding related to or resulting from the domestic or sexual violence.

For purposes of this policy, family member includes a biological, adopted or foster child, stepchild or legal ward or a child to whom the employee stands in loco parentis; a biological, foster, stepparent or adoptive parent or legal guardian of the employee or the employee's spouse or a person who stood in loco parentis when the employee was a minor child; a person to whom the employee is legally married under the laws of Pennsylvania; a grandparent or spouse of a grandparent; a grandchild; a biological, foster or adopted sibling or spouse of a biological, foster or adopted sibling; and a life partner as defined under the Philadelphia Code.

Employees' use of paid sick time will not be conditioned upon searching for or finding a replacement worker.

Unless employees advise the Company otherwise, we will assume, subject to applicable law, that employees want to use available paid sick time for absences for reasons set forth above and they will be paid for such absences to the extent they have paid sick time available.

Notice and Documentation

If the need for paid sick time is foreseeable, the employee must provide written or oral notice in advance of the use of the paid sick time to the Employee's Supervisor and make a reasonable effort to schedule the use of paid sick time in a manner that does not unduly disrupt business operations. For all other absences, the employees must provide notice to the Employee's Supervisor before the start of their scheduled work hours, or as soon as practicable if the need arises immediately before or after the employee has reported for work. When possible, employees should indicate the expected duration of their absence.

For paid sick time of more than two (2) consecutive days, the employee may be required to provide reasonable documentation that the sick time is covered. For absences due to the purposes described in 1 and 2 above, documentation signed by a health care professional indicating that sick time is necessary shall be considered reasonable documentation. For absences due to the purposes described in 3 above, the following shall be considered reasonable documentation: documentation signed by a health care professional; a police report indicating that the employee was a victim of domestic abuse, stalking or sexual assault; a court order; or a signed statement from a representative of a victim services organization affirming that the employee was a victim of domestic abuse, stalking or sexual assault. The required documentation need not explain the nature of the illness or the details of the violence.

Payment

Paid sick time will be paid at the same rate as the employee earns at the time the employee uses such time. Use of paid sick time is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Employees may carry over up to forty (40) hours of accrued, unused paid sick time under this policy to the following calendar year. Accrued but unused paid sick time under this policy will not be paid at separation.

Enforcement and Retaliation

Chestnut Health Systems prohibits any threat, discharge, suspension, demotion, other adverse employment action against the employee for the exercise of any right under this policy; or interference with, or punishment for, participating in any manner in an investigation, proceeding or hearing under this policy.

Any employee has the right to file a complaint with the Office of Benefits and Wage Compliance or bring a civil action if sick time as required is denied by the Company or the employee is retaliated against for requesting or taking sick time.

If employees have any questions regarding this policy, they should contact Human Resources.

Pittsburgh Paid Sick Time

Eligibility

Chestnut Health Systems provides paid sick time to employees who work in the City of Pittsburgh for at least thirty-five (35) hours in the calendar year in accordance with the Paid Sick Days Act (the "Ordinance") and the County of Allegheny in accordance with Article XXIV ("Paid Sick Days") of the Allegheny County Health Department Rules and Regulation (the "County Ordinance"). For employees who work in the City of Pittsburgh who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave law or ordinance.)

Accrual

Employees begin accruing paid sick time pursuant to this policy at the start of employment. Employees accrue one (1) hour for every thirty-five (35) hours worked, up to a maximum accrual of forty (40) hours each calendar year. Exempt employees are assumed to work forty (40) hours in each workweek unless their normal workweek is less than forty (40) hours, in which case paid sick time accrues based upon that normal workweek. For purposes of this policy, the calendar year is the consecutive 12-month period beginning January 1 and ending on December 31.

Usage

Employees may use paid sick time on the 90th calendar day following commencement of employment. Paid sick time may be used in in the smaller of hourly increments or the smallest increment that the payroll system uses to account for absences or use of other time. Employees may not use more than their maximum hours of paid sick time in any calendar year.

Employees may use paid sick time for absences due to:

- their mental or physical illness, injury or health condition; their personal need for medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; their personal need for preventive medical care;
- care of a family member with a mental or physical illness, injury or health condition; care of a family member who needs medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; care of a family member who needs preventive medical care; or

- closure of the employee's place of business by order of a public official due to a public health emergency or the employee's need to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency, or care for a family member when it has been determined by the health authorities having jurisdiction or by a health care provider that the family member's presence in the community may jeopardize the health of others because of the family member's exposure to a communicable disease, whether or not the family member has actually contracted the communicable disease.

For purposes of this policy, family member includes:

- a biological, adopted or foster child, stepchild or legal ward, a child of a domestic partner, or a child to whom the employee stands in loco parentis;
- a biological, foster, stepparent or adoptive parent or legal guardian of the employee or the employee's spouse or domestic partner or a person who stood in loco parentis when the employee was a minor child;
- a person to whom the employee is legally married under the laws of any state;
- a grandparent or spouse or domestic partner of a grandparent;
- a grandchild;
- a biological, foster or adopted sibling;
- a domestic partner; or
- any individual for whom the employee has received oral permission from the employer to care for at the time of the employee's request to make use of sick time.

An employee's use of paid sick time will not be conditioned upon searching for or finding a replacement worker.

Unless the employee advises otherwise, the Company will assume, subject to applicable law, that employees want to use available paid sick time for absences for reasons set forth above and they will be paid for such absences to the extent they have paid sick time available.

Notice and Documentation

Requests to use paid sick time may be made orally, in writing, or electronically (e.g., via email), and whenever possible, the request must include the expected duration of the absence. When the use of paid sick time is foreseeable, the employee is required to make a good faith effort to provide notice of the need for such time to the Employee's Supervisor seven (7) days in advance of the use of the paid sick time or as early as possible under the circumstances and make a reasonable effort to schedule the use of earned paid sick time in a manner that does not unduly disrupt operations. When the use of paid sick time is not foreseeable, the employee is required to provide notice to the Employee's Supervisor at least one (1) hour prior to the start of the workday or as soon as possible under the circumstances.

For paid sick time of three (3) or more full consecutive days, the Company may require reasonable documentation that the paid sick time has been used for a covered purpose. Documentation signed by a

health care professional indicating that sick time is necessary shall be considered reasonable documentation. Documentation provided to the Company should not explain the nature of the illness or health condition.

Payment

Paid sick time will be paid at the same base rate of pay and with the same benefits, including health care benefits, as the employee would have earned at the time of their use of the paid sick time, but no less than the applicable minimum wage, unless otherwise required by applicable law. Use of paid sick time is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Employees may carry over up to forty (40) hours of accrued, unused paid sick time to the following calendar year. Unused paid sick time will not be paid at separation.

Enforcement and Retaliation

The Company prohibits retaliation or discrimination against employees because they have exercised rights protected under the Ordinance or County Ordinance. Such rights include but are not limited to the right to use sick time pursuant to the Ordinance and County Ordinance; the right to file a complaint with the Mayor's Office of Equity or the Department or other County Agency designated by the Allegheny County Manager to effectuate the provisions of the County Ordinance or court; the right to inform any person about any employer's alleged violations of this Ordinance or County Ordinance; and the right to inform employees of their potential rights under the Ordinance or County Ordinance. Employees may file a complaint if sick time is denied or if they are subjected to retaliation for requesting or taking sick time.

Questions about rights and responsibilities under the law can be answered by Human Resources.

Philadelphia Domestic Violence, Sexual Assault or Stalking Leave

Employees who are victims of domestic violence, sexual assault or stalking or who have a family or household member who is a victim of domestic violence, sexual assault or stalking, may take up to eight (8) workweeks of unpaid leave in a twelve- (12-) month period. For purposes of this policy, "family or household members" include spouses or persons who have been spouses, persons living as spouses or who lived as spouses, parents and children, other persons related by consanguinity or affinity, current or former sexual or intimate partners, persons who share biological parenthood or "Life Partners" (as defined under the Philadelphia Code).

[NOTE: For fewer than 50 total employees nationwide, the limit is 4 weeks; with 50 or more total employees, the limit is 8 weeks.]

Leave under this policy may be taken to:

1. seek medical attention for, or recovering from, physical or psychological injuries caused by domestic violence, sexual assault or stalking to the employee or the employee's family or household member;

2. obtain services from a victim services organization for the employee or the employee's family or household member;

3. obtain psychological or other counseling for the employee or the employee's family or household member;

4. participate in safety planning, temporarily or permanently relocating or taking other actions to increase the safety of the employee or the employee's family or household member from future domestic violence, sexual assault or stalking or to ensure economic security; or

5. seek legal assistance or remedies to ensure the health and safety of the employee or the employee's family or household member, including preparing for or participating in any civil or criminal legal proceeding related to or derived from domestic violence, sexual assault or stalking.

Leave may be taken intermittently or on a reduced work schedule.

Employees must provide at least forty-eight (48) hours' advance notice of their intention to take leave under this policy, unless providing such notice is not practicable. The Company may require certification verifying that the employee or their family or household member is a victim of domestic violence, sexual assault or stalking and the leave is a qualifying purpose. Employees can satisfy the certification requirement by providing a sworn statement and any of the following:

- documentation from the employee, agent or volunteer of a victim services organization, an attorney, a member of the clergy or a medical or other professional from whom the employee or the employee's family or household member has sought assistance in addressing domestic violence, sexual assault or stalking or the effects of the violence;

- a police or court record; or

- other corroborating evidence.

Employees who fail to provide this certification within forty-five (45) days of the Company's request may be subject to disciplinary action.

Any information provided by the employee pursuant to this policy will be kept confidential unless disclosure is requested or consented to in writing by the employee or otherwise required by applicable federal, state or local law.

During an approved leave, the Company will maintain the employee's health benefits as if the employee continued to be actively employed. However, if the employee fails to return from leave after the leave entitlement has expired, and the reason for the failure to return is unrelated to the continuation, recurrence or onset of domestic violence, sexual assault or stalking, the Company may recover from the employee the premium it paid to maintain the employee's coverage during the period of leave.

Employees may substitute any accrued paid time off for the unpaid leave provided under this policy, but substitution does not extend the length of the leave. Leave under this policy will run concurrently with leave under applicable federal, state, or local laws to the maximum extent permitted under such applicable law.

Employees who take leave under this policy will be returned to the position they held at the time when the leave commenced, or to a position with equivalent benefits, pay and other terms and conditions of employment.

Employees with questions or concerns regarding this policy can contact Human Resources.

CHESTNUT HEALTH SYSTEMS

PENNSYLVANIA SUPPLEMENT ACKNOWLEDGMENT

This Pennsylvania Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Pennsylvania Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

145. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;

146. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;

147. obscene or vulgar gestures, posters or comments;

148. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;

149. propositions or suggestive or insulting comments of a sexual nature;

150. derogatory cartoons, posters and drawings;

151. sexually-explicit e-mails, text messages or voicemails;

152. uninvited touching of a sexual nature;

153. unwelcome sexually-related comments;

154. conversation about one's own or someone else's sex life;

155. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and

156. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

ADDENDUM – South Carolina Supplement – 2024



Chestnut Health Systems

Personnel Policies

South Carolina Supplement

2024

CHESTNUT
HEALTH SYSTEMS

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This South Carolina Supplement

Chestnut Health Systems (“Chestnut” or “the Company”) is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, South Carolina employees will receive the Company’s Personnel Policies and the South Carolina Supplement to the Personnel Policies (“South Carolina Supplement) (together the “Employee Handbook”).

The South Carolina Supplement applies only to South Carolina employees. It is intended as a resource containing specific provisions derived under South Carolina law that apply to the employee’s employment. It should be read together with the National Handbook and, to the extent that the policies in the South Carolina Supplement are different from or more generous than those in the National Handbook, the policies in the South Carolina Supplement will apply.

The South Carolina Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. Only the CEO of the Company or that person’s authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

South Carolina Pregnancy Accommodations

In compliance with South Carolina law (S.C. Code Ann. §1-13-80), Chestnut Health Systems will not discriminate against an individual because of pregnancy, childbirth or related medical conditions, including, but not limited to, lactation. The Company will endeavor to make reasonable accommodations for the employee's medical needs arising from pregnancy, childbirth or related medical conditions, unless doing so would impose an undue hardship on the operation of the business.

Reasonable Accommodations

Reasonable accommodations may include, but are not limited to:

1. **making existing facilities readily accessible to, and usable by, such employees, including acquiring or modifying equipment or devices necessary for performing essential job functions;**
2. **providing more frequent or longer break periods;**
3. **providing more frequent bathroom breaks;**
4. **providing a private place, other than a bathroom stall for the purpose of expressing milk;**
5. **modifying the Company's food or drink policy;**
6. **modifying work schedules;**
7. **providing seating or allowing the employee to sit more frequently;**
8. **providing assistance with manual labor and limits on lifting;**
9. **temporarily transferring the employee to a less strenuous or hazardous vacant position, if qualified; or**
10. **providing job restructuring or light duty, if available.**

The Company will not:

- **deny employment opportunities to the employee based on the need to make such reasonable accommodations;**
- **require the employee to accept an accommodation that the employee chooses not to accept, if the employee does not have a known limitation related to pregnancy, or if the accommodation is unnecessary for the employee to perform the essential duties of their job;**
- **require the employee to take leave under any leave law or Company policy if another reasonable accommodation can be provided to the employee; or**
- **take any adverse action against the employee in the terms, conditions or privileges of employment for requesting or using a reasonable accommodation.**

Contact for Questions and Requests

If employees have any questions concerning this policy or if they wish to request an accommodation, they should contact Human Resources.

PAY PRACTICES

South Carolina Lactation Accommodation

Pursuant to the South Carolina Lactation Support Act, Chestnut Health Systems supports the legal right and necessity of employees who choose to express milk in the workplace. This policy is to establish guidelines for promoting a breastfeeding-friendly work environment and supporting lactating employees at the Company.

The Company will make reasonable efforts to provide a reasonable amount of unpaid break time to accommodate employees desiring to express breast milk for their child. If possible, the lactation break time must run concurrently with break time already provided to employees. Lactation break time that cannot run concurrently with paid break time already provided will be unpaid, subject to applicable law.

The Company will make reasonable efforts to provide employees with use of a room or location in close proximity to their work area, other than a toilet stall, in order to express milk in private.

Employees will not be discriminated against or retaliated against for choosing to express breast milk in the workplace in compliance with this policy and the law. Employees can contact Human Resources with questions regarding this policy.

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as "protected characteristics"). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with

an individual's work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone's way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- **submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or**
- **submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or**
- **the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.**

Examples of conduct that violate this policy include:

157. **unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;**
158. **requests for sexual favors or demands for sexual favors in exchange for favorable treatment;**
159. **obscene or vulgar gestures, posters or comments;**
160. **sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;**
161. **propositions or suggestive or insulting comments of a sexual nature;**
162. **derogatory cartoons, posters and drawings;**
163. **sexually-explicit e-mails, text messages or voicemails;**
164. **uninvited touching of a sexual nature;**
165. **unwelcome sexually-related comments;**

166. conversation about one's own or someone else's sex life;

167. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and

168. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

Chestnut Health Systems

Employee Handbook Supplement

Date of Issuance: June 2024

SOUTH CAROLINA

This acknowledgement should be signed by the employee and given to the employee.

Pursuant to South Carolina law, I acknowledge and understand that this employee handbook does not create an express or implied contract of employment between the Company and me.

I agree and acknowledge that I am an at-will employee, meaning that I can quit or be terminated at any time, for any reason or no reason. I agree and acknowledge that this at-will relationship cannot be altered and that no contract can be formed regarding any term or condition of employment unless it is in writing and signed by the CEO.

I also agree and acknowledge that this is the first page of the handbook given to me.

_____

Employee Signature

_____

Date

Chestnut Health Systems

Employee Handbook Supplement

Date of Issuance: June 2024

SOUTH CAROLINA

This acknowledgement should be signed by the employee and maintained as the first page of the Handbook.

Pursuant to South Carolina law,I acknowledge and understand that this employee handbook does not create an express or implied contract of employment between the Company and me.

I agree and acknowledge that I am an at-will employee, meaning that I can quit or be terminated at any time, for any reason or no reason. I agree and acknowledge that this at-will relationship cannot be altered and that no contract can be formed regarding any term or condition of employment unless it is in writing and signed by the CEO.

I also agree and acknowledge that this is the first page of the handbook given to me.

_____

Employee Signature

_____

Date

ADDENDUM – Tennessee Supplement – 2024

Chestnut Health Systems

Personnel Policies

Tennessee Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Tennessee Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Tennessee employees will receive the Company's Personnel Policies and the Tennessee Supplement to the Personnel Policies ("Tennessee Supplement) (together the "Employee Handbook").

The Tennessee Supplement applies only to Tennessee employees. It is intended as a resource containing specific provisions derived under Tennessee law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Tennessee Supplement are different from or more generous than those in the National Handbook, the policies in the Tennessee Supplement will apply.

The Tennessee Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

Tennessee Pregnancy Accommodations

In compliance with Tennessee Pregnant Workers Fairness Act, Chestnut Health Systems will make reasonable accommodations for medical needs arising from pregnancy, childbirth or related medical conditions of an applicant for employment or an employee, unless the accommodation would impose an undue hardship on business operations.

The Company will not take adverse action against employees in terms, conditions or privileges of employment for requesting or using a reasonable accommodation to the known limitations for medical needs arising from pregnancy, childbirth or related conditions, including, but not limited to, counting an absence related to pregnancy under the attendance policy. The Company will not require employees to

take leave if another reasonable accommodation can be provided to the known limitations for medical needs arising from pregnancy, childbirth or related conditions.

Reasonable accommodations include but are not limited to:

1. making existing facilities used by employees readily accessible and usable;
2. providing more frequent, longer or flexible breaks;
3. modifying food or drink policy;
4. providing modified seating or allowing employees to sit more frequently if the job requires standing;
5. providing assistance with manual labor and limits on lifting;
6. authorizing a temporary transfer to a vacant position;
7. providing job restructuring or light duty, if available;
8. acquiring or modifying equipment, devices or work stations;
9. modifying work schedules;
10. allowing flexible scheduling for prenatal visits; and
11. providing a private place, other than a bathroom stall, for the purpose of expressing milk.

The Company reserves the right, to the maximum extent permitted by applicable law, to request medical certification from a healthcare professional if an individual is requesting a reasonable accommodation related to temporary transfer to a vacant position, job restructuring, light duty or accommodations that require time away from work. The Company will engage in an interactive process with the individual to determine if a reasonable accommodation can be provided, absent undue hardship, while the individual is making a good faith effort to obtain the medical certification. The Company will not take adverse action against employees related to their need for accommodation while they are engaging in good faith efforts to obtain medical certification.

Any questions about or requests for a reasonable accommodation pursuant to this policy, should be directed to Human Resources.

GENERAL EMPLOYMENT PRACTICES

Tennessee Abusive Conduct Prevention

At Chestnut Health Systems all employees have the right to be treated with dignity and respect. Chestnut Health Systems does not tolerate and prohibits abusive conduct in the workplace. These behaviors are unacceptable in the workplace and in any work-related settings such as business trips and Company-sponsored social functions.

Abusive Conduct Defined

Abusive conduct is defined under this policy as acts or omissions that would cause a reasonable person, based on the severity, nature and frequency of the conduct, to believe that the employee was subject to an abusive work environment, which can include but is not limited to:

- repeated verbal abuse in the workplace, including derogatory remarks, insults and epithets;
- verbal, nonverbal or physical conduct of a threatening, abusive, violent, intimidating or humiliating nature in the workplace; or
- the sabotage or undermining of the employee's work performance in the workplace.

Abusive conduct does not include:

- disciplinary procedures in accordance with adopted Company policies;
- routine coaching and counseling, including feedback about and correction of work performance;
- reasonable work assignments, including shift, post and overtime assignments;
- individual differences in styles of personal expression;
- passionate, loud expression with no intent to harm others;
- differences of opinion on work-related concerns; and
- the non-abusive exercise of managerial prerogative.

Reporting Procedures

If employees believe someone has violated this policy, they should promptly bring the matter to the immediate attention of Human Resources. Every supervisor who learns of any employee's concern about conduct in violation of this policy, whether in a formal complaint or informally, or who otherwise is aware of conduct in violation of this policy, must immediately report the issues raised or conduct to Human Resources.

Investigation Procedures

Upon receiving a complaint, the Company will promptly conduct an investigation into the facts and circumstances of any claim of a violation of this policy. Employees who file complaints will not suffer negative consequences for reporting others for inappropriate behavior. To the extent possible, the Company will endeavor to keep confidential each party involved in the investigation. However, complete confidentiality may not be possible in all circumstances. Employees are required to cooperate in all investigations conducted pursuant to this policy. The Company will take corrective measures against any person who it finds to have engaged in conduct in violation of this policy, if the Company determines such measures are necessary. These measures may include, but are not limited to, counseling, suspension or immediate termination.

Retaliation

The Company will not tolerate retaliation, including any act of reprisal, interference, restraint, penalty, discrimination, intimidation or harassment against an individual or individuals exercising their rights under this policy.

Employees with questions or concerns regarding this policy should contact Human Resources.

CHESTNUT
HEALTH SYSTEMS

TENNESSEE SUPPLEMENT ACKNOWLEDGMENT

This Tennessee Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Tennessee Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

169. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;

170. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;

171. obscene or vulgar gestures, posters or comments;

172. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;

173. propositions or suggestive or insulting comments of a sexual nature;

174. derogatory cartoons, posters and drawings;

175. sexually-explicit e-mails, text messages or voicemails;

176. uninvited touching of a sexual nature;

177. unwelcome sexually-related comments;

178. conversation about one's own or someone else's sex life;

179. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and

180. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

ADDENDUM – Virginia Supplement – 2024



Chestnut Health Systems

Personnel Policies

Virginia Supplement

2024

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Virginia Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Virginia employees will receive the Company's Personnel Policies and the Virginia Supplement to the Personnel Policies ("Virginia Supplement) (together the "Employee Handbook").

The Virginia Supplement applies only to Virginia employees. It is intended as a resource containing specific provisions derived under Virginia law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Virginia Supplement are different from or more generous than those in the National Handbook, the policies in the Virginia Supplement will apply.

The Virginia Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

Virginia Pregnancy Accommodations

In compliance with Virginia law, Chestnut Health Systems will provide reasonable accommodation to the known limitations of a person related to pregnancy, childbirth, or related medical conditions, unless the Company can demonstrate that the accommodation would impose an undue hardship on the Company.

The Company will not:

- Take adverse action against individuals who request or use a reasonable accommodation pursuant to this policy, including failure to reinstate any such employee to their previous position or an equivalent position with equivalent pay, seniority, and other benefits when the need for a reasonable accommodation ceases;

- Deny employment or promotion opportunities to an otherwise qualified individual because the Company will be required to make reasonable accommodation to the known limitations of such individual related to pregnancy, childbirth, or related medical conditions; or

- Require employees to take leave if another reasonable accommodation can be provided to the known limitations related to the pregnancy, childbirth, or related medical conditions.

The Company will endeavor to engage in a timely, good faith interactive process with employees who request an accommodation pursuant to this section to determine if the requested accommodation is reasonable and, if such accommodation is determined not to be reasonable, discuss alternative accommodations that may be provided.

Reasonable Accommodations

Reasonable accommodations may include, but are not limited to:

1. More frequent or longer bathroom breaks;

2. Breaks to express breast milk;

3. Access to a private location other than a bathroom for the expression of breast milk;

4. Acquisition or modification of equipment or access to or modification of employee's seating;

5. A temporary transfer to a less strenuous or hazardous position;

6. Assistance with manual labor;

7. Job restructuring;

8. A modified work schedule;

9. Light duty assignments; and

10. Leave to recover from childbirth.

Any questions about or requests for a reasonable accommodation pursuant to this policy, should be directed to Human Resources.

Virginia Reasonable Accommodation for Persons with Disabilities

In accordance with the Virginia Human Rights Act (the “Act”), employees have the right to reasonable accommodations for disabilities and to be free from unlawful discriminatory practices based on disability.

Under the Act, the Company may not:

- refuse to make reasonable accommodation to the known physical and mental impairments of an otherwise qualified person with a disability, if necessary to assist such person in performing a particular job, unless the Company can demonstrate that the accommodation would impose an undue hardship on the Company;

- take adverse action against an employee who requests or uses a reasonable accommodation pursuant to this section;
- deny employment or promotion opportunities to an otherwise qualified applicant or employee because the Company will be required to make reasonable accommodation for a person with a disability;
- require an employee to take leave if another reasonable accommodation can be provided to the known limitations related to the disability; or
- fail to engage in a timely, good faith interactive process with an employee who has requested an accommodation pursuant to this section to determine if the requested accommodation is reasonable and, if such accommodation is determined not to be reasonable, discuss alternative accommodations that may be provided.

In determining whether an accommodation would constitute an undue hardship upon the Company, the following will be considered:

- hardship on the conduct of the Company's business, considering the nature of the Company's operation, including composition and structure of the Company's workforce;
- size of the facility where employment occurs;
- the nature and cost of the accommodations needed, taking into account alternative sources of funding or technical assistance available by way of the vocational services offered by the state Department for Aging and Rehabilitative Services;
- the possibility that the same accommodations may be used by other prospective employees; and
- safety and health considerations of the person with a disability, other employees and the public.

If employees have any questions about or would like to request a reasonable accommodation pursuant to this policy, they should contact the CEO.

CHESTNUT HEALTH SYSTEMS

VIRGINIA SUPPLEMENT ACKNOWLEDGMENT

This Virginia Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Virginia Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

181. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;

182. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;

183. obscene or vulgar gestures, posters or comments;

184. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;

185. propositions or suggestive or insulting comments of a sexual nature;

186. derogatory cartoons, posters and drawings;

187. sexually-explicit e-mails, text messages or voicemails;

188. uninvited touching of a sexual nature;

189. unwelcome sexually-related comments;

190. conversation about one's own or someone else's sex life;

191. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and

192. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

ADDENDUM – Washington Supplement – 2024



Chestnut Health Systems

Personnel Policies

Washington Supplement

2024

CHESTNUT HEALTH SYSTEMS

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Washington Supplement

Chestnut Health Systems ("Chestnut" or "the Company") is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Washington employees will receive the Company's Personnel Policies and the Washington Supplement to the Personnel Policies ("Washington Supplement) (together the "Employee Handbook").

The Washington Supplement applies only to Washington employees. It is intended as a resource containing specific provisions derived under Washington law that apply to the employee's employment. It should be read together with the National Handbook and, to the extent that the policies in the Washington Supplement are different from or more generous than those in the National Handbook, the policies in the Washington Supplement will apply.

The Washington Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person's authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

GOVERNING PRINCIPLES OF EMPLOYMENT

Washington Pregnancy Accommodations

In compliance with Washington law, Chestnut Health Systems will not discriminate against the employee in relation to pregnancy and pregnancy-related health conditions. The Company will endeavor to provide reasonable accommodations for conditions related to pregnancy and pregnancy-related health conditions, including the need to express breast milk. Reasonable accommodations include:

1. providing more frequent, longer or flexible restroom breaks;
2. modifying a no food or drink policy;

3. job restructuring, part-time or modified work schedules, reassignment to a vacant position or acquiring or modifying equipment, devices or the employee's work station;

4. providing seating or allowing the employee to sit more often if the employee's job requires the employee to stand;

5. providing for a temporary transfer to a less strenuous or less hazardous position;

6. providing assistance with manual labor and limits on lifting;

7. scheduling flexibility for prenatal visits;

8. providing reasonable break time for an employee to express breast milk each time the employee needs to express the milk and providing a private location, other than a bathroom; and

9. any further pregnancy accommodation the employee may request, and to which the Company must give reasonable consideration in consultation with information provided on pregnancy accommodation by the Washington Department of Labor and Industries or the attending health care provider of the employee.

The Company may request that the employee provide a written certification from the employee's treating health care professional regarding the need for reasonable accommodation except for accommodations listed in points 1, 2, 4, and 8 above or limits on lifting in point 6 of more than 17 pounds. The employer may refuse accommodations listed in points 3, 5, 6 (for lifting, only if involves 17 pounds or less), 7, 8, and 9 if the accommodation would pose an undue hardship on the Company’s program, enterprise or business.

The Company is not required to create additional employment that would not otherwise have been created or discharge any employee, transfer any employee with more seniority or promote any employee who is not qualified to perform the job, unless the Company does so or would do so for other classes of employees who need accommodation.

The Company will not take adverse action against the employee who requests, declines or uses an accommodation under this policy. Further, the Company will not deny employment opportunities to an otherwise qualified employee or prospective employee if such denial is based on the Company’s need to reasonably accommodate the employee's or prospective employee's condition related to pregnancy, childbirth or a related medical condition. Additionally, the Company will not require the employee to take leave if another reasonable accommodation can be provided for the employee’s pregnancy and pregnancy-related health conditions.

If employees have any questions about or would like to request a reasonable accommodation pursuant to this policy, they should contact Human Resources.

PAY PRACTICES

Washington Meals and Rest Periods (for Non-Exempt Employees)

Rest Breaks

Non-exempt employees who work at least four (4) hours per workday are allowed to take one (1) ten- (10-) minute rest break for every four (4) hours worked in one (1) work period. For example, if the employee

works four (4) or more hours, but not more than eight (8) hours in a workday, the employee is required to take one (1) ten- (10-) minute rest break during the first four (4) hours of the shift. If an employee works eight (8) hours or more, but no more than twelve (12) hours in a day, the employee is required to take two (2) ten- (10-) minute rest breaks, and so on.

Rest breaks should be taken as close to the middle of each work period of four (4) hours as is practical but in no event shall employees work more than three (3) consecutive hours without a rest break. Employees must take their rest breaks and are prohibited from working during their rest breaks. Employees are paid for all rest break periods and do not need to clock out when taking a rest break.

Rest breaks may not be combined with each other or with the meal period. In addition, rest breaks may not be taken at the beginning or end of the workday to arrive late or leave early. Unless otherwise instructed, rest breaks are self-directed and unscheduled, and may be taken as time allows on either a continuous or intermittent basis (e.g., two (2) to three (3) "mini" breaks totaling 10 minutes). Examples of "mini" rest breaks are personal phone calls, eating a snack, having a cup of coffee, personal conversations, smoke breaks, and whenever the employee has the opportunity to take a break for a few minutes or more during a shift. It is a mandatory job duty for employees to advise Human Resources if they feel they do not have adequate opportunity for rest breaks, if they miss a rest break, or if they feel pressured to skip their rest breaks so they can be properly compensated.

Meal Periods

Non-exempt employees who work more than five (5) consecutive hours in a workday are provided an unpaid, off-duty and uninterrupted meal period of at least thirty (30) minutes which must be taken between the second and fifth hour of the work period. Thereafter, a meal period of at least thirty (30) minutes is required for each five (5) consecutive hours worked during the workday.

Employees working three (3) or more hours longer than a normal workday will be allowed one (1) thirty- (30-) minute meal period prior to or during the overtime. For purposes of this requirement, a normal workday is the shift the employee is regularly scheduled to work.

Employees are responsible for scheduling their own meal periods but should discuss strategies and plans for ensuring their meal periods with their supervisor(s) as needed. When scheduling meal periods, employees should try to anticipate their workflow and deadlines but must take their meal periods no later than at the end of each five (5) hour period worked. During a meal period, employees are relieved of all duties and should not work during this time. When taking a meal period, employees should completely stop working for at least thirty (30) minutes. Employees are prohibited from working "off the clock" during their meal period.

Those employees who use a time clock must clock out for their meal periods. Employees are required to clock back in and promptly return to work at the end of any meal period. Employees who record their time manually must accurately record their meal periods by recording the beginning and end of each work period. Employees must immediately notify Human Resources if they believe that they are prevented by the nature of their work from taking a timely and/or complete meal period so that they can be properly compensated.

If any the employee's meal period is interrupted due to the employee performing a task, upon completion of the task, the meal period will be continued until the employee has received thirty (30) minutes total of mealtime (with the entire meal period being paid and reported as hours worked, and the time spent performing the task not being considered part of the meal period).

Meal Period Waiver

Non-exempt employees are encouraged to take their meal periods. However, with the Company's permission, employees may be allowed to voluntarily waive their meal periods, and if they wish to do so on a standing basis, should complete a form documenting the same. Employees who execute a standing waiver can revoke this waiver at any time, either on an occasional or continuing basis. Employees should contact Human Resources to obtain this waiver form.

No Working During Rest Breaks and Meal Periods

Non-exempt employees are completely relieved of all work duties and responsibilities during their rest breaks and meal periods. Where practicable, rest breaks and meal periods should be taken outside employees' work areas, such as in a break room. Employees may leave the premises during meal periods, but may not leave the premises during rest periods. Employees should not visit or socialize with employees who are working while taking their rest break or meal period. Employees are required to notify Human Resources immediately if they believe they are being pressured or coerced by any supervisor or other employee to forego any portion of a provided rest break or meal period.

Summary Chart

Below is a chart that generally summarizes the number of rest breaks and meal periods provided to employees (these figures may vary depending on the timing of the employees' breaks).

Hours of Work	Rest Breaks	Meal Breaks
Less than 4 hours	0	0
4 hours – 4 hours 59 min	1	0
5 hours – 7 hours 59 min	1	1
8 hours – 9 hours 59 min	2	1
10 hours – 11 hours 59 min	2	2
12 hours – 14 hours 59 min	3	2
15 hours – 15 hours 59 min	3	3
16 hours – 19 hours 59 min	4	3
20 hours – 23 hours 59 min	5	4

TIME OFF AND LEAVES OF ABSENCE

Washington Paid Sick Leave

Eligibility

The Company provides paid sick leave to non-exempt employees who work in Washington. For non-exempt employees who work in Washington who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin accruing paid sick leave pursuant to this policy on January 1, 2018 or at the start of employment, whichever is later. Employees accrue one (1) hour for every forty (40) hours worked. For purposes of this policy, the accrual period is the consecutive twelve- (12-) month period beginning on January 1 and ending on December 31.

Usage

Employees may use paid sick leave beginning on the 90th calendar day of employment. Paid sick leave must be used in one- (1-) hour intervals.

Employees may use paid sick leave for absences due to:

- an absence resulting from the employee's mental or physical illness, injury or health condition; to accommodate the employee's need for medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; or the employee's need for preventive medical care;
- to allow the employee to provide care for a family member with a mental or physical illness, injury or health condition; care of a family member who needs medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; or care for a family member who needs preventive medical care;
- when the employee's place of business has been closed by order of a public official for any health-related reason or when the employee's child's school or place of care has been closed for such a reason; or
- an absence covered under Washington’s Domestic Violence Leave Act, as addressed further within the Leave for Victims of Domestic Violence.

For purposes of this policy, family member includes:

- a child, including a biological child, adopted child, foster child, stepchild; or a child to whom the employee stands in loco parentis, is a legal guardian of, or is a de facto parent, regardless of age or dependency status;
- a parent, including a biological parent, adoptive parent, de facto parent, foster parent, stepparent, or legal guardian of the employee or the employee's spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child;
- a spouse;
- a registered domestic partner;

- a grandparent;
- a grandchild; or
- a sibling.

The employee's use of paid sick leave will not be conditioned upon searching for or finding a replacement worker.

Unless advised otherwise by the employee, the Company will assume, subject to applicable law, that employees want to use available paid sick leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have paid sick leave available.

The Company may withhold payment of paid sick leave hours where the employee is demonstrated to have used paid sick leave for an uncovered purpose, however, their available paid sick leave hours will not be deducted.

Employees will be notified of their available paid sick leave on each itemized wage statement.

Notice and Documentation

Employees are required to give reasonable notice of an absence from work. Employees should make a reasonable effort to schedule the use of paid sick time in a manner that does not unduly disrupt the Company's operations. Requests to use earned paid leave time may be made orally, in writing, or electronically (e.g., via email), and whenever possible, the request must include the expected duration of the employee's absence. When the use of paid sick leave is foreseeable, the employee is required to make a good faith effort to provide notice of the need for such time to their Supervisor at least 10 days in advance of the use of the paid sick leave or as soon as practicable. When the use of earned sick time is not foreseeable, the employee is required to provide notice to their Supervisor as soon as possible before the start of their workday or as soon as practicable under the circumstances. In the event it is impracticable for the employee to provide notice, a person may provide notice on the employee's behalf.

For paid sick leave of more than three (3) consecutive work days, the Company requires documentation verifying that the employee's use of paid sick leave is for an authorized purpose. Documentation must be provided within a reasonable time period during or after the leave. Documentation should not explain the nature of the employee's or a family member's health condition or the details of the domestic violence, sexual violence, abuse or stalking. Employees have the right to assert that the verification requirement results in an unreasonable burden or expenses on the employee. If the employee anticipates that the requirement will result in an unreasonable burden or expense, the employee may provide an oral or written explanation to their Supervisor which asserts that the employee's use of paid sick leave was for a covered purpose and how the verification requirement creates an unreasonable burden or expense on the employee.

Payment

Paid sick leave will be paid at the same hourly rate the employee earns from their employment at the time the employee uses such time, but no less than the applicable minimum wage, unless otherwise required by applicable law. Use of paid sick leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

The employee may carry over up to forty (40) hours of accrued, unused paid sick leave to the following calendar year. Unused paid sick leave will not be paid at separation.

Enforcement and Retaliation

Retaliation or discrimination against the employee who requests paid sick days or uses paid sick days or both is prohibited, and employees may file a complaint with the Washington State Department of Labor & Industries against an employer who retaliates or discriminates against the employee.

Questions about rights and responsibilities under the law can be answered by Human Resources.

Seattle Paid Sick and Safe Time (for Employees also Covered under Washington Paid Sick Leave)

Eligibility

Employees who work within the City of Seattle will be provided with paid sick and safe time (PSST) in accordance with the Seattle Paid Sick and Safe Time Ordinance ("Ordinance") (SMC 14.16) and the Washington State Paid Sick Leave law. For employees who work in Seattle who are eligible for sick time under the general sick days policy and/or any other applicable sick time/leave law or ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general sick days policy and/or any other applicable sick time/leave law or ordinance.

Accrual

Employees begin to accrue PSST pursuant to this policy from the date of hire. Eligible employees accrue PSST at a rate of one (1) hour for every forty (40) hours worked based on the Company's status as a Tier 2 employer. In the case of exempt employees, PSST will only accrue for hours worked up to a forty- (40-) hour workweek. If their normal work in a work week is less than forty (40) hours, PSST accrues based on that employee's normal work week. For purposes of this policy, the calendar year is the consecutive twelve- (12-) month period beginning January 1 and ending on December 31.

Usage

Eligible employees are entitled to use accrued PSST beginning on the 90th calendar day after the commencement of their employment. For non-exempt employees, PSST may be used in one- (1-) hour increments; for exempt employees, PSST may be used in a minimum increment of one (1) hour and then fifteen- (15-) minute increments thereafter.

PSST may be used for the following reasons:

- an absence resulting from the employee's mental or physical illness, injury or health condition; to accommodate the employee's need for medical diagnosis, care, or treatment of a mental or physical illness, injury or health condition; or the employee's need for preventive medical care;

- to allow the employee to provide care for a family member with a mental or physical illness, injury or health condition; care for a family member who needs medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; or care for a family member who needs preventive medical care;

- when the employee's place of business has been closed by order of a public official, for any health-related reason, to limit exposure to an infectious agent, biological toxin or a hazardous material;
- when the employee's place of business has reduced operations or closed because of any health or safety reason (only available when the employer has 250 or more employees);
- when the employee needs to care for a family member whose school or place of care has been closed;
- for any of the following reasons related to domestic violence, sexual assault or stalking:

    1. to enable the employee to seek legal or law enforcement assistance or remedies to ensure the health and safety of the employee or the employee's family or household members including, but not limited to, preparing for, or participating in, any civil or criminal legal proceeding related to or derived from domestic violence, sexual assault or stalking;
    2. to enable the employee to seek treatment by a health care provider for physical or mental injuries caused by domestic violence, sexual assault or stalking or to attend to health care treatment for a victim who is the employee's family or household member;
    3. to enable the employee to obtain or assist a family or household member in obtaining, services from a domestic violence shelter, a rape crisis center or another social services program for relief from domestic violence, sexual assault or stalking;
    4. to enable the employee to obtain, or assist a family or household member in obtaining, mental health counseling related to an incident of domestic violence, sexual assault or stalking, in which the employee or the employee's family member was a victim of domestic violence, sexual assault or stalking; or
    5. to enable the employee to participate in safety planning, temporarily or permanently relocate, or take other actions to increase the safety of the employee or employee's family or household members from future domestic violence, sexual assault or stalking.

For purposes of this policy, family member includes: a child, including a biological child, adopted child, foster child, stepchild, or a child to whom the employee stands *in loco parentis*, is a legal guardian, or is a de facto parent, regardless of age or dependency status; a parent, including a biological parent, adoptive parent, de facto parent, foster parent, stepparent or legal guardian of the employee or the employee's spouse or registered domestic partner or a person who stood *in loco parentis* when the employee was a minor child; a spouse; a registered domestic partner; a person with whom the employee has a dating relationship; a grandparent; a grandchild; or a sibling.

For purposes of this policy, household member includes: spouses; domestic partners; former spouses; former domestic partners; persons who have a child in common regardless of whether they have been married or have lived together at any time; adult persons related by blood or marriage; adult persons who are presently residing together or who have resided together in the past; persons sixteen (16) years of age or older who are presently residing together or who have resided together in the past and who have or have had a dating relationship; persons sixteen (16) years of age or older with whom a person sixteen (16) years of age or older has or has had a dating relationship; and persons who have a biological or legal parent-child relationship, including stepparents and stepchildren and grandparents and grandchildren.

The employee's use of PSST will not be conditioned upon searching for or finding a replacement worker.

Unless the employee advises the Company otherwise, the Company will assume, subject to applicable law, that employees want to use available PSST for absences for reasons set forth above and employees will be paid for such absences to the extent they have PSST available.

Employees will be notified (on employee pay stubs) of available PSST each time wages are paid.

Notice and Documentation

PSST will be provided upon the request of the employee. When possible, the request should include the expected duration of the absence. If the need to use PSST is foreseeable, the employee must provide a written request at least ten (10) days, or as early as possible, in advance of the use of PSST. Further, employees must give advance oral or written notice as soon as possible for the foreseeable use of PSST to address domestic violence, sexual assault or stalking involving the employee, a family member or a household member. If the need to use PSST is unforeseeable, the employee must provide notice as soon as is practicable and must comply with normal notification policies and/or call-in procedures. In the event it is impracticable for the employee to provide notice, someone else may provide notice on their behalf. In the case of an unforeseen absence related to domestic violence, sexual assault or stalking; however, oral or written notice must be provided no later than the end of the first work day that the employee takes such leave, if possible.

The employee must provide supporting documentation if the employee uses PSST for more than three (3) consecutive work days or any parts thereof. For documentation regarding illness, injury or health condition, the Company may request a certification, to be completed by the employee's (or family member's) health care provider, confirming their inability to work as a result of an illness, injury or health condition or the need to care for a family member with an illness, injury or health condition, to the extent permitted and in accordance with applicable law. For documentation of the closure of a school or place of care, the employee can provide notice of the closure in whatever format the employee received it. For verification of leave taken for domestic violence, sexual assault or stalking, the employee may provide a police report; applicable evidence from the court or the prosecuting attorney; documentation from an advocate, attorney, member of the clergy, medical or other professional; or the employee's written statement.

Employees have the right to assert that the verification requirement results in an unreasonable burden or expenses on the employee. If the employee anticipates that the requirement will result in an unreasonable burden or expense, the employee may provide an oral or a written explanation that asserts that the employee's use of PSST was for a covered purpose and how the verification requirement creates an unreasonable burden or expense on the employee.

Payment

PSST under this policy will be compensated at the employee's normal hourly compensation and with the same benefits as the employee would have earned during the time the paid leave is taken, in accordance with the Ordinance and state law. Use of PSST is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

Employees may carry over PSST from year to year, up to a maximum of fifty-six (56) hours. Accrued but unused PSST will not be paid on separation.

[NOTE: For companies with 1-49 employees across the country, the carryover maximum is 40 hours; 50-249 employees is 56 hours, and 250 or more total employees is 72 hours.]

Enforcement and Retaliation

The Company prohibits retaliation or the threat of retaliation against the employee for exercising or attempting to exercise any right to PSST in accordance with the Ordinance and state law. The Seattle Office of Labor Standards (OLS) is responsible for enforcing the Ordinance and ensuring that employees are not retaliated against for using PSST and the Washington State Department of Labor & Industries is responsible for enforcing the state law. Employees who experience a violation of PSST rights may file a complaint with the OLS or bring a civil action. The OLS also provides free technical assistance, brochures, posters and other resources. For more information from the OLS, call 206-684-4500 or visit: http://www.seattle.gov/laborstandards/ordinances/paid-sick-and-safe-time. A non-exempt employee who experiences a violation of PSST rights also may file a complaint with the Washington State Department of Labor and Industries. Contact the department online: https://www.lni.wa.gov/workers-rights/; call: 1-866-219-7321, toll-free; visit: https://www.lni.wa.gov/agency/contact/#office-locations; or email: ESgeneral@Lni.wa.gov.

If employees have questions about PSST benefits, they should contact Human Resources.

Tacoma Paid Leave (for Employees also Covered under Washington Paid Sick Leave Law)

Eligibility

The Company provides paid leave to employees who work in Tacoma.

For employees who work in Tacoma who are eligible for sick time under the general Sick Days policy and/or any other applicable sick time/leave ordinance, this policy applies solely to the extent it provides greater benefits/rights on any specific issue or issues than the general Sick Days policy and/or any other applicable sick time/leave ordinance.

Accrual

Employees begin accruing paid leave pursuant to this policy at the start of employment. Eligible employees will accrue one (1) hour of paid leave for every forty (40) hours worked. Exempt employees will be presumed to work forty (40) hours in each workweek for accrual purposes unless their normal workweek is less than forty (40) hours, in which case accrual will be based on that normal workweek. For purposes of this policy, the calendar year is the consecutive twelve- (12-) month period beginning January 1 and ending on December 31.

Usage

Employees may begin using paid leave on the 90th calendar day of employment. Paid leave may be used in minimum increments of one (1) hour.

The employee may use paid leave for the following qualifying absences:

1. an absence resulting from the employee's mental or physical illness, injury or health condition; to accommodate medical diagnosis, care or treatment of a mental or physical illness, injury or health condition or preventive medical care;

2. care for a family member with a mental or physical illness, injury or health condition; care for a family member who needs medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; or care for a family member who needs preventive medical care;

3. when the employee's place of business has been closed by order of a public official for any health related reason;

4. to allow the employee to care for a child whose school or place of care has been closed by order of a public official;

5. to enable the employee to seek legal or law enforcement assistance or remedies to ensure the health and safety of the employee or the employee's family members, including, but not limited to, preparing for or participating in any civil or criminal legal proceeding related to or derived from domestic violence, sexual assault or stalking;

6. to enable the employee to obtain, or assist a family member in obtaining, services from a domestic violence shelter, rape crisis center or other social services program for relief from domestic violence, sexual assault or stalking;

7. to enable the employee to participate in safety planning, temporarily or permanently relocate or take other actions to increase the safety of the employee or employee's family members from future domestic violence, sexual assault or stalking; or

8. to enable the employee to take leave for bereavement for the death a family member.

For purposes of this policy, family member includes: a child, including a biological child, adopted child, foster child, stepchild or a child to whom the employee stands in loco parentis, is a legal guardian or is a de facto parent, regardless of age or dependency status; a parent, including a biological parent, adoptive parent, de facto parent, foster parent, stepparent, or legal guardian of the employee or the employee's spouse or registered domestic partner or a person who stood in loco parentis when the employee was a minor child; a spouse; a registered domestic partner; a grandparent; a grandchild; or a sibling.

Unless the employee advises the Company otherwise, the Company will assume, subject to applicable law, that employees want to use available paid leave for absences for reasons set forth above and employees will be paid for such absences to the extent they have paid leave available.

Employees will be notified of available paid leave each time wages are paid on employee pay stubs and/or electronically.

Notice and Documentation

If the need for paid leave is foreseeable, the employee must provide written notice at least ten (10) days in advance or as early as possible in advance of the leave. Employees must make a reasonable effort to schedule this leave in a manner that does not unduly disrupt business operations. If the need for paid leave is unforeseeable, the employee must provide notice as soon as it is practicable and must comply with the Company's Punctuality and Attendance policy.

For absences exceeding three (3) days, the Company may require verification that the employee's use of paid sick leave is for an authorized purpose. If verification is required, it must be provided within a reasonable time period during or after the leave. If the Company requires employees to give reasonable notice of an absence from work for the use of paid sick leave for an authorized purpose under the Domestic Violence Leave Act, any such reasonable notice requirements will comply with state law. Specifically, when leave is needed for the employee's own illness or injury or to care for a family member's illness or injury, the employee may be required to provide a certification from a medical provider supporting the need for paid leave. When leave is needed for bereavement purposes, the employee may be required to provide verification of the funeral date and location as well as relation to the deceased. When leave is needed for a child because of their school closure by a public official, the employee may be required to provide a letter from the child's school confirming the dates of closure. When leave is needed for reasons related to domestic violence, sexual assault or stalking, the employee may be required to provide legal documentation supporting the need for paid leave. Alternatively, for leave needed for any of the eight (8) reasons set forth above, employees may provide a signed personal statement that they need or needed paid leave for a qualifying purpose, and if applicable, the employee's relationship to the family member for whom leave is needed. Documentation must be provided within seven (7) calendar days of the employee taking paid leave, unless, for good cause shown or as otherwise permitted by the Company, the employee requires more time to provide such documentation. Failure to comply with the reasonable documentation requirements, without a reasonable justification, may result in denial of pay for absences already taken, recoupment of the amount paid for paid leave from future pay, as an overpayment, or otherwise taking appropriate disciplinary action, to the extent permitted by applicable law. Employees have the right to assert that the verification requirement results in an unreasonable burden or expenses on the employee. If the employee anticipates that the requirement will result in an unreasonable burden or expense, the employee may provide an oral or written explanation that asserts that the employee's use of paid leave was for a covered purpose and how the verification requirement creates an unreasonable burden or expense on the employee.

Payment

Paid leave will be paid at the same rate as the employee earns from their employment at the time the employee uses such leave, unless otherwise required by applicable law. Use of paid leave is not considered hours worked for purposes of calculating overtime.

Carryover and Payout

The employee may carry over up to forty (40) hours of accrued, unused paid leave under this policy to the following calendar year. Accrued but unused paid leave under this policy will not be paid at separation.

Enforcement and Retaliation

The Company prohibits any threat, discharge, suspension, demotion or other adverse employment action against the employee for the exercise of any right under this policy; or interference with, or punishment for, participating in any manner in an investigation, proceeding or hearing under this policy.

If employees have any questions regarding this policy, they should contact Human Resources.

Washington Paid Family and Medical Leave (PFML)

Eligibility

Employees who have worked 820 hours in the qualifying period (equal to 16 hours a week for a year) are eligible to apply for paid medical leave or paid family leave (collectively PFML). "Qualifying period" means the first four (4) of the last five (5) completed calendar quarters or, if eligibility is not established, the last four (4) completed calendar quarters immediately preceding the application for PFML. The 820 hours are cumulative, regardless of the number of employers or jobs someone has during a year. All paid work over the course of the year counts toward the 820 hours, including part-time, seasonal, and temporary work.

Entitlement

PFML is available to eligible employees for up to twelve (12) weeks within any fifty-two (52) consecutive week period. PFML may be used:

- To participate in providing care, including physical or psychological care, for a family member (child, grandchild, grandparent, parent, sibling, spouse, child's spouse or state registered domestic partner, or anyone who has an expectation to rely on the employee for care, whether living in the same household or not) with a serious health condition;
- To bond with the employee's child after the child's birth or after the placement of a child under the age of 18 with the employee;
- Because of any qualifying military exigency as permitted under the federal Family and Medical Leave Act (FMLA) for the employee's family member (child, grandchild, grandparent, parent, sibling, spouse, child's spouse or state registered domestic partner of an employee);
- Because of the employee's own serious health condition; or
- Because of the death of the employee's child for whom the employee would have qualified for medical leave for the birth of the child or would have qualified for family leave to bond with the child during the seven (7) calendar days following the death.

For purposes of the above, unless the context clearly requires otherwise, "child" includes: biological, adopted, or foster child; a stepchild or a child to whom the employee stands in loco parentis, is a legal guardian or is a de facto parent regardless of age or dependency status. "Parent" includes biological, adoptive, de facto or foster parent, stepparent or legal guardian of the employee or the employee's spouse or state registered domestic partner or an individual who stood in loco parentis to the employee when the employee was a child.

Qualifying military exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, caring for the parents of the military member on covered active duty, and attending post-deployment reintegration briefings.

If the employee faces multiple events in a year, the employee may be eligible to receive up to 16 weeks, and up to 18 weeks if the employee experiences a serious health condition during pregnancy that results in incapacity.

Leave to care for the employee's child after birth, or placement for adoption or foster care must be taken within one (1) year of the child's birth or placement. Leave for any other reason must be taken within one (1) year of the date of which the employee filed an application for the benefits.

These benefits are financed through both employee and Chestnut Health Systems contributions to the PFML program. The program is administered by the Washington Employment Security Department (ESD). The Company will calculate and withhold premiums from employees' paychecks and send both employees' shares and the Company's share, if applicable, to ESD on a quarterly basis.

While on PFML, employees are entitled to partial wage replacement at a portion of their average weekly pay. There is a waiting period of up to seven (7) consecutive calendar days of leave, but employees may use any paid time off (including vacation leave, personal leave, medical leave, sick leave, compensatory leave or any other paid leave offered under the Company's established policy) to receive compensation during that waiting period. No waiting period is required where leave is for the medical leave for the birth parent taken upon the birth of a child, family leave for bonding after birth or placement of a child or for a military exigency. A waiting period will not reduce the maximum duration of an employee's available paid family or medical leave.

If the employee's average weekly wage is fifty percent (50%) or less of the state average weekly wage, the employee's weekly benefit is ninety percent (90%) of the average weekly wage. If the employee's weekly benefit is greater than fifty percent (50%) of the of the state average weekly wage, the weekly benefit is the sum of:

- ninety percent (90%) of fifty percent (50%) of the state average weekly wage; and
- fifty percent (50%) of the employee's average weekly wage that is greater than fifty percent (50%) of the state average weekly wage.

The ESD sets the maximum weekly benefit for PFML, and it will be adjusted effective January 1 of each subsequent year as determined by the state based on ninety percent (90%) of the state's average weekly wage. Employees will be paid benefits directly by ESD rather than by the Company.

In any week in which the employee is eligible to receive benefits under Title 50 (unemployment compensation) or certain provisions of Title 51 (industrial insurance) of the Revised Code of Washington, or any other applicable federal unemployment compensation, industrial insurance or disability insurance laws, the employee is disqualified from receiving PFML.

Definition of a Serious Health Condition

A serious health condition is an illness, injury, impairment or physical or mental condition that involves: inpatient care in a hospital, hospice, or residential medical care facility; or continuing treatment by a health care provider. Subject to certain conditions, the continuing treatment requirement may include, but is not limited to:

- A period of incapacity of more than three (3) consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition;
- Any period of incapacity due to pregnancy, or for prenatal care;
- Any period of incapacity or treatment for such incapacity due to a chronic serious health condition;
- A period of incapacity which is permanent or long term due to a condition for which treatment may not be effective; or

- Any period of absence to receive multiple treatments, including any period of recovery from the treatments, by a healthcare provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for: restorative surgery after an accident or other injury; or a condition that would likely result in a period of incapacity of more than three (3) consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer, severe arthritis, or kidney disease.

Use of PFML

Employees do not need to use PFML in one block. PFML can be taken intermittently in minimum increments of eight (8) consecutive hours. PFML taken on an intermittent basis will not result in a reduction of the total amount of PFML to which the employee is entitled beyond the amount of PFML actually taken.

Employee Notice

Employees must provide the Company at least thirty (30) days' written notice before PFML is to begin if the need for PFML is foreseeable based on an expected birth, placement of a child or planned medical treatment for a serious health condition. Employees must provide the Company written notice as soon as is practicable when thirty (30) days' notice is not possible, such as because of a lack of knowledge of approximately when PFML will be required to begin, a change in circumstances or a medical emergency. Employees must provide written notice as soon as is practicable for foreseeable PFML due to a qualifying military exigency, regardless of how far in advance such PFML is foreseeable. When the need for PFML is not foreseeable, employees must provide written notice as soon as is practicable under the facts and circumstances of the particular situation. If the employee is unable to provide notice personally, written notice may be given by another responsible party, such as the employee's spouse, neighbor or coworker.

The employee must provide written notice to make the Company aware that the employee may need PFML. The notice must contain at least the anticipated timing and duration of the PFML. Written notice includes, but is not limited to, handwritten or typed notices, and all forms of written electronic communications such as text messages and email.

Whether PFML is to be continuous or is to be taken intermittently or on a reduced schedule basis, written notice need only be given one time, but the employee must inform the Company as soon as is practicable if dates of the scheduled PFML change, are extended or were initially unknown.

Filing Claims with the ESD

The employee may apply for PFML benefits by:

- Using the ESD online services;
- Contacting the paid family and medical leave customer care center by telephone; or
- Using alternate methods authorized by ESD.

When the employee submits an application for PFML benefits, the employee must provide information sufficient for ESD to determine eligibility for benefits. This information includes, but is not limited to, information identifying the employee, the type and anticipated duration of PFML, as well as certification or documentation to validate the qualifying event. If the employee is in a claim year and has need for successive periods of benefits for the same qualifying event beyond what was originally approved, the

employee must update the application. If the employee experiences a new qualifying event during a claim year, the employee must reopen the claim and provide additional information required by ESD before benefits can be paid. Any time the employee applies for PFML benefits, the application must be supported by documentation or certification as required by applicable law. For example, when PFML is taken because of the employee's own serious health condition or the serious health condition of a family member, medical certification from a health care provider will be required. However, the employee does not need to obtain medical certification during the six (6)-week postnatal period.

The ESD is solely responsible for determining if an employee is eligible for benefits.

Supplemental Benefits During PFML

The Company offers the following supplemental benefits to employees who are receiving PFML: salary continuation, vacation leave, other paid time off.

Job Benefits and Protection

Employees' eligibility for health insurance benefits while using PFML depends upon the terms of the insurance plan and/or the employees' use of FMLA, if applicable. If Employees are eligible to maintain their health coverage during PFML leave, Employees who contribute to the cost of their health insurance must continue to pay their portion of the premium cost while on PFML.

Employees who return from PFML generally will be restored to a same or equivalent job if the Company has 50 or more employees and the employee has worked for the Company for at least twelve (12) months, and has worked 1,250 hours in the twelve (12) months before taking PFML (about 24 hours per week, on average). Otherwise, Employees taking PFML are not guaranteed job reinstatement unless they qualify for such reinstatement under federal and/or state leave laws or other applicable laws.

The use of PFML cannot result in the loss of any employment benefits that accrued prior to the start of PFML.

FMLA Concurrent with PFML

Any time off for PFML purposes will run concurrently with FMLA, if applicable, with the exception of any leave for sickness or temporary disability because of pregnancy or childbirth, which is in addition to leave under PFML. Please see the "Family and Medical Leave" policy for eligibility requirements under the FMLA and see the "Pregnancy and Childbirth Leave" policy for eligibility requirements for pregnancy leave.

Questions and/or Complaints about PFML

The Company is prohibited from discriminating or retaliating against employees for requesting or taking PFML.

For more information on PFML, employees may go to paidleave.wa.gov or speak with Human Resources.

Washington Leave for Victims of Domestic Violence

If the employee or the employee's family member is a victim of domestic violence, the employee may be eligible to take reasonable, unpaid time off from work for one or more of the following reasons:

- seek legal or law enforcement assistance or remedies to ensure the health and safety of the employee or a family member including, but not limited to, preparing for or participating in any civil or criminal legal proceeding related to or derived from domestic violence, sexual assault or stalking;
- seek treatment by a health care provider for physical or mental injuries caused by domestic violence, sexual assault or stalking, or to attend to health care treatment for a victim who is a family member;
- obtain or assist a family member in obtaining services from a domestic violence shelter, rape crisis center or other social services program for relief from domestic violence, sexual assault or stalking;
- obtain or assist a family member in obtaining mental health counseling related to an incident of domestic violence, sexual assault or stalking, in which the employee or family member was a victim of domestic violence, sexual assault or stalking; or
- participate in safety planning, temporarily or permanently relocate or take other actions to increase personal safety or that of family members from future domestic violence, sexual assault or stalking.

Employees may elect to use any sick leave or other paid time off for leave pursuant to this policy. Leave may take the form of reasonable unpaid leave from work, intermittent leave or leave on a reduced leave schedule.

Employees wishing to take leave pursuant to this policy must give advance notice of their intention to take leave. When advance notice cannot be given because of an emergency or unforeseen circumstance due to domestic violence, sexual assault or stalking, the employee or a designee must give notice no later than the end of the first day on which such leave is taken.

Verification of the need for leave may be required.

Washington Pregnancy and Childbirth Leave

Employees are eligible to take unpaid leave for the actual period of time that they are sick or temporarily disabled because of pregnancy, childbirth or related medical conditions.

Any employees wishing to request leave because of a pregnancy-related disability must provide appropriate medical certification.

This leave is available regardless of whether the employee qualifies for leave under Chestnut Health Systems Family & Medical Leave policy. This leave does not count towards the employee's leave entitlement, if any, under the Washington State Paid Family and Medical Leave Act (PFML), but FMLA leave will run concurrently with this leave.

During this leave, employees must use any applicable paid time off benefits that they have available to cover some or all of the absence. Otherwise, the leave will be unpaid. Group health and other benefits will be handled in the same manner as for any other similar pregnancy or non-pregnancy related absence.

If employees take this leave only for the actual period of disability, as certified by their health care provider, then they ordinarily will be allowed to return from this leave to the same job they held when the leave began or to a similar job of at least the same pay. Exceptions to this general rule will be made only if the Company has a business necessity to do otherwise.

If employees have any questions regarding this policy, they should contact Human Resources.

CHESTNUT HEALTH SYSTEMS

WASHINGTON SUPPLEMENT ACKNOWLEDGMENT

This Washington Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Washington Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

193. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;

194. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;

195. obscene or vulgar gestures, posters or comments;

196. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;

197. propositions or suggestive or insulting comments of a sexual nature;

198. derogatory cartoons, posters and drawings;

199. sexually-explicit e-mails, text messages or voicemails;

200. uninvited touching of a sexual nature;

201. unwelcome sexually-related comments;

202. conversation about one's own or someone else's sex life;

203. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and

204. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

ADDENDUM – Wisconsin Supplement – 2024



Chestnut Health Systems

Personnel Policies

Wisconsin Supplement

2024

CHESTNUT HEALTH SYSTEMS

INTRODUCTION

Welcome

For employees who are commencing employment with Chestnut Health Systems ("Chestnut Health Systems" or "the Company"), on behalf of Chestnut Health Systems, let me extend a warm and sincere welcome.

For employees who have been with us, thanks for your past and continued service.

I extend my personal best wishes for success and happiness here at Chestnut Health Systems. We understand that it is our employees who provide the services that our customers rely upon, and who will enable us to create new opportunities in the years to come.

David A. Sharar Ph.D., CEO

About This Wisconsin Supplement

Chestnut Health Systems (“Chestnut” or “the Company”) is committed to workplace policies and practices that comply with federal, state and local laws. For this reason, Wisconsin employees will receive the Company’s Personnel Policies and the Wisconsin Supplement to the Personnel Policies (“Wisconsin Supplement) (together the “Employee Handbook”).

The Wisconsin Supplement applies only to Wisconsin employees. It is intended as a resource containing specific provisions derived under Wisconsin law that apply to the employee’s employment. It should be read together with the National Handbook and, to the extent that the policies in the Wisconsin Supplement are different from or more generous than those in the National Handbook, the policies in the Wisconsin Supplement will apply.

The Wisconsin Supplement is not intended to create a contract of continued employment or alter the at-will employment relationship. **Only the CEO of the Company or that person’s authorized representative has the authority to enter into an agreement that alters the at-will employment relationship and any such agreement must be in writing signed by the CEO of the Company or an authorized representative**.

If employees have any questions about these policies, they should contact Human Resources.

TIME OFF AND LEAVES OF ABSENCE

Wisconsin Organ and Bone Marrow Donor Leave

Employees may take up to six (6) weeks of unpaid leave in a twelve- (12-) month period for the purpose of serving as bone marrow or organ donors. Leave may only be taken for the period necessary to undergo and recover from the bone marrow or organ donation procedure.

In order to take leave to serve as a bone marrow or organ donor, employees must provide the Company with advance notice of the bone marrow or organ donation in a reasonable and practicable manner. Employees must make a reasonable effort to schedule the bone marrow or organ donation procedure so that it does not unduly disrupt the Company's operations (subject to the approval of the bone marrow or organ recipient's health care provider).

Employees may substitute paid time off while taking otherwise unpaid leave under this policy, and the substitution of paid time does not extend the length of leave under this policy. If applicable, this leave also will run concurrently with FMLA and/or applicable state law.

If applicable, the Company will maintain group health insurance coverage under the conditions that applied immediately before the leave began. In these cases, the Company reserves the right to require the employee to have in escrow with the Company an amount equal to the entire premium or similar expense for eight (8) weeks of the employee's group health insurance coverage (which may be paid in equal installments at regular intervals over at least a twelve- (12-) month period and which the Company will deposit in an interest-bearing account).

The Company may require certification issued by a health care provider (of either the employee or the bone marrow/organ recipient, as appropriate) which indicates:

- the recipient has a serious health condition that necessitates a bone marrow or organ transplant;
- the employee is eligible and has agreed to serve as a bone marrow or organ donor for the recipient; and
- the amount of time expected to be necessary for the employee to recover from the bone marrow or organ donation procedure.

When employees return from bone marrow and organ donation leave, the Company will return them to the position they held immediately before going on leave or, if that position is not available, to an equivalent position with equivalent compensation, benefits, working shift, hours of employment and other terms and conditions of employment. If the employee wishes to return to work before the end of the leave as scheduled, the Company will return the employee to the same or a similar position (as described above) within a reasonable time (not to exceed the duration of the originally-scheduled leave).

When employees end their employment with the Company, any payments in escrow (as described above) will be returned to them. If employees end their employment during or within 30 days after taking bone marrow and organ donation leave, the Company reserves the right to deduct from the amount returned to the employee any premium or similar expense paid for the employee's group health insurance coverage while the employee was on leave under this policy.

Wisconsin Family and Medical Leave

Employees may be entitled to a leave of absence under the Family and Medical Leave Act ("FMLA") and/or the Wisconsin Family and Medical Leave Act ("WFMLA"). This policy provides employees information concerning FMLA and/or WFMLA entitlements and obligations employees may have during such leaves. Whenever permitted by law, the Company will run FMLA leave concurrently with WFMLA and any other leave provided under state or local law. If employees have any questions concerning FMLA and/or WFMLA leave, they should contact Human Resources.

I. Eligibility

FMLA leave is available to "FMLA eligible employees." To be an "FMLA eligible employee," the employee must: 1) have been employed by the Company for at least twelve (12) months (which need not be consecutive); 2) have been employed by the Company for at least 1,250 hours of service during the 12-

month period immediately preceding the commencement of the leave; and 3) be employed at a worksite where fifty (50) or more employees are located within seventy-five (75) miles of the worksite.

Special hours of service eligibility requirements apply to airline flight crew employees.

WFMLA leave is available to "WFMLA eligible employees." To be a WFMLA eligible employee, the employee must: 1) have worked for the Company for at least fifty-two (52) consecutive weeks and have worked at least 1,000 hours in the fifty-two (52) weeks preceding the commencement of leave; **and** 2) be employed by an employer that has fifty (50) or more employees.

II. Entitlements

As described below, the FMLA and WFMLA provide eligible employees with a right to leave, health insurance benefits and, with some limited exceptions, job restoration.

A. Basic FMLA and WFMLA Leave Entitlement

The FMLA provides eligible employees up to twelve (12) workweeks of unpaid leave for certain family and medical reasons during a twelve- (12-) month period. The WFMLA provides eligible employees up to six (6) weeks of unpaid leave during a calendar year if the leave is due to childbirth or adoption, an additional two (2) weeks of leave for the employee's serious health condition, and an additional two (2) weeks to care for a parent, spouse, son or daughter with a serious health condition (employees, however, are entitled to no more than a total of eight (8) weeks of family/medical unpaid leave, not to exceed ten (10) weeks within the 12-month period under the WFMLA - see further information below).

For WFMLA the 12-month period is measured by a calendar year from January 1 to December 31.

Leave may be taken for any one, or for a combination, of the following reasons:

- To care for the employee's child after birth, or placement for adoption (or foster care - FMLA only);
- To care for the employee's spouse (or domestic partner WFMLA only), son, daughter or parent (and under the WFMLA parent-in-law) who has a **serious health condition**;
- For the employee's own **serious health condition** (including any period of incapacity due to pregnancy, prenatal medical care or childbirth) that makes the employee unable to perform one or more of the essential functions of the employee's job); and/or
- Because of any **qualifying exigency** arising out of the fact that the employee's spouse, son, daughter or parent is a military member on covered active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty) in the Reserve component of the Armed Forces for deployment to a foreign country in support of contingency operation or Regular Armed Forces for deployment to a foreign country. (FMLA only).

Under the FMLA, a **serious health condition** is an illness, injury, impairment or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) consecutive calendar days combined with at least two (2) visits to a health care provider

or one (1) visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Under the WFMLA, a **serious health condition** means a disabling physical or mental illness, injury, impairment or condition involving inpatient care in a hospital, nursing home or hospice, or out-patient care that requires continuing treatment or supervision by a health care provider.

Qualifying exigencies for FMLA leave may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, caring for the parents of the military member on covered active duty and attending post-deployment reintegration briefings.

B. Additional Military Family Leave Entitlement (Injured Servicemember Leave) (FMLA only)

In addition to the basic FMLA leave entitlement discussed above, an eligible employee who is the spouse, son, daughter, parent or next of kin of a **covered servicemember** is entitled to take up to twenty-six (26) weeks of leave during a single 12-month period to care for the servicemember with a serious injury or illness. FMLA leave to care for a servicemember shall only be available during a single 12-month period and, when combined with other FMLA-qualifying leave, may not exceed twenty-six (26) weeks during the single 12-month period. The single 12-month period begins on the first day an eligible employee takes leave to care for the injured servicemember.

A **"covered servicemember"** is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status or is on the temporary retired list, for a serious injury or illness. These individuals are referred to in this policy as "current members of the Armed Forces." **Covered servicemembers** also include a veteran who is discharged or released from military service under conditions other than dishonorable at any time during the five- (5-) year period preceding the date the eligible employee takes FMLA leave to care for the covered veteran, and who is who is undergoing medical treatment, recuperation or therapy for a serious injury or illness. These individuals are referred to in this policy as "covered veterans".

The FMLA definitions of a "serious injury or illness" for current Armed Forces members and covered veterans are distinct from the FMLA definition of "serious health condition" applicable to FMLA leave to care for a covered family member.

C. Intermittent Leave and Reduced Leave Schedules

FMLA and/or WFMLA leave usually will be taken for a period of consecutive days, weeks or months. However, employees also may be entitled to take leave intermittently or on a reduced leave schedule when medically necessary due to a serious health condition of the employee or covered family member (both FMLA and WFMLA) or the serious injury or illness of a covered servicemember (FMLA only) or birth or adoption (WFMLA only).

D. No Work While on Leave

The taking of another job while on FMLA/WFMLA or any other authorized leave of absence is grounds for immediate termination, to the extent permitted by applicable law.

E. Protection of Group Health Insurance Benefits

During FMLA/WFMLA leave, eligible employees are entitled to receive group health plan coverage on the same terms and conditions as if they had continued to work.

F. Restoration of Employment and Benefits

At the end of FMLA leave, subject to some exceptions, including situations where job restoration of "key employees" will cause the Company substantial and grievous economic injury, employees generally have a right to return to the same or equivalent positions with equivalent pay, benefits and other employment terms. The Company will notify employees if they qualify as "key employees," if it intends to deny reinstatement and of their rights in such instances. A "key employee" is defined under the FMLA as the employee among the highest paid ten percent (10%) of all employees who are employed within seventy-five (75) miles of the worksite. Use of FMLA leave will not result in the loss of any employment benefit that accrued prior to the start of an eligible employee's FMLA leave.

As with FMLA leave, at the end of WFMLA leave, subject to some exceptions, employees generally have the right to return to the same or equivalent position with equivalent pay, benefits and other terms. There is no key employee exception under WFMLA.

G. Notice of Eligibility for, and Designation of, FMLA and WFMLA Leave

Employees requesting FMLA leave are entitled to receive written notice from the Company telling them whether they are eligible for FMLA leave and, if not eligible, the reasons why they are not eligible. When eligible for FMLA leave, employees are entitled to receive written notice of: 1) their rights and responsibilities in connection with such leave; 2) the Company's designation of leave as FMLA-qualifying or non-qualifying, and if not FMLA-qualifying, the reasons why; and 3) the amount of leave, if known, that will be counted against the employee's leave entitlement.

The Company may retroactively designate leave as FMLA and/or WFMLA leave with appropriate written notice to employees provided the Company's failure to designate leave as FMLA- or WFMLA-qualifying at an earlier date did not cause harm or injury to the employee. In all cases where leaves qualify for FMLA and/or WFMLA protection, the Company and employee can mutually agree that leave be retroactively designated as FMLA and/or WFMLA leave. **[Note: There is always risk with retroactive designations.]**

III. Employee FMLA and/or WFLA Leave Obligations

A. Provide Notice of the Need for Leave

Employees who wish to take FMLA and/or WFMLA leave must timely notify the Company of their need for FMLA and/or WFMLA leave. The following describes the content and timing of such employee notices

1. Content of Employee Notice

To trigger FMLA and/or WFMLA leave protections, employees must inform Human Resources of the need for FMLA/WFMLA-qualifying leave and the anticipated timing and duration of the leave, if known. Employees may do this by either requesting FMLA and/or WFMLA leave specifically, or explaining the reasons for leave so as to allow the Company to determine that the leave is FMLA/WFMLA-qualifying. For example, employees might explain that.

- a medical condition renders them unable to perform the functions of their job;

- they are pregnant or have been hospitalized overnight;
- a covered family member (including domestic partner and parent-in-law under WFMLA) are under the continuing care of a health care provider or a condition renders the family member unable to perform daily activities;
- the leave is due to a qualifying exigency cause by a military member being on covered active duty or called to covered active-duty status to a foreign country (FMLA only); or
- a family member is a covered servicemember with a serious injury or illness (FMLA only).

Calling in "sick," without providing the reasons for the needed leave will not be considered sufficient notice for leave under this policy. Employees must respond to the Company's questions to determine if absences are potentially leave-qualifying.

If employees fail to explain the reasons for leave, the leave may be denied. When employees seek leave due to FMLA/WFMLA-qualifying reasons for which the Company has previously provided FMLA/WFMLA-protected leave, employees must specifically reference the qualifying reason for the leave or the need for FMLA and/or WFMLA leave.

2. Timing of Employee Notice

Employees must provide thirty (30) days' advance notice of the need to take FMLA and/or WFMLA leave when the need is foreseeable. When thirty (30) days' notice is not possible, or the approximate timing of the need for leave is not foreseeable, employees must provide the Company notice of the need for leave as soon as practicable under the facts and circumstances of the particular case. Employees who fail to give thirty (30) days' notice for foreseeable leave without a reasonable excuse for the delay, or otherwise fail to satisfy FMLA and/or WFMLA notice obligations, may have leave delayed or denied.

B. Cooperate in the Scheduling of Planned Medical Treatment (Including Accepting Transfers to Alternative Positions) and Intermittent Leave or Reduced Leave Schedules

When planning medical treatment, employees must consult with the Company and make a reasonable effort to schedule treatment so as not to unduly disrupt the Company's operations, subject to the approval of the employee's health care provider. Employees must consult with the Company prior to the scheduling of treatment to work out a treatment schedule that best suits the needs of both the Company and the employees, subject to the approval of the employee's health care provider. If employees providing notice of the need to take leave on an intermittent basis for planned medical treatment neglect to fulfill this obligation, the Company may require employees to attempt to make such arrangements, subject to the approval of the employees' health care provider.

When employees take intermittent or reduced work schedule leave for foreseeable planned medical treatment for the employee or a family member, including during a period of recovery from a serious health condition or to care for a covered servicemember, the Company may temporarily transfer employees, during the period that the intermittent or reduced leave schedules are required, to alternative positions with equivalent pay and benefits for which the employees are qualified and which better accommodate recurring periods of leave, to the extent permitted by law.

When employees seek intermittent leave or a reduced leave schedule for reasons unrelated to the planning of medical treatment, upon request, employees must advise the Company of the reason why such leave is medically necessary. In such instances, the Company and employee shall attempt to work out a leave schedule that meets the employee's needs without unduly disrupting the Company's operations, subject to the approval of the employee's health care provider.

C. Submit Medical Certifications Supporting Need for Leave (Unrelated to Requests for Military Family Leave)

Depending on the nature of leave sought, employees may be required to submit medical certifications supporting their need for FMLA/WFMLA-qualifying leave. As described below, there generally are three types of medical certifications: an **initial certification**, a **recertification** and a **return to work/fitness for duty certification**.

It is the employee's responsibility to provide the Company with timely, complete and sufficient medical certifications. Whenever the Company requests employees to provide medical certifications, employees must provide the requested certifications within fifteen (15) calendar days after the Company's request, unless it is not practicable to do so despite the employee's diligent, good faith efforts. The Company will inform employees if submitted medical certifications are incomplete or insufficient and provide employees at least seven (7) calendar days to cure deficiencies. The Company will deny leave to employees who fail to timely cure deficiencies or otherwise fail to timely submit requested medical certifications.

With the employee's permission, the Company (through individuals other than the employee's direct supervisor) may contact the health care provider to authenticate or clarify completed and sufficient medical certifications. If the employee chooses not to provide the Company with authorization allowing it to clarify or authenticate the certification with the health care provider, the Company may deny leave if the medical certification is unclear.

Whenever the Company deems it appropriate to do so, it may waive its right to receive timely, complete and/or sufficient medical certifications.

1. Initial Medical Certifications

Employees requesting leave because of their own, or a family member's serious health condition, or to care for a covered servicemember, must supply medical certification supporting the need for such leave from their health care provider or, if applicable, the health care provider of their covered family or service member. If employees provide at least thirty (30) days' notice of medical leave, they should submit the medical certification before leave begins. A new initial medical certification will be required on an annual basis for serious medical conditions lasting beyond a single leave year.

If the Company has reason to doubt initial medical certifications, it may require employees to obtain a second opinion at the Company's expense. If the opinions of the initial and second health care providers differ, the Company may, at its expense, require employees to obtain a third, final and binding certification from a health care provider designated or approved jointly by the Company and the employee, to the extent permitted by applicable law.

2. Medical Recertifications

Depending on the circumstances and duration of FMLA leave, the Company may require employees to provide recertification of medical conditions giving rise to the need for leave. The Company will notify employees if recertification is required and will give employees at least fifteen (15) calendar days to provide medical recertification.

3. Return to Work/Fitness for Duty Medical Certifications

Unless notified that providing such certifications is not necessary, the employee returning to work from leave that was taken because of their own serious health conditions that made the employee unable to perform their job must provide the Company medical certification confirming the employee is able to return to work and the employee's ability to perform the essential functions of the employee's position, with or without reasonable accommodation, to the extent permitted by law. The Company may delay and/or deny job restoration until the employee provides a return to work/fitness for duty certification, subject to applicable law.

D. Submit Certifications Supporting Need for Military Family Leave

Upon request, the first time employees seek leave due to qualifying exigencies arising out of the covered active duty or call to covered active duty status of a military member, the Company may require employees to provide: 1) a copy of the military member's active duty orders or other documentation issued by the military indicating the military member is on covered active duty or call to covered active duty status and the dates of the military member's covered active duty service; and 2) a certification from the employee setting forth information concerning the nature of the qualifying exigency for which leave is requested. Employees shall provide a copy of new active-duty orders or other documentation issued by the military for leaves arising out of qualifying exigencies arising out of a different covered active duty or call to covered active-duty status of the same or a different military member.

When leave is taken to care for a covered servicemember with a serious injury or illness, the Company may require employees to obtain certifications completed by an authorized health care provider of the covered servicemember. In addition, and in accordance with the FMLA regulations, the Company may request that the certification submitted by employees set forth additional information provided by the employee and/or the covered servicemember confirming entitlement to such leave.

E. Substitute Paid Leave for Unpaid FMLA and WFMLA Leave

Employees may use any accrued paid time while taking unpaid FMLA leave. Employees may elect to use any accrued paid time while taking unpaid WFMLA leave. The substitution of paid time for unpaid FMLA and/or WFMLA leave time does not extend the length of FMLA and/or WFMLA leaves and the paid time will run concurrently with the employee's FMLA and/or WFMLA entitlement.

During the leave, employees may be eligible for compensation, such as temporary disability benefits, family leave benefits or workers' compensation benefits. Any compensation or leave taken in connection with any other policy/plan shall run concurrently with any FMLA/WFMLA leave entitlement. Upon [written] request, the Company will allow employees to use accrued paid time to supplement any paid disability benefits and workers' compensation benefits.

F. Pay Employee's Share of Health Insurance Premiums

During FMLA/WFMLA leave, employees are entitled to continued group health plan coverage under the same conditions as if they had continued to work. Unless the Company notifies employees of other arrangements, whenever employees are receiving pay from the Company during leave, the Company will deduct the employee portion of the group health plan premium from the employee's paycheck in the same manner as if the employee was actively working. If leave is unpaid, employees must pay their portion of the group health premium through a method determined by the Company upon leave.

The Company's obligation to maintain health care coverage ceases if the employee's premium payment is more than thirty (30) days late. If the employee's payment is more than fifteen (15) days late, the Company will send a letter notifying the employee that coverage will be dropped on a specified date unless the co-payment is received before that date. If employees do not return to work within thirty (30) calendar days at the end of the leave period (unless employees cannot return to work because of a serious health condition or other circumstances beyond their control), they will be required to reimburse the Company for the cost of the premiums the Company paid for maintaining coverage during their unpaid FMLA leave.

IV. Coordination of FMLA/WFMLA Leave with Other Leave Policies

The FMLA and WFMLA do not affect any federal, state or local law prohibiting discrimination, or supersede any State or local law that provides greater family or medical leave rights. However, whenever permissible by law, the Company will run FMLA leave concurrently with WFMLA and any other leave provided under state or local law. For additional information concerning leave entitlements and obligations that might arise when FMLA/WFMLA leave is either not available or exhausted, please consult the Company's other leave policies in this handbook or contact Human Resources.

V. Questions and/or Complaints about FMLA/WFMLA Leave

If you have questions regarding this FMLA/WFMLA policy, please contact Human Resources. The Company is committed to complying with the FMLA and, whenever necessary, shall interpret and apply this policy in a manner consistent with the FMLA/WFMLA.

The FMLA makes it unlawful for employers to: 1) interfere with, restrain or deny the exercise of any right provided under FMLA; or 2) discharge or discriminate against any person for opposing any practice made unlawful by FMLA or involvement in any proceeding under or relating to FMLA. If employees believe their rights have been violated, they should contact Human Resources immediately. Company will investigate any complaints and take prompt and appropriate remedial action to address and/or remedy any violation. Employees also may file FMLA complaints with the United States Department of Labor or may bring private lawsuits alleging FMLA violations.

Wisconsin Leave for Emergency Responders

Eligible employees who are volunteer firefighters, emergency medical technicians, first responders or ambulance drivers for a volunteer fire department, a public agency or a nonprofit corporation (“volunteer provider”) are eligible for unpaid leave to respond to an emergency prior to the time they are to report to work.

Employees who become a member of a volunteer provider must notify Chestnut Health Systems in writing within 30 days that they are a volunteer firefighter, emergency medical technician, first responder or ambulance driver. Additionally, if the employee's status changes, including termination of that status, the employee must notify the Company of the change in status.

Employees who are going to be late or absent from work due to an emergency that involves their service as a volunteer firefighter, emergency medical technician, first responder or ambulance driver, must make every effort to notify the Company that they may be late or absent from work due to the emergency. If prior notification is not possible, the employee must provide a written statement from the chief of the volunteer fire department or person in charge of the ambulance service explaining why prior notification was not possible. Following being late or absent from work due to responding to an emergency, employees must provide a written statement from the chief of the volunteer fire department or person in charge of the ambulance service certifying that they were responding to an emergency and indicating the date and time of the response to the emergency.

CHESTNUT
HEALTH SYSTEMS

WISCONSIN SUPPLEMENT ACKNOWLEDGMENT

This Wisconsin Supplement of the Chestnut Health Systems National Handbook is an important document intended to help employees become acquainted with the Company. This document is intended to provide guidelines and general descriptions only; it is not the final word in all cases. Individual circumstances may call for individual attention.

Because the Company's operations may change, the contents of this Handbook Supplement may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of this Supplement.

I have received and read a copy of Chestnut Health Systems Wisconsin Supplement to the National Handbook. I understand that the policies, rules and benefits described in it are subject to change at the sole discretion of the Company at any time.

I further understand that my employment is terminable at will, either by myself or the Company, with or without cause or notice, regardless of the length of my employment or the granting of benefits of any kind.

I understand that no representative of Chestnut Health Systems other than the CEO may alter "at will" status and any such modification must be in a signed writing.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Company's Employee Handbook.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to Human Resources - it will be filed in your personnel file.

CHESTNUT
HEALTH SYSTEMS

RECEIPT OF ANTI-DISCRIMINATION AND NON-HARASSMENT POLICY

It is Chestnut Health Systems policy to prohibit intentional and unintentional harassment of or against job applicants, contractors, interns, volunteers or employees by another employee, supervisor, vendor, customer or any third party on the basis of actual or perceived race, color, creed, religion, national origin, ancestry, citizenship status, age, sex or gender (including pregnancy, childbirth and pregnancy-related conditions), gender identity or expression (including transgender status), sexual orientation, marital status, military service and veteran status, physical or mental disability, genetic information or any other characteristic protected by applicable federal, state or local laws (referred to as “protected characteristics”). Such conduct will not be tolerated by Chestnut Health Systems.

The purpose of this policy is not to regulate our employees' personal morality, but to ensure that no one harasses another individual in the workplace, including while on Company premises, while on Company business (whether or not on Company premises) or while representing the Company. In addition to being a violation of this policy, harassment or retaliation based on any protected characteristic as defined by applicable federal, state, or local laws also is unlawful. For example, sexual harassment and retaliation against an individual because the individual filed a complaint of sexual harassment or because an individual aided, assisted or testified in an investigation or proceeding involving a complaint of sexual harassment as defined by applicable federal, state, or local laws are unlawful.

Harassment Defined

Harassment generally is defined in this policy as unwelcome verbal, visual or physical conduct that denigrates or shows hostility or aversion towards an individual because of any actual or perceived protected characteristic or has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment can be verbal (including slurs, jokes, insults, epithets, gestures or teasing), visual (including offensive posters, symbols, cartoons, drawings, computer displays, text messages, social media posts or e-mails) or physical conduct (including physically threatening another, blocking someone’s way, etc.). Such conduct violates this policy, even if it does not rise to the level of a violation of applicable federal, state or local laws. Because it is difficult to define unlawful harassment, employees are expected to behave at all times in a manner consistent with the intended purpose of this policy.

Sexual Harassment Defined

Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other verbal, visual or physical conduct of a sexual nature when:

- submission to that conduct or those advances or requests is made either explicitly or implicitly a term or condition of an individual's employment; or
- submission to or rejection of the conduct or advances or requests by an individual is used as the basis for employment decisions affecting the individual; or
- the conduct or advances or requests have the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Examples of conduct that violate this policy include:

205. unwelcome flirtations, leering, whistling, touching, pinching, assault, blocking normal movement;

206. requests for sexual favors or demands for sexual favors in exchange for favorable treatment;

207. obscene or vulgar gestures, posters or comments;

208. sexual jokes or comments about a person's body, sexual prowess or sexual deficiencies;

209. propositions or suggestive or insulting comments of a sexual nature;

210. derogatory cartoons, posters and drawings;

211. sexually-explicit e-mails, text messages or voicemails;

212. uninvited touching of a sexual nature;

213. unwelcome sexually-related comments;

214. conversation about one's own or someone else's sex life;

215. conduct or comments consistently targeted at only one gender, even if the content is not sexual; and

216. teasing or other conduct directed toward a person because of the person's gender.

Reporting Procedures

If the employee has been subjected to or witnessed conduct which violates this policy, the employee should immediately report the matter to the Employee's Supervisor. If the employee is unable for any reason to contact this person, or if the employee has not received an initial response within five (5) business days after reporting any incident of what the employee perceives to be harassment, the employee should contact Human Resources. If the person toward whom the complaint is directed is one of the individuals indicated above, the employee should contact any higher-level manager in the reporting hierarchy.

Investigation Procedures

Every report of perceived harassment will be fully investigated, and corrective action will be taken where appropriate. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. All employees must cooperate with all investigations conducted pursuant to this policy.

Retaliation Prohibited

In addition, the Company will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this policy. If the employee has been subjected to any such retaliation, the employee should report it in the same manner in which the employee would report a claim of perceived harassment under this policy.

Violation of this policy including any improper retaliatory conduct will result in disciplinary action, up to and including termination.

I have read and I understand Chestnut Health Systems Anti-Discrimination and Non-Harassment Policy.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this receipt should be given to Human Resources - it will be filed in your personnel file.

Chestnut Health Systems

Personnel Records and Training Policies

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 10 Human Resources Department Policies		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 10 HUMAN RESOURCES DEPARTMENT POLICIES

The Human Resources Department will provide consultation to employees, supervisory/management staff, and the Board of Directors regarding employment issues and practices to assure compliance with employment and labor laws, applicable regulations and Chestnut Health Systems personnel policies.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 20 Recruitment		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 20 RECRUITMENT

Human Resources staff shall provide consultation, assistance, and direction to supervisors regarding the recruitment and hiring of new staff. All hiring decisions and job offers will fall to the Human Resources Managers to monitor and administer as per existing Chestnut protocol. Human Resources staff members are responsible for coordinating a variety of recruitment tasks to assure compliance with fair labor standards, equal employment opportunities and personnel policies of Chestnut Health Systems.

All of Chestnut's employment practices will be under the direction of the Human Resources Director as authorized by the Chief Executive Officer. The Human Resources Director will be consulted on any complex or unique employment scenarios and will make all final hiring decisions in consultation with the applicable Executive Leadership Council member. If needed, the Chief Operating Officer will serve as the arbitrator on any unresolved employment matters

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 30 New Employee Records		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 30 NEW EMPLOYEE RECORDS

Human Resources staff are responsible for ensuring that the required employment paperwork and on-line procedures are completed for all newly hired employees, including Chestnut's benefit plan enrollment. In addition, the Human Resources staff shall ensure that all pre-employment obligations have been met in accordance with applicable labor and employment laws, regulations and Chestnut's personnel policies. Human Resources staff shall ensure that all necessary paper documentation is complete and placed in the employee's personnel file.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 40 New Employee Orientation		
Revision Date:	8/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 40 NEW EMPLOYEE ORIENTATION

All new employees are required to participate in a formal new employee orientation ("NEO") program within the first thirty days of employment. NEO consists of live full day presentations by selected Chestnut departments in conjunction with multiple on-line NEO modules via Chestnut's on-line learning management system. The Director of Employee Experience, or their designee, will administer and present live NEO and is responsible for reviewing and updating NEO content. Permissions to allow a new employee to forego live NEO, and to complete all of NEO on-line, will be very limited for select scenarios and requires supervisor approval.

Prior to participation in the new employee orientation session, all newly hired employees will meet with Human Resources staff on or before the first day of employment to complete a basic orientation on organizational policies and benefits. During this meeting new employees complete the necessary paperwork and are provided with an overview of required information, documentation and on-line processes.

The new employee's supervisor is responsible for providing program-specific orientation within the first seven days of employment. Completion of all parts of the new employee orientation program is documented by a checklist from Human Resources, a checklist from the reporting supervisor, and a transcript within Chestnut's on-line learning management system. Paper checklists are placed in the employee personnel file.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 50 Leadership Consultation		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 50 LEADERSHIP CONSULTATION

The Human Resources management team and the Director of Employee Experience will provide ongoing consultation to the Board of Directors and the Executive Leadership Council regarding employment issues, concerns, and complaints as well as current trends, developments, and requirements in the human resources industry.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 60 Personnel Policies Maintenance		
Revision Date:			
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 60 PERSONNEL POLICIES MAINTENANCE

Human Resources staff will conduct periodic reviews of the organization's personnel policies to assure that Chestnut Health Systems' personnel policies and practices are in compliance with existing labor and employment laws and regulations.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 70 Benefits Package		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 70 BENEFITS PACKAGE

The Human Resources staff will review the employee benefits package periodically. The Chief Operating Officer, the Director of Employee Experience, and Human Resources Director shall make recommendations to the Executive Leadership Council and Board of Directors regarding benefit changes and their impact on available resources and employee's needs and desires.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 80 Staff Competencies		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 80 STAFF COMPETENCIES

Chestnut Health Systems shall ensure that staff qualifications are commensurate with anticipated job responsibilities as defined in job descriptions. Immediate supervisors are responsible for ensuring that there are accurate and up to date job descriptions in place and that staff have demonstrated the necessary current competencies to perform their job responsibilities. Competencies will be evaluated initially at the time of hire, after 90 days of service and annually when needed, and through the performance evaluation process.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 90 Staff Development Responsibility		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 90 STAFF DEVELOPMENT RESPONSIBILITY

Oversight of an employee's development is the responsibility of the assigned Chestnut supervisor. Supervisors are expected to:

1. Identify staff development needs of their assigned staff.

2. Incorporate quality improvement activities and results as means to evaluate staff performance issues.

3. Document staff development for individual staff in the employee's performance evaluation, especially any areas of need.

4. Develop training plans for their staff within Chestnut's on-line learning management system (LMS) and ensure compliance, including coordinating in-service presentations concerning significant programmatic or administrative changes.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 130 Corporate Compliance Training		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 130 CORPORATE COMPLIANCE TRAINING

Chestnut has implemented a Corporate Compliance Program, which is an integral part of the Code of Ethics. One of the goals of the Corporate Compliance Program is to provide effective training and education to employees with regard to the Code of Ethics and Corporate Compliance Program.

A. Code of Ethics and Overview of Corporate Compliance Program

1. All employees will be trained regarding the Code of Ethics and will be given a general overview of the Corporate Compliance Program.
2. All new employees will receive training regarding the Code of Ethics and an overview of the Corporate Compliance Program during New Employee Orientation (NEO).

B. Special Trainings

1. All clinical staff will receive specialized training in the area of clinical records documentation, and professional conduct and ethical boundaries. New clinical employees will receive these trainings during their first month of employment.
2. All employees will receive training in the area of confidentiality and fraud and abuse. Clinical employees will receive more in-depth and specialized training in the area. New employees will receive confidentiality training during initial orientations.
3. All appropriate employees involved in the claim development and billing process will receive specialized training regarding applicable legal requirements pertaining to the claim development and billing process. New accounting and billing employees will receive comprehensive training during their first month of employment.
4. Appropriate management employees will receive specialized training in the areas of general billing restrictions, tax exemption, antitrust, labor and employment laws, Medicaid 2090 requirements, record retention, contract certifications and funding contract conditions.

C. Updates

1. In the event of significant changes to the Code of Ethics, Compliance Program or substantive legal areas of compliance, appropriate employees will be notified of the

changes and the relationship between the changes and the employee's job description or job functions, duties and responsibilities.
2. All employees will receive periodic confidentiality training.
3. All management employees will receive an update on significant statutory and regulatory changes impacting Chestnut's operations when such changes become effective.
4. In the event of changes to the licensure, Medicaid or funding regulations, appropriate staff will receive training.
5. Education and training may be conducted in a variety of ways, including but not limited to: in-service trainings conducted by staff and consultants, virtual webinars, videotapes, training booklets, comprehensive manuals, online learning management course assignments, attendance at external seminars, dissemination of policies and procedures, posters, brochures and fliers.
6. Chestnut strives to foster an ongoing awareness of the Corporate Compliance Program and integration of the Code of Ethics in day-to-day operations. Employee awareness and commitment to corporate compliance shall be demonstrated in a variety of ways which may include: annual reports, Chestnut's website, email messages, posters, brochures, employee newsletters and other promotional media.

D. Verification

1. Each employee who attends a live training that is not in the Chestnut on-line learning management system curriculum must complete and sign a training report documenting that the employee attended the training or submit a certificate of completion. The training report or certificate is to be submitted by the applicable staff to ReliasHelp@chestnut.org.
2. Each employee who completes a training course within the Chestnut on-line learning management system must certify their course(s) in order to create a transcript.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 140 Supervisor Training		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CSB 45 Responsibilities of Leadership		
Citation(s):			

PRT 140 SUPERVISOR TRAINING

Chestnut Health Systems is committed to providing continuing education to supervisors as a way to enhance their leadership skills. Leaders are oriented to the following:

- Chestnut's mission and vision
- Chestnut's safety goals
- Chestnut's organization structure and decision-making process
- Chestnut's budget process and interpretation of the financial statements
- The population served by Chestnut programs and services and issues related to that population
- The Leadership responsibilities detailed in the policy Corporate Structure and By-laws CSB 45 Responsibilities of Leadership
- Applicable state and federal laws and regulations

Chestnut will offer a series of mandatory trainings for supervisors to familiarize them with Chestnut's management philosophy, personnel policies, employment issues and corporate compliance program. The trainings may be provided by Chestnut staff, outside consultants, or Chestnut's on-line learning management system. It will be the responsibility of all Directors that their supervisory teams have designated supervisor training plans and that they are completed within the designated timeframes. It is Chestnut's expectation that these trainings will include an assessment of the skills learned by participants and a participant evaluation of the training provided.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 150 Ongoing In-Service Programs		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 150 ONGOING IN-SERVICE PROGRAMS

Ongoing in-service programs will be provided as part of the staff development expectations of staff. Employees are expected to attend such programs when notified. Staff members who are unable to attend a particular in-service program are expected to view or listen to any provided recordings and/or materials regarding the presentation.

Individual staff members may be assigned to view an in-service topic as part of their staff development or work-improvement plan. Most of these will be utilizing Chestnut's on-line learning management system. For other training events, training reports documenting that the employee participated in the in-service program are to be completed and submitted to ReliasHelp@chestnut.org. This documentation will be placed in the employee's training file.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 160 Continuing Education		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 160 CONTINUING EDUCATION

Employees are expected to fulfill any training needed in order to meet minimum job requirements, for either their current position or for advancement. This may include recommended training to strengthen an individual's area(s) of need identified in the performance evaluation. Documentation of this training is to be provided to Human Resources and logged via Chestnut's on-line learning management system. Any paper documentation will be placed in the employees' electronic training file within their personnel records, as applicable.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 180 Sources for Continuing Education		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 180 SOURCES FOR CONTINUING EDUCATION

Sources for continuing education include, but are not limited to, the following:

1. Formal continuing education courses that are offered under the auspices of a university continuing education program and/or under the auspices of a professional association's continuing education program.
2. Training programs that operate for the purpose of professional training.
3. College and university courses which are offered by accredited institutions, are part of a formal degree related curriculum, and are offered as credit toward a degree.
4. Programs, workshops, seminars, conferences, conventions, etc. which are educational and offered by and/or formally approved by professional associations, treatment agencies, governmental agencies, etc.
5. Agency in-service education and training programs which are related to the employee's job duties.
6. Existing on-line education modules within the Chestnut learning management system, whether mandatory or voluntary.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Personnel Records and Training Policies		
Policy Name and Number:	PRT 190 Documentation of Continuing Education and Training		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

PRT 190 DOCUMENTATION OF CONTINUING EDUCATION AND TRAINING

Staff should submit to ReliasHelp@chestnut.org and Human Resources the appropriate documentation for each educational experience. This documentation will be placed in the employee's training file and within their personnel records, as applicable.

Acceptable documentation must include the following information:

- Name of staff
- Title of training
- Dates(s) of training
- Contact hours of training
- Name of trainer or organization providing training
- Listing of the Continuing Education credits for a specific license or certification (that includes valid CEU license number of training organization or certified program number, if applicable)

If documented on a Chestnut Training Report, also include the following items:

- Summary of content of the training
- Evaluation of application to current job and development of skills
- Printed name and signature of staff person
- Signature of Supervisor or Trainer attesting to attendance at training

Acceptable Forms of Documentation

1. For formal continuing education courses, training programs, seminars, workshops, or conventions:

   a. Certificate of completion or evidence of program attendance and completion provided by the sponsors of the continuing education courses. Certificates of completion or verification shall bear the name of the attendee and the number of hours in the program.

   b. For certificates and/or verification of attendance that do not indicate the number of education hours, the attendee must submit a program brochure or other documentation of the number of hours in the program.

2. For college or university courses:

   a. Transcripts, copy of receipt of grade or other official university correspondence, which indicates proof of successful course completion. (Documentation of registration will not be accepted.)

3. For agency in-service education or training programs:
    a. Staff will need to complete the course requirements in the Learning Management System.

CHESTNUT HEALTH SYSTEMS

Chestnut Health Systems
Quality Management

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Quality Management		
Policy Name and Number:	QM 10 Quality Management System Principles		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Missouri Department of Mental Health, Performance Improvement, 9 CSR §10-7.040; 9 CSR §10-7.030		

QM 10 QUALITY MANAGEMENT SYSTEM PRINCIPLES

Chestnut Health Systems (Chestnut) implements a system of Quality Management to ensure that patients receive excellent care and achieve desired outcomes. Chestnut's Quality Management System (QMS) places emphasis on these principles:

1. Leadership driven
   - Leadership will prioritize and allocate resources for strategic initiatives, performance goals, objectives and indicators consistent with Chestnut's organizational goals
   - Producing and sharing reports to support decision-making and oversight regarding the provision of services
   - Appreciation of data driven decision making to assess and improve the quality of services
   - Systems approach to understanding errors
2. Data driven
   - Completing periodic assessments to inform the provision of services
   - Make full use of descriptive data from multiple sources to understand new and emerging patterns of unmet need
   - Translate research findings into "best practices" at Chestnut
3. Staff contribution
   - Respect for staff's knowledge and contributions
4. Continual quality
   - Adhering to current evidence based clinical guidance, standards of care and standards of practice in the provision of services
   - A quality emphasis in the design of support processes and treatment services
   - Continual monitoring and improvement of processes and practices
5. Patient safety
   - Emphasis on prevention rather than detection of problems
   - Reduction of variations in the processes of client service and minimization of errors through standardization of processes
   - Identifying, analyzing and addressing patient safety and adverse events, implementing follow-up action, as necessary
   - Conducting monthly case reviews of all critical interventions that occurred during the previous month and incorporating the results into Chestnut's performance improvement processes
6. Patient outcomes
   - Adoption and adherence to best practices models and protocols

- Outcome based treatment approaches
- Routinely measure, monitor, and report on outcomes and results of interventions and treatments

7. Customer perception
   - A customer-first orientation recognizing the needs and expectations of the internal and external customers
   - Addressing patient satisfaction
   - Hearing and resolving patient grievances
   - Respect for the client's beliefs, values, culture, expectations and attitudes about physical health, behavioral health, and quality of life. Access to comprehensive, integrated, patient centered health care
   - Components within Chestnut are interdependent and share responsibility for improving the quality of client care and services
   - Cooperation and involvement of all areas within Chestnut in the assessment of performance, identification of opportunities for improvement and participation in the decision making processes that affect their function in the organization
8. Staff competency
   - Provision of initial and ongoing staff training
   - Assessment of competency through credentialing and ongoing performance review
   - Focus on staff development
   - Assessment of staff's provision of services, including staff's uniform administration of Chestnut's screening processes
9. Infrastructure
   - Implement leading practices to promote prudent hiring, retention, and engagement
   - Maintain modern information technology assets and tools
   - Maintain safe and quality facilities

The QM System shall be described in this Policy Handbook. The QM policies contained in this Handbook shall be reviewed and approved annually by the Board of Directors.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Quality Management		
Policy Name and Number:	QM 15 Quality Management Framework		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

QM 15 QUALITY MANAGEMENT FRAMEWORK

Chestnut's Quality Management System (QMS) aligns strategic initiatives to business unit performance goals, objectives and indicators. Monitoring of identified performance goals, objectives and indicators drive subsequent quality activities.

The QMS framework focuses on these functions:

1. Compliance Monitoring – Activities to ensure that a business activity is taking place and that the expected results are occurring.
2. Risk Management – activities, processes and policies aimed at preventing harm to patients and managing, minimizing and mitigating associated risks and reducing liability.
3. Outcomes Driven - Measurement, monitoring, and reporting on outcomes and results of interventions and treatments
4. Performance Improvement – A systematic approach to analyzing performance and designing, testing and monitoring interventions to reach desired performance
5. Technical Assistance - Communications and collaborations amongst Chestnut business units intended to bridge identified gaps between policy, process, and practice.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Quality Management		
Policy Name and Number:	QM 20 Quality Management Plan		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Missouri Department of Mental Health, Performance Improvement, 9 CSR §10-7.040		

QM 20 QUALITY MANAGEMENT PLAN

Chestnut has established a Quality Management Plan that complies with regulatory and accreditation guidelines. The plan is approved by the Board of Directors annually. It further provides structure and outlines activities designed to improve the service, care, and health of consumers.

The Quality Management Plan is a detailed and overreaching organizational document for quality management activities. It addresses internal structure and functionality. Program specific addendums are added, as necessary and appropriate.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Quality Management		
Policy Name and Number:	QM 30 Organization of the Quality Management System		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	QM 10 - Quality Management System Principles		
Citation(s):	QM Plan		

QM 30 ORGANIZATION OF THE QUALITY MANAGEMENT SYSTEM

The Quality Management System ("QMS") is organized and designed based principles set forth by Chestnut. Operation and organization is the responsibility of the Quality and Compliance Program Manager in consultation with the Medical Director(s) and in coordination with the Executive Leadership Council. Executive leadership will determine priorities for Quality Management.

Chestnut's QMS is designed to ensure accountability at all levels. The Quality and Compliance Program Manager has determined an organizational committee structure which ensures the systematic collection, review and analysis of data for quality management processes. The QM Plan outlines the committee structure and responsibilities.

The Board of Directors during its meetings, monitors quality management activities via direct monthly reports from the Quality and Compliance Program Manager or designee.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Quality Management		
Policy Name and Number:	QM 40 Data Collection and Analysis		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 220 – Proprietary Information		
Citation(s):			

QM 40 DATA COLLECTION AND ANALYSIS

Data collection and analysis are fundamental to quality management. Leadership sets priorities for and identifies the frequency of data collection. Minimally, the following data will be collected:

- Identified clinical performance measures
- Identified performance improvement priorities
- Medication management, including significant medication errors and significant adverse medication reactions
- Consumer feedback, including treatment involvement and progress towards treatment goals
- Performance of high-risk, high-volume, problem-prone processes

It is the intent of QMS that activities be based, as much as possible, upon objective and quantifiable methods and measures. These data may come from a variety of sources including;

- client records,
- practitioner documentation,
- standardized forms documenting patient care activities,
- consumer surveys,
- patient grievances,
- employee surveys,
- incident reports,
- monitoring activities,
- utilization review findings,
- facility safety data,
- internal & external database reports, or
- other available sources.

Data will be compiled into formats that lend themselves to analysis. As appropriate, internal data will be compared over time and/or with external sources. A variety of tools are utilized to analyze data. These tools may include, but are not limited to:

- checklists,
- electronic information systems to track and trend data,
- plotted data over time to identify trends and progress,
- comparison to benchmark, and
- quality reports highlighting data (graphs, tables).

Sources of information for selection and prioritization of Quality Management activities include those named above and other sources, including but are not limited to:

- The Joint Commission Accreditation Standards – Behavioral Health Care and Ambulatory Care
- Federal Regulations & Reporting Requirements
- State Regulations & Reporting Requirements
- Contractual Obligations
- Compliance Reports – accrediting, licensing and certification reports, internal and external auditing reports, internal and external environmental reports, insurance reviews
- External Source Provider Performance Reports – managed care companies reports
- Routine Internal Audits – utilization review, medical records reviews, peer review, coding review
- Financial Reports
- Service Utilization Data
- Facilities Data – demographic data, missed appointments, patient flow data, wait time data
- Access Data
- Uniform Data System (UDS) Reports
- Client/Patient Input and Feedback, Satisfaction Surveys
- Patient Grievances and Complaints
- Staff Input
- Clinical Quality- Evidenced Based Practices and Fidelity Models
- Safety Reports – incident reports, medication related reports
- Outcomes Data

When patient medical records are accessed for the purpose of quality management activities, policies and procedures are in place in alignment with state and federal confidentiality and privacy regulations to guarantee the security and privacy of protected patient information.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Quality Management		
Policy Name and Number:	QM 60 Improvement Opportunities		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

QM 60 IMPROVEMENT OPPORTUNITIES

Analysis of data identifies trends, patterns, and performance levels that suggest opportunities for improvement.

Performance management, safety, and quality improvement data is gathered on an on-going basis and reviewed no less than quarterly. When the performance measurement system identifies an opportunity for improvement of services or organizational functioning, Chestnut will respond to the opportunity in a matter and fashion that is most likely to bring about a timely and desired outcome.

It is recognized that some opportunities for improvement lend themselves well to deliberate performance improvement methodologies. When executive and program leaders identify and prioritize such an opportunity, such methodologies will be implemented, monitored and measured by the appropriate quality management committee. Results of such activities will be documented and reported at Quality Management Committee meetings.

If identified improvement opportunities cannot be accomplished through established infrastructure or processes, task force work groups may be established by directive of leadership.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Quality Management		
Policy Name and Number:	QM 80 Authorized Corrective Action		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

QM 80 AUTHORIZED CORRECTIVE ACTION

The Chief Executive Officer has the authority from the Board of Directors to take the following immediate corrective actions when problems are identified which adversely affect client care, clinical performance, or cost efficiency or when opportunities are recognized to improve client care systems, clinical performance, or cost efficiency:

1. Revise existing policies effective immediately and with follow-up confirmation by the Board of Directors;

2. Issue new policies effective immediately and with follow-up confirmation by the Board of Directors;

3. Carry out any necessary equipment, facility, or staffing changes within the parameters of the budget approved by the governing body;

4. Recommend revisions in the budget as needed during the year in response to identified problems or opportunities; or

5. Authorize actions to be taken by Chief Clinical Officer, Vice Presidents of Integrated Health.

Corrective actions taken by the Chief Executive Officer in conjunction with the Quality Management System are reported to the Board of Directors at its regular Board meetings and documented in the minutes of those meetings. These reports may be made by the CEO or by designated staff members.

The Chief Executive Officer has delegated the following authority to the Vice Presidents of Integrated Health:

1. Review recommendations from the QM Committees with regards to changes or improvements in program methods, procedures, practices, goals, objectives, policies, management, and administration;

2. Upon discovery of any problem associated with the delivery of services or the effective functioning of the program, it is the responsibility of the Vice Presidents of Integrated Health to take immediate corrective action; and

3. Prescription of corrective educational or training programs for individual clinical staff members as part of training and staff development or process of supervision.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Quality Management		
Policy Name and Number:	QM 90 Strategic Plan		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

QM 90 STRATEGIC PLAN

Chestnut has established a Strategic Plan. The Strategic Plan is an overreaching organization document which evolves from a systematic process of envisioning Chestnut's view of its future and translating that into broadly defined initiatives, goals, and objectives for achievement. The plan is authorized by the Board of Directors.

The plan is communicated to all staff. Ideally, every staff person sees himself/herself in the plan and is involved in some activity or effort to help meet the goals.

Each fiscal year, Chestnut Family Health Center establishes a program specific strategic plan outlining goals and tasks. This plan is approved by the Board of Directors.
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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Quality Management		
Policy Name and Number:	QM 120 Utilization Review		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

QM 120 UTILIZATION REVIEW

The Utilization Review process is aimed at assuring appropriate placement of non-330 funded behavioral health program clients. The Utilization Review function is conducted by the program supervisors or designees and conducted according to admission and discharge/transfer criteria listed in each program's procedure manual. Modifications to individual services may be influenced by UR findings.

Program Directors shall be responsible for managing the Utilization Review (UR) process for their programs in coordination with a designated Quality Management staff. The QM staff will collect, aggregate, analyze, and summarize UR data from each program component. Utilization data will be provided to program supervisors on an ongoing basis. Program supervisors are responsible to provide follow-up and oversee/monitor corrective actions. Program supervisors will work with program and QM staff to involve medical records and/or billing supervisors as appropriate regarding follow-up and corrective actions.

Program Directors shall be responsible for reviewing their program's admission/readmission, continuing stay, and transfer/discharge, criteria and making recommendations to the Vice Presidents of Integrated Care for changes based on UR findings.

No individual shall be responsible for utilization review activities related to his/her own work.

Chestnut Health Systems
Recordkeeping and Information Systems

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 10 Client Record System		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) Comprehensive Accreditation Manual for Behavioral Health Care of The Joint Commission Health Resources and Services Administration Health Center Program Compliance Manual Comprehensive Accreditation Manual for Ambulatory Care of The Joint Commission Illinois Department of Human Services, Division of Substance Use Prevention and Recovery licensure regulations (77 Ill. Admin. Code 2060) Illinois Department of Human Services, Division of Mental Health Medicaid Community Mental Health Services Program (59 Ill. Admin. Code 132) Medicaid Program Standards (77 Ill. Adm. Code 2090, 89 Ill. Adm. Code 120, and 89 Ill. Adm. Code 140) Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110) Mental Health and Developmental Disabilities Code (405 ILCS 5) Missouri Code of State Regulations, Title 9 – Department of Mental Health Section 630.140 of the Department of Mental Health Section of the Missouri Revised Statutes Disclosure of Confidential HIV Information Section 191.657 of the Missouri Revised Statutes Disclosure of Confidential HIV Information Section 191.656 of the Missouri Revised Statutes Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as amended (“HIPAA”), including the Privacy Rule and Security Rule at 45 CFR Parts 160 and 164 Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) AIDS Confidentiality Act (410 ILCS 305)		

RI 10 CLIENT RECORD SYSTEM

Chestnut Health Systems (“Chestnut”) will maintain client record systems that comply with all federal and state requirements and applicable accrediting standards, and any applicable amendments, including but not limited to:

- Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2)
- The most recent edition of the Comprehensive Accreditation Manual for Behavioral Health Care of The Joint Commission
- The most recent edition of the Comprehensive Accreditation Manual for Ambulatory Care of The Joint Commission
- The most recent edition of the Health Resources and Services Administration Health Center Program Compliance Manual
- The most recent edition of the Federal Tort Claims Act Health Center Policy Manual
- The Illinois Department of Human Services, Division of Substance Use Prevention and Recovery licensure regulations (77 Ill. Admin. Code 2060)
- The Illinois Department of Human Services, Division of Mental Health Medicaid Community Mental Health Services Program (59 Ill. Admin. Code 132)
- Medicaid Program Standards (77 Ill. Adm. Code 2090, 89 Ill. Adm. Code 120, and 89 Ill. Adm. Code 140)
- Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110)
- Mental Health and Developmental Disabilities Code (405 ILCS 5)
- Missouri Code of State Regulations, Title 9 – Department of Mental Health
- Section 630.140 of the Department of Mental Health Section of the Missouri Revised Statutes
- Disclosure of Confidential HIV Information Section 191.657 of the Missouri Revised Statutes
- Disclosure of Confidential HIV Information Section 191.656 of the Missouri Revised Statutes
- Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as amended (“HIPAA”), including the Privacy Rule and Security Rule at 45 CFR Parts 160 and 164
- Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009)
- AIDS Confidentiality Act (410 ILCS 305)

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 20 Functions of the Client Record System		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Missouri Department of Mental Health, Service Delivery Process and Documentation, 9 CSR §10-7.030		

RI 20 FUNCTIONS OF THE CLIENT RECORD SYSTEM

The client record system has the following major functions:

1. Allows for systematic collection and documentation of client health information and care delivery.
2. Allows for complete and usable records.
3. Allows for efficient and accurate retrieval of information within the client record.
4. Provides timely and easy access to records and facilitates communication for care provision, coordination and continuity of care.
5. Provides a mechanism for internal and external monitoring and evaluation.
6. Provides for evidence that care rendered complies with applicable federal and state regulations, licensing requirements and accreditation standards.
7. Ensures security and confidentiality to prevent unauthorized access and protect the integrity of patient records.
8. Provides an accounting of care for financial transactions such as billing, claims management and processing of payments.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 50 Responsibility for the Client Record System		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	Chestnut Health Systems' Privacy Policies and Procedures		
Citation(s):			

RI 50 RESPONSIBILITY FOR THE CLIENT RECORD SYSTEM

The responsibility for the management of client records is assigned to the Support Services Coordinator, Chestnut Family Health Center Business Manager, Support Services Manager, or Manager/Director of Integrated Support. The responsibility for establishing procedures for protecting confidentiality and privacy of health information is the role of the Privacy Officers. The responsibility for the security of electronic records is assigned to the Security Officer.

All staff are held responsible for compliance with Chestnut's Privacy Policies and Procedures.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 55 Content of the Client Record Systems		
Revision Date:	06/27/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

RI 55 CONTENT OF THE CLIENT RECORD SYSTEMS

Client records will include, at a minimum, documentation of contact with clients from screening intake to assessment, treatment, and discharge. They shall contain disclosure authorizations, acknowledgement of receipt of privacy practices and client rights documents, consent to treat the client, identifying information, assessment, diagnosis, justification for treatment, treatment planning, treatment service and results, correspondence, continuity of care planning and services, discharge planning and services, and documentation of unexpected events. Client records shall also include appropriate information for family members and other collaterals involved in a client's treatment.

A client record is maintained for individuals assigned or admitted to a Chestnut program.

Individuals who request services but are determined to be ineligible or not appropriate for Chestnut services are admitted to a pre-admission program.

Documentation related to the financial activities of accounts receivable such as charges for services and recorded receipts for payment of fees are maintained in the medical record.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 56 Designated Record Set		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

RI 56 DESIGNATED RECORD SET

The Designated Record Set ("DRS") means the medical and billing records maintained by Chestnut and any information used in whole or in part by Chestnut to make decisions about a patient.

The records included as part of the DRS will be defined by the Privacy Office and maintained in the electronic medical record system. Any variations by business unit to what is included as part of a DRS must be approved by the Privacy Office. Each clinical business unit will update the documentation of its DRS in a timely way as changes occur.

The Privacy Office will coordinate an internal mechanism to review and approve any forms used to collect or store information as part of the DRS. The process will involve clinical, medical, and administrative staff, as appropriate. The Privacy Office will coordinate the distribution of new/revised forms and the elimination of obsolete forms.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 57 Access to Records		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

RI 57 ACCESS TO RECORDS

Access to records is allowed only to Chestnut staff and contractors who have a need to do so in the course of performing job duties. The information accessed must only be the minimum necessary in order to perform such duties.

Records of any of the following individuals will be treated the same as other Chestnut clients, and thus accessible to Chestnut staff who have a need to do so in the course of performing job duties:

- a client who is a Chestnut staff person,
- a client who is a family member of a Chestnut staff person,
- a client who is a member of the Chestnut Board of Directors,
- a client who is a family member of a member of the Chestnut Board of Directors, and
- a client who has a personal relationship with a Chestnut staff person.

The foregoing references to “client” and “Chestnut staff person” refer to those of any Chestnut program, including the Chestnut Family Health Center.

Clients and authorized third parties may access records in accordance with applicable federal and state laws and regulations and Chestnut HIPAA patient rights policies.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 60 Description of Types of Records		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 320 Dual Relationships/Conflicts (Applies To All Staff)		
Citation(s):			

RI 60 DESCRIPTION OF TYPES OF RECORDS

Open Records

Open Records include:

1. Records of clients currently admitted to a treatment or service component.
2. Records of clients recently discharged that are awaiting completion of documentation.
3. Records of clients involved in the assessment process, not yet admitted to a treatment component.

Closed Records

Closed Records include:

1. Records of clients who are not currently admitted to a treatment or service component, but who have been in contact with Chestnut at some time during the past five years.
2. Records of clients who have been recently discharged and do not have any outstanding documentation or expected correspondence.
3. Records of clients who have been discharged from services, whose documentation is complete but maintain an open financial balance.
4. Records of Chestnut Family Health Center clients whereby the patient separates from the medical home, leaves the geographic service area or becomes deceased.

Inactive Records

A record may be rendered inactive when the client has had no contact with Chestnut over a five-year period.

Protected-Records

The medical record of individuals whose status due to contractual, legal, media or other high-profile considerations may be designated as a protected record by any of the following, in consultation with the Privacy Officer, the Manager/Director of Integrated Support, the Support Services Manager, or a member of the CFHC Management Team. Such records will be viewable to only those with a need to know in the course of performing job duties.

The medical record of current and former clients known to have a personal or dual relationship with a staff member will be designated as a protected record from the staff member. A staff member must, without exception, immediately inform his/her supervisor when he/she discovers that a personal or dual relationship exists between a staff member and a current or former client. Supervisors will report the relationship to the Privacy Officer who will make the protected record designation specific to the identified staff member. The Privacy Officer will maintain a list of records protected due to personal or dual relationships.

If the Manager/Director of Integrated Support, the Support Services Managers, or the CFHC Management Team perceives the need to protect a medical record(s) for reasons not stated in this policy, the Corporate Compliance Officer will be consulted prior to making a determination and taking such action.

In each protected record matter, the individual responsible for making the designation will contact the database administrator to take necessary action to protect the record. Electronically stored protected records are restricted from the view of unauthorized staff.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 100 Entries to the Client Record		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CR 15 Mandated Reporting		
Citation(s):			
Referenced Documents:	Approved Abbreviations List		

RI 100 ENTRIES TO THE CLIENT RECORD

All information recorded in the client record must be as objective and as accurate as reasonably possible. Entries of a speculative, judgmental or unsubstantiated nature are to be avoided. Staff are responsible for the content and accuracy of documentation.

Entries to the client record may be made only by staff authorized to do so. All entries to a client paper record must be typed or written in blue or black ink, signed with highest applicable credential, and dated by the staff member making the entry. Authentication within the client record is by electronic or computer-generated signature codes or written signature. If the staff signature is not clearly legible, the staff's printed name is to be included on the entry or cross referenced to a signature key. Staff should sign their name consistent with any licensure document held and as his/her name is established within the clinical record database.

Only abbreviations on the Approved Abbreviations list may be used when documenting in the medical record. Abbreviations on the Do Not Use list may not be used when documenting orders or other medication related information in the medical record. Both lists are maintained on the intranet.

Documentation errors should never be blacked out or whited out. Corrections to the electronic or paper based client record must allow for the retention of the original entry and identification of the correction. To correct paper-based records, the staff member should draw a single line through the error, write in the correction, and then date and initial the correction.

Corrections to an electronic document that generates a bill are handled in conjunction with Accounts Receivable staff utilizing established procedures.

The use of the copy-and-paste function (CPF) in Chestnut's clinical documentation is acceptable. While improving efficiency, capturing complex information, and reducing transcription errors are benefits of this functionality, copy and paste carries increased risks that may negatively impact patient safety. When

information is reused, it is to be reused in the safest possible manner. It is the responsibility of staff to ensure that the information relied upon when using CPF is accurate, timely, and reliable.

Entries to the client record are to be made within timeframes established by the program director and in compliance with all applicable laws. These timeframes are described in program procedural manuals. The program manuals will identify expected time frames for completion of documentation of the assessment, progress notes, treatment plans and other relevant clinical documentation according to applicable licensure and accreditation rules. Clinical staff will complete and submit documentation of services provided through the electronic medical record system. This documentation must be completed and submitted for entry into the appropriate automated systems in a timely and accurate manner as established by their supervisor. An alternate method for such documentation will be implemented in the event of sustained unavailability of the electronic system.

Mandated reports are to be documented consistent with CR 15 – Mandated Reporting.

A behavioral health medical records manual is maintained by Support Services Managers and Director/Manager of Integrated Support for the purpose of providing operational procedures for clinical and administrative staff working in behavioral healthcare programs.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 110 Completeness of Client Records		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

RI 110 COMPLETENESS OF CLIENT RECORDS

Medical Records staff or approved Chestnut Family Health Center staff will place all received documentation into the medical record within 3 working days of receiving the document.

Medical records are reviewed by medical records staff for completeness. Files which are closed due to discharge are expected to contain all required documentation within 30 days.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 140 Storage and Disposal of Client Records		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	Privacy Policies HR 104		
Citation(s):	Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) Health Information Technology for Economic and Clinical Health Act (“HITECH”)		

RI 140 STORAGE AND DISPOSAL OF CLIENT RECORDS

Client records will be stored in a secure manner either in paper or electronic formats. Procedures to be followed for client record storage will be in compliance with Privacy Policies HR 104 and will be documented in each clinical program’s procedure manual.

In the event that a client record cannot be located, records staff will conduct a thorough search of the possible locations of the file, such as the records room, clinician offices and nurse’s offices. All relevant staff will be alerted to return the file to the appropriate records storage room. A list of files that cannot be located is maintained by the Support Services Manager, CFHC Business Manager or the Director/Manager of Integrated Support. Once the file has been located, it will be returned to the proper location for storage and removed from the list.

Retention of records shall be in accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act (“HITECH”), and the implementing regulations thereunder; the rules and regulations set forth by the Illinois Department of Human Services, Division of Mental Health; the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse; Missouri Department of Social Services, Missouri Department of Mental Health and other contracted entities.

Records of deceased clients are maintained for ten years following last date of service in a "Deceased" file. As determined necessary by the CFHC Business Manager, Support Services Manager, or Director/Manager of Integrated Support, a deceased client file may be further designated as a protected file and stored in accordance with that procedure.

If any claim, litigation, audit or other action has begun prior to the expiration of the retention period, the record will be retained until completion of the action and resolution of all issues. Older records may be maintained at an approved storage facility. Upon cessation of a program at a facility, the records will be maintained at another facility or at an approved storage facility. Electronic records will be maintained in accordance with IT record retention policies.

Disposal and storage of the records are under the supervision of the CFHC Business Manager, Support Services Manager, and Director/Manager of Integrated Support.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 160 Unusual Events		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RM 60 - Incident Reporting		
Citation(s):			

RI 160 UNUSUAL EVENTS

Clinical observations and information on unusual events such as accidents, injuries, death, or complications occurring during treatment are recorded in the patient's medical record. An incident report should be completed. The incident report is an administrative document and should not be mentioned or included in the patient record.

CHESTNUT
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Policy Handbook Section:	Recordkeeping and Information Services		
Policy Name and Number:	RI 190 Non-Medical Records Retention		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RI 195 – Record Retention Schedule		
Citation(s):			

RI 190 NON-MEDICAL RECORDS RETENTION

It is of the utmost importance that all records generated by Chestnut be maintained in a consistent manner that facilitates access to needed information while ensuring confidentiality and proper collection and maintenance of information.

All administrative, business and accounting records will be maintained in accordance with the Record Retention Schedule set forth in RI 195. However, if any claim, litigation, audit or other action has begun prior to the expiration of the retention period; the record will be retained until completion of the action and resolution of all issues. Older records may be maintained at an approved storage facility. Upon cessation of a program at a facility, the records will be maintained at another facility or at an approved storage facility. Electronic records will be maintained in accordance with IT record retention policies.

To the extent that any business, financial or accounting records may contain confidential patient information, such records must be maintained in locked file cabinets in designated areas of the business office or a locked designated room. All staff must ensure that such records are returned to this room when not in actual use. All file cabinets containing such records must be locked when not in actual use.

At the end of a specified record retention period, records will be destroyed in a timely and appropriate manner. Administrative records containing the names of Chestnut clients will be destroyed by shredding or incineration. Disposal and storage of records are under the supervision of the Director/Manager of Integrated Services, CFHC Business Manager, and/or Support Services Manager with consultation by the Vice President(s) of Integrated Care or CFHC Director, as appropriate. Consideration will be given to recycling of documents not requiring incineration or shredding.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section: Recordkeeping and Information Services

Policy Name and Number: RI 195 Record Retention Schedule

Revision Date: 06/28/2023

Applies To: ☒Employees ☐Clinical Staff Only ☐Interns ☐Contractors ☐Administrative Staff Only ☐Board Members ☐Volunteers

Type of Policy: ☒Administrative ☐Clinical

Policy Cross Reference(s):

Citation(s): Missouri Department of Mental Health, Fiscal Management, 9 CSR §10-7.100
Mo. Rev. Stat. §516.105
Mo. Rev. Stat. §516.097
Illinois Department of Human Services, Division of Mental Health
Illinois Department of Human Services, Division of Alcoholism and Substance Abuse

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RI 195 RECORD RETENTION SCHEDULE

Record	**Retention Period**
General Corporate Records	
Articles of Incorporation and Amendments	Permanently
Bylaws (expired)	3 years
Contracts and leases (expired)	10 years
Corporate Correspondence (general)	3 years
Corporate Correspondence (legal and important matters)	Permanently
Deeds, mortgages and bills of sale	Permanently
Email Retention by External Archive	10 years
Governmental reports/correspondence (if special exemption granted or regulatory interpretation given – maintain permanently)	5 years
Internal Compliance/Investigation records	5 years
Internal reports (miscellaneous)	3 years

Record	Retention Period
Inspection of grounds, buildings, fire safety systems	5 years
Journals (Financial)	Permanently
Minutes of Corporation and Listing of Directors/Officers	Permanently
Minutes of Organizational Committee Meeting Minutes	10 years
Property appraisals by outside appraisers (may want to keep until updated appraisal is completed – could go beyond 7 years)	Permanently
Property records-including costs, depreciation reserves, end-of-year trial balances, depreciation schedules, blueprints, surveys, title, policies, and plan	3 years after disposal
Surveys, studies, inspection reports	5 years
Stock and Bond Certificates (cancelled)	7 years
Finance Records	
A/P Ledgers and Schedules	7 years
Audit Reports	Permanently
Bank Reconciliation	7 years
Benefit Plan Reports or Descriptions	7 years
Budget – Worksheets and Final Copy	7 years
Cash books	7 years
Cash Receipts	7 years
Charts of Accounts	7 years
Checks – Canceled (for important payments, i.e. taxes, purchases of property, special contracts, etc.)	7 years
Check Register	Permanently
Payroll Register	7 years
Depreciation schedules	7 years
Duplicate deposit slips	7 years
Expense analysis and expense distribution schedules	7 years
Federal grant records	7 years
Financial statements, annual	Permanently
General and private ledgers, end-of-year trial balances	Permanently

Record	Retention Period
Insurance policies (expired Claims – Made Forms)	10 years
Insurance records, current accident reports, claims, policies, etc.	Permanently
Internal audit reports (in some situations longer retention periods may be desirable)	7 years
Invoices to customers	7 years
Invoices from vendors	7 years
Notes, receivables, ledgers and schedules	7 years
Payroll records and summaries, including payments to pensioners	7 years
Petty cash vouchers (*sites*)	7 years
Purchase orders (except Payables copy)	7 years
Receiving Sheets (packing list)	7 years
Requisitions	7 years
Subsidiary ledgers	7 years
Voucher registers and schedules	7 years
Vouchers for payments to vendors, employees, etc… (includes allowances and reimbursements of employees, officers, etc. for travel and entertainment expenses)	7 years
Human Resources Records	
Accident Reports and Claims	6 years after settlement
Administrative Policies and Procedures (including Training Manuals) (expired)	Permanently
Employee health documents of employees exposed to toxic substances/blood borne pathogens/potentially infectious materials/tuberculosis 29 CRF 1910.20 (OSHA)	Permanently
Employment applications and resumes	3 years
Hepatitis B Vaccination documents	7 years
Influenza Vaccination documents	7 years
Personnel records regarding age of employee	5 years after termination
Personnel records (after termination) (DOL – 2 years, 2060 – 5 years)	5 years after termination
Privileging Files (inactive)	5 years
OSHA 300 Logs and Records (regarding occupational injuries)	5 years

Record	Retention Period
Time Cards	3 years
Staff Tuberculosis Screening/Testing documents	7 years
Unemployment Compensation documents	5 years
Workers Compensation documents - no compensation paid - from last compensation paid - related to exposure to radiological materials or asbestos	3 years 2 years after last payment Termination + 28 years
Patient Records	
Mental Health and Substance Use patient records (adults and non-DCFS adolescent patients) -adolescent patient -deceased patients	10 years 10 years or up to the patient's 23rd birthday 10 years
Primary Care Patient Records	10 years for adults or up to the patient's 23rd birthday for minors
Criminal records requests	5 years
Consumer Credit Counseling Records	7 years
Centers for Medicare and Medicaid Services – Consumer Directed Option (CDO) Outreach and Enrollment Activities	6 years
Medicaid records	10 years for adults or up to the patient's 23rd birthday for minors
Patient Billing Records	10 years for adults or up to the patient's 23rd birthday for minors

Record	Retention Period
Restraint and Seclusion documentation	10 years for adults or up to the patient's 23rd birthday for minors
Other Records	
Continuing Education Unit (CEU) Sponsorship documents	5 years
Controlled Substances Logs	10 years for adults or up to the patient's 23rd birthday for minors
Emergency Preparedness Compliance documents	5 years
Incident Reports	10 years for adults or up to the patient's 23rd birthday for minors
Inventories of products, materials and supplies	7 years
Licenses/Certification records (expired)	7 years
Medication Inventory Logs	10 years for adults or up to the patient's 23rd birthday for minors
Research data	5 years
Research findings reviewed by IRB	3 years
Research related documentation	6 years
Shift Reports	10 years for adults or up to the patient's 23rd birthday for minors
Utilization Review documentation	10 years for adults or up to the patient's 23rd birthday for minors
Volunteer Records	5 years after termination

Chestnut Health Systems
Research

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Research		
Policy Name and Number:	RE 50 Research Integrity		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RE 60 – Institutional Review Board Policies and Procedures		
Citation(s):			

RE 50 RESEARCH INTEGRITY

It is the policy of Lighthouse Institute ("LI") and Chestnut Health Systems ("Chestnut") to maintain an environment that fosters research integrity based on the highest ethical principles of conduct in the performance and reporting of the Institute's work and research.

The conduct of research at LI/Chestnut is based on the following principles:

- Research must be carried out with the objective of providing as unbiased as possible a portrait of the "truth."
- Data, information, and results shall not be fabricated, falsified, or plagiarized. Erroneous data resulting from honest mistakes must be treated according to protocols accepted in the scientific community. Selection of data subsets for analysis (data dredging) should be documented and reported with any resulting conclusions.
- LI/Chestnut will not acquiesce to requests for conclusions unsupported by the available data.
- Credit should be given where credit is due and only when it is deserved.
- The utmost honesty must be practiced in dealing with clients and fellow employees.
- All employees must recognize and report any activities that appear to be dishonest or unethical, consistent with employee reporting mechanisms developed through Chestnut's Corporate Compliance Program.

Research Integrity Committee

A Research Integrity Committee, appointed by the CEO, has primary responsibility for achieving and maintaining the Chestnut research integrity policy objective. This committee includes the General Counsel as Chairperson, and two staff members from Chestnut's Research Institute. This is a standing committee that meets to take action on written complaints and conduct annual reviews of research Policy and Procedures or new guidelines issued by the U.S. Department of Health and Human Services, Office of Research Integrity.

Research Integrity Officer

The Research Integrity Committee shall appoint a Research Integrity Officer, whose principal responsibility shall be to administer these policies and procedures for addressing allegations of research misconduct.

Responsible Conduct of Research Coordinator

The Research Integrity Officer shall appoint a Responsible Conduct of Research Coordinator, whose principal responsibility shall be to assure that LI fosters a research environment that promotes the responsible conduct of research and discourages research misconduct. See RE 60.

Research Integrity Committee Responsibilities

1. Developing and recommending to the CEO a code of ethics for the conduct of scientific research that succinctly captures the highest standards of performance.

2. With appropriate involvement by the Responsible Conduct of Research Coordinator, developing and implementing information and continuing education that foster scientific integrity and heighten staff consciousness of ethical standards in research, and that reduce the likelihood of unethical research behavior or scientific misconduct. See RE 60.

3. With appropriate involvement by the Research Integrity Officer, establishing Procedures of Review for dealing with instances of alleged unethical research behavior or scientific misconduct by staff, evaluating and revising them in the light of actual experience, and keeping staff informed and aware of them. These procedures cover the steps to be followed in the verification, reporting and resolution of each instance of alleged misconduct brought to the attention of the Chairperson for the Research Integrity Committee. Procedures for the committee should satisfy the following requirements:

    - Be just and fair, protecting the rights and reputations of everyone involved, including those who report perceived misconduct.

    - Include a mechanism for recusal from the committee's discussion and decision in the event of a conflict of interest.

    - Minimize undue harm by maintaining as high a degree of confidentiality as is consistent with the effectiveness of the investigation.

    - Permit expeditious resolution of any charges of misconduct, including appropriate discipline consistent with the Chestnut Corporate Compliance Program Response and Correction policy.

    - Base decisions on credible evidence.

    - Provide for final review of findings.

4. Reviewing and revising, at appropriate time intervals, Chestnut's policy and procedures in dealing with research integrity.

Findings, Recommendations, and Actions

In response to any specific allegations, the Research Integrity Committee, with appropriate involvement by the Research Integrity Officer, shall submit a written report to the CEO summarizing the complaint, findings, and recommended actions to be taken. The CEO shall accept or modify these recommendations and coordinate any resulting actions to be taken.

The recommendations will vary depending on the nature of the incident. Below are several general expectations set out for these recommendations:

- Where a charge was not substantiated, actions that might be necessary to restore the reputation of the parties involved will be recommended.

- Where reported findings or information was in error (whether intentionally misrepresented or not), actions that might be necessary to correct any reports, manuscripts or prior statements will be recommended.

- Where a charge of scientific misconduct was substantiated, specific punitive actions will be recommended and reviewed with appropriate federal, state, local, or funding sources.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Research		
Policy Name and Number:	RE 55 Training on Responsible Conduct in Research		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	National Institutes of Health (NIH)		

RE 55 TRAINING ON RESPONSIBLE CONDUCT IN RESEARCH

The National Institutes of Health (NIH) requires that all trainees, fellows, participants, and scholars receiving support through any NIH training, career development award (individual or institutional), research education grant, and dissertation research grant must receive instruction in responsible conduct of research. The NIH defines "responsible conduct in research" as the practice of scientific investigation with integrity, which involves the awareness and application of established professional norms and ethical principles in the performance of all activities related to scientific research.

Training on responsible conduct in research will occur both informally through the research training experience and formally. The Research Integrity Committee, is responsible for recommending, developing and administering information and continuing education on responsible conduct in research. Topics may include the following topics:

- Conflicts of interest (personal, professional, and financial);
- Policies regarding human subjects;
- Data acquisition and laboratory tools, management, sharing and ownership;
- Research misconduct and policies for handling misconduct;
- Responsible authorship and publication

All staff employed by LI are required to undergo instruction at least once every three years in a human research protections course approved by Chestnut's IRB. LI/Chestnut will monitor course attendance and make available to each trainee a certificate or documentation of participation upon course completion. LI/Chestnut will maintain records sufficient to demonstrate that individuals have received the required instruction.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Research		
Policy Name and Number:	RE 58 Training on Good Clinical Practice (GCP)		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

RE 58 TRAINING ON GOOD CLINICAL PRACTICE (GCP)

The training of investigators and research teams to conduct clinical research is crucial to assure the safety, integrity, and quality of clinical trials. In order to secure comprehensive competency-based training for clinical research personnel involved in NIH-funded research, Chestnut Health Systems ("Chestnut") requires certification of training in Good Clinical Practices ("GCP") for all investigators and personnel responsible for clinical study coordination, data collection and data management. This requirement applies to studies reviewed by both the Chestnut Institutional Review Board ("IRB") and approved external IRBs.

All Chestnut employees who participate in NIH-funded clinical trials must have certification of completion of GCP training from a course approved by Chestnut's IRB in order to submit a protocol to the IRB for review and approval. Certification must have been achieved within the three (3) years immediately preceding such submission.

At a minimum, recertification must be achieved every three (3) years.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Research		
Policy Name and Number:	RE 60 Institutional Review Board Policies and Procedures		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	42 CFR Part 46 "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research," OPRR Reports, April 18, 1979		

RE 60 INSTITUTIONAL REVIEW BOARD POLICIES AND PROCEDURES

ARTICLE 1 GENERAL PROVISIONS

Section 1.1 Establishment

Chestnut Health Systems, an Illinois not-for-profit corporation (the "Institution"), through its research arm, Lighthouse Institute, is engaged in research involving human subjects. Therefore, the Institution has created an Institutional Review Board ("IRB") whose purpose is to review and approve all research involving human subjects conducted by the Institution. The Institution shall provide the IRB provisions for meeting space and sufficient staff to support the IRB's recordkeeping and review duties. The CEO of the Institution shall be responsible for the oversight of research and IRB functions.

Section 1.2 Purpose

In establishing an IRB, Chestnut Health Systems accepts its responsibility to protect the dignity and rights of individuals who participate in research studies it sponsors. In discharging its responsibility, the IRB will focus its review of research studies on those materials necessary to determine that adequate safeguards are in place to inform, minimize, or prevent risk to research participants. In carrying out this responsibility, the IRB will focus attention on research protocols only to assess and protect participants from risk related to research. Judging the scientific or clinical merit of each research study and its related protocols is beyond the scope of the IRB.

Section 1.3 Statement of Principles

It is the policy of the Institution to adhere to the basic ethical principles of respect for persons, beneficence and justice that underlay the acceptable conduct of research involving human subjects. Therefore, the IRB shall comply with all state and federal regulations applicable to the protection of human subjects, and specifically to 42 CFR Part 46 (the "Federal Regulations") including 42 CFR Part 46, subpart A ("The Common Rule"). The IRB shall also be bound by the principles set forth in "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research," OPRR Reports, April 18, 1979.

Section 1.4 Jurisdiction

The IRB is an administrative body established to protect the rights and welfare of human research subjects recruited to participate in research activities conducted under the auspices of the Institution. The IRB has the authority to approve, require modifications in, or disapprove all research activities that fall within its jurisdiction

as specified by the Federal Regulations and this policy and procedure. The Institution's IRB will review research projects proposed by the Institution.

Section 1.5 Exempt Research

To determine whether the IRB has jurisdiction over approval of the research, the Director of Research and Development or the Chairperson of the IRB must determine whether the activity involves research, and second, whether it involves human subjects. These terms are defined in the Federal Regulations and incorporated into the definitions in Article 2.

Unless otherwise required, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

(1) Research conducted in established or commonly accepted educational settings, involving normal educational practices that are not likely to adversely impact students' opportunity to learn required educational content, or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

(2) Research that only includes interactions involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met): (i) information obtained by the investigator is recorded in such a manner that the identity of the human subjects cannot directly be ascertained, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; (iii) the information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination.

(3) (i) Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met: (A) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; (B) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or (C) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7). (ii) For the purpose of this provision, benign behavioral interventions are brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing. Provided all such criteria met, examples of such benign behavioral interventions would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else. (iii) if the research involves deceiving the subjects regarding the nature or purposes of the research, this exemption is not applicable unless the subject authorizes the deception through a prospective agreement to participate in research in circumstances in which the subject is informed that he or she will be unaware of or misled regarding the nature or purposes of the research.

(4) Secondary research for which consent is not required: Secondary research uses of identifiable private information or identifiable biospecimens, if at least one of the following criteria is met: (i) the identifiable private information or identifiable biospecimens are publicly available; (ii) information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or

through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects; (iii) the research involves only information collection and analysis involving the investigator's use of identifiable health information when that use is regulated for the purposes of "health care operations" or "research" or for "public health activities and purposes"; or (iv) the research is conducted by, or on behalf of, a Federal department of agency using government-generated or government-collected information obtained for nonresearch activities, if the research generated identifiable private information that is or will be maintained on information technology that is subject to an in compliance with section 208(b) of the E-Government Act of 2002, 44 U.S.C. 3501 note, if all of the identifiable private information collected, used, or generated as part of the activity will be maintained in systems of records subject to the Privacy Act of 1974, 5 U.S.C. 552a, and, if applicable, the information used in the research was collected subject to the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 et seq .

(5) Research and demonstration projects which are conducted by or supported by a Federal department or agency, or subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated by authority to conduct the research and demonstration projects),, and which are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including; procedures for obtaining benefits or services under those programs,possible changes in or alternatives to those programs or procedures,or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants. Exempt projects also include waivers of otherwise mandatory requirements using authorities such as sections 1115A of the Social Security Act, as amended. (i) Each federal department or agency conducting or supporting the research and demonstration projects must establish, on a publicly accessible Federal website or in such other manner as the department or agency head may determine, a list of the research and demonstration projects that the Federal department or agency conducts or supports under this provision. The research or demonstration project must be published on this list prior to commencing the research involving human subjects.

(6) Taste and food quality evaluation and consumer acceptance studies: (i) If wholesome foods without additives are consumed, or (ii) If a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

(7) Storage or maintenance for secondary research for which broad consent is required: Storage or maintenance of identifiable private information or identifiable biospecimens for potential secondary research use if an IRB conducts a limited IRB review and makes the determinations required.

(8) Secondary research for which broad consent is required: Research involving the use of identifiable private information or identifiable biospecimens for secondary research use, if the following criteria are met: (i) broad consent for the storage, maintenance, and secondary research use of the identifiable private information, or identifiable biospecimens was obtained, (ii) documentation of informed consent or waiver of documentation of consent was obtained, (iii) an IRB conducts a limited IRB review and makes the determination required by 46.111(a)7 and makes the determination that the research to be conducted is within the scope of the broad consent referenced, and (iv) the investigator does not include returning individual research results to subjects as part of the study plan. This provision does not prevent an investigator from abiding by any legal requirements to return individual research results.

ARTICLE 2 DEFINITIONS

Section 2.1 Assent

A child's affirmative agreement to participate in research. Mere failure to object should not, absent affirmative agreement, be construed as assent.

Section 2.2 Certification

The official notification by the Institution to the supporting Federal department or agency components, in accordance with the requirements of this policy, that a research project or activity involving human subjects has been reviewed and approved by the IRB in accordance with an approved assurance.

Section 2.3 Children

Persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the laws of the state of Illinois.

Section 2.4 Federalwide Assurance (FWA)

This assurance is the only type of assurance of compliance approved by OHRP for institutions engaged in non-exempt human subjects research conducted or supported by HHS. Under an FWA, an institution commits to HHS that it will comply with the requirements set forth in 45
CFR. Part 46.

Section 2.5 Human Subject

A living individual about whom an investigator (whether professional or student) conducting research: (i) obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens or (ii) obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens. Intervention includes both physical procedures by which information or biospecimens are gathered and manipulations of the subject or the subject's environment that are performed for research purposes. *An identifiable biospecimen* is a biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen. Interaction includes communication or interpersonal contact between investigator and subject. Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and that the individual can reasonably expect will not be made public (for example, a medical record). *Identifiable private information* is private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information.

Section 2.6 Legally Authorized Representative

An individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research. If there is no applicable law addressing the issue, legally authorized individual means an individual recognized by institutional policy as acceptable for providing consent in the nonresearch context on behalf of the prospective subject to the subject's participation in the procedure(s) involved in the research.

Section 2.7 Public Health Authority

An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, an Indian tribe, or a foreign government, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

Section 2.8 Minimal Risk

The probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

Section 2.9 Permission

The agreement of parent(s) or guardian to the participation of their child or ward in research.

Section 2.10 Prisoner

Any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures which provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing.

Section 2.11 Research

A systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities. For purposes of this part, the following activities are deemed not to be research: (i) Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information that focus directly on the specific individuals about whom the information is collected. (ii) Public health surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. Such activities are limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance (including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products). Such activities include those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters). (iii) Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes. (iv) Authorized operational activities (as determined by each agency) in support of intelligence, homeland security, defense, or other national security missions.

Section 2.12

Written, or in writing, for purposes of this part, refers to writing on a tangible medium (e.g. paper) or in an electronic format.

Section 2.13

Clinical trial means a research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of the interventions on biomedical or behavioral health-related outcomes.

ARTICLE 3 INSTITUTIONAL REVIEW BOARD MEMBERSHIP/MEETINGS

Section 3.1 Appointment of Members

Members of the IRB shall be appointed by the CEO of the Institution or his/her designee.

Section 3.2 Alternate Members

The CEO may appoint and may remove alternate members to the IRB. The alternate member shall have qualifications substantially equal to the IRB member for which the individual is acting as an alternate. The alternate member must fulfill the same requirements as the IRB member, including completing the OHRP online training program. The alternate member must be designated as an alternate, and may only act as an alternate, for one IRB member, and may not act as an alternate for any other IRB member. Alternate members shall have voting rights and shall be counted for purposes of determining whether there is a quorum present.

Section 3.3 Term

The members of the IRB (including alternate members) shall serve an initial term of two years unless removed by the CEO pursuant to Section 3.4 or until their resignation. Members may serve consecutive terms without any term limits.

Section 3.4 Removal of Members

The CEO of the Institution may remove members of the IRB for any of the following reasons:

a. Failure of the member to attend three meetings of the IRB within a two-year term;

b. Termination of employment with the Institution if the member is an employee;

c. Termination of a contractual relationship between the member and the Institution if the member is a contracted consultant;

d. If the member is found to have committed misconduct in science by the Research Integrity Committee; or

e. If in the sole discretion of the CEO the member acts contrary to the interest of the IRB or the protection of human subjects.

Section 3.5 Meetings

The IRB shall meet at least four times a year, and additional meetings shall be called when necessary as determined by a majority of the members. A member who is absent from three meetings shall be deemed to have resigned from their position.

Section 3.6 Quorum

To constitute a quorum, a majority of the IRB members must be present, except when an expedited review procedure is used. In order for research to be approved, it must be approved by a majority of those members present at the meeting.

Section 3.7 Special Meetings

If a situation occurs requiring action by the full IRB prior to the next scheduled meeting and the situation does not qualify for expedited review, a special meeting may be called.

Section 3.8 Telephonic Meetings

IRB members may participate in and act at any meeting through the use of a conference telephone or other communications equipment by means of which all persons participating in the meeting can communicate effectively with each other. Participation in such a meeting shall constitute attendance and presence in person at the meeting of the person or persons so participating.

Section 3.9 Chairperson

Members shall elect one member to serve as its Chairperson every two years, by a majority vote of all members. The IRB Chairperson shall be a respected individual from within or outside the Institution, fully capable of managing the IRB and the matters brought before it with fairness and impartiality.

Section 3.10 Membership

The IRB shall have at least five members. The members will be chosen from varying backgrounds in order to promote an adequate review of research activities commonly conducted by the Institution. The IRB shall be sufficiently qualified through the experience and expertise of its members (professional competence) and the diversity of their backgrounds, including race, gender, and cultural backgrounds and their sensitivity to issues such as community attitudes, to promote respect for the advice and counsel of the IRB in safeguarding the rights and welfare of human subjects. In addition to possessing the professional competence necessary to review specific research activities, the IRB shall ascertain the acceptability of proposed research in terms of Institution commitments, policies and resources, regulations, applicable law, and standards of professional conduct and practice. The IRB shall therefore include persons with knowledge in those areas and will not consist entirely of members of one profession.

If the IRB regularly reviews research that involves a category of subjects that is vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision making capacity, or economically or educationally disadvantaged persons, consideration must be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these subjects.

If the IRB reviews research involving prisoners, the majority of the IRB members (exclusive of any prisoner members) cannot have any association with the prison involved, other than their membership in the IRB. Further, at least one member of the IRB must be a prisoner, or a prisoner representative who has a close working knowledge, understanding and appreciation of prison conditions from the perspective of the prisoner. This membership requirement applies to initial, continuing, and final review of the research. The IRB will not need to meet this requirement if the research involving prisoners is also reviewed by another IRB that does meet this requirement.

The IRB will include at least one member whose primary concern is in a scientific area and at least one member whose primary concern is in a nonscientific area. The IRB must include at least one member who is not otherwise affiliated with the Institution and who is not part of the immediate family of a person who is affiliated with the Institution. Every nondiscriminatory effort must be made to ensure that the IRB does not consist entirely of men or entirely of women.

The IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of issues that require expertise beyond or in addition to that available on the IRB. These individuals have no voting rights.

Section 3.11 Conflict of Interest

No IRB member may participate in the review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. Therefore, an investigator may be a member of the IRB; however, the investigator-as-member cannot participate in the vote on any project in which he or she has a present or potential conflict of interest. Where the investigator-member has a conflicting interest, he or she should be present only to provide information and answer questions regarding the project in which he or she has a present or potential conflict of interest; however, the investigator-member must excuse himself or herself during final deliberations and voting on the project in question. The IRB minutes should reflect whether or not these requirements have been met.

Section 3.12 Changes in IRB Membership

Changes in IRB membership must be reported to the federal funding department or agency head, unless there is an HHS-approved assurance. In this case, change in IRB membership must be reported to the Office for Human Research Protections (“OHRP”), HHS. Also, the IRB will notify OHRP of any changes in the membership occasioned by the addition of a prisoner or prisoner representative.

Section 3.13 Training of IRB Members

IRB members charged with the responsibility for reviewing and approving research will receive detailed training in the regulations, guidelines and policies applicable to human subjects research. Attendance at workshops

and other educational opportunities focused on IRB functions are encouraged and supported to the extent possible.

ARTICLE 4 RECORDKEEPING/REPORTING

Section 4.1 IRB Records

The IRB, in conjunction with the Institution, shall prepare and maintain required documentation of IRB activities, including the following:

a. Copies of all research protocols reviewed, approved sample consent documents, project reports submitted by investigators, and reports of injuries to subjects, as well as requests regarding changes on protocols that occur during the course of the research;

b. Minutes of IRB meetings which shall be in sufficient detail to show attendance at each meeting; actions taken by the IRB; the vote on actions taken including the number of members voting for, against and abstaining; the basis for requiring changes in or disapproving research; and a written summary of the discussion of controverted issues and their resolution;

c. Records of approvals and/or disapprovals of research, whether by initial review, expedited review or continuing review activities, including the rationale for conducting continuing or more than annual review of research that otherwise would not require continuing or annual review;

d. Copies of all correspondence pertinent to the research project between the IRB and person(s)/institutions submitting research for review, or having received prior approval;

e. A list of all IRB members identified by name; earned degrees; representative capacity; indications of experience such as board certifications or licenses sufficient to describe each member's chief anticipated contributions to IRB deliberations; and any employment relationship or other relationship between each member and the Institution;

f. Written procedures for the IRB;

g. Statements of significant new findings provided to subjects;

h. Requests to waive or alter authorizations and supporting documentation.

i. The rationale for an expedited reviewer’s determination that research appearing on the expedited review list is more than minimal risk; and

j. Documentation specifying the responsibilities that an institution and an organization operating an IRB each will undertake to ensure compliance.

A separate file shall be maintained for each research project that has come before the board for review, with a record of any and all action taken. A record of all required reviews shall also be included.

Section 4.2 Record Retention

All required records shall be retained for at least three years after completion of the research, and the records shall be accessible for inspection and copying by authorized representatives of any pertinent funding body at reasonable times and in a reasonable manner. A nominal fee may be charged for all copies.

Section 4.3 Reporting

a. Any Institution personnel, researchers or investigators, or contractors shall immediately report to the IRB, via the Chairperson, any of the following occurrences:

1. Any serious or continuing noncompliance with 45 CFR Part 46 or the requirements or determinations of the IRB; or

2. Any unanticipated problems involving risks to subjects or others.

b. The IRB, via the Chairperson, shall promptly report, within 5 working days, to the responsible program official of the funding institute and OHRP any of the following occurrences:

1. Any serious or continuing noncompliance with 45 CFR Part 46;

2. Any unanticipated problems involving risks to subjects or others that are the direct result of the research; or

3. Any suspension or termination of IRB approval for a project.

c. The IRB, via the Chairperson, shall promptly report, within five (5) working days, any suspension or termination of IRB approval for a project to the investigator.

d. Any incident report submitted to OHRP will comply with the "Guidance on Reporting Incidents to OHRP", June 20, 2011, as amended from time to time (see Attachment G).

ARTICLE 5 RESEARCH

Section 5.1 IRB Responsibilities

In accordance with these procedures, the IRB shall:

a. Follow the procedures set forth in Article 8 regarding assurances;

b. Review proposed research at meetings convened in accordance with Article 3; and

c. Be responsible for reporting to the appropriate Institution officials or the Research Integrity Committee any serious or continuing non-compliance under the regulations of the IRB.

Section 5.2 Review of Research

The IRB shall review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities submitted to the IRB for review by persons conducting research, including exempt research activities under §46.104 for which limited IRB review is a condition of exemption. Any proposed modifications to research protocols or disapproval of research shall be restricted to concerns over research risks to participants.

The IRB shall determine, in its review of research protocols, which projects will require IRB review more often than annually.

The qualifications of the principal investigator shall be considered when reviewing proposals.

The IRB shall require that information given to human subjects (or legally authorized representatives, when appropriate) as part of the informed consent be in accordance with 45 CFR 46.116-46.117. The IRB may require that information, in addition to that specifically mentioned in the procedures, be given to the subjects when in the IRB's judgment the information would meaningfully add to the protection of the rights and welfare of the subjects.

The IRB shall require that documentation of **i**nformed consent be documented by the use of a written informed consent form approved by the IRB and signed (including in an electronic format) by the subject or the subject's legally authorized representative. A written copy shall be given to the person signing the informed consent form.

The IRB may waive the requirement for the investigator to obtain a signed informed consent form for some or all subjects if it finds any of the following: (i) That the only record linking the subject and the research would be the informed consent form and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject (or legally authorized representative) will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; (ii) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context; or (iii) If the subjects or legally authorized representatives are members of a distinct cultural group or community in which signing forms is not the norm, that the research presents no more than minimal risk of harm to subjects and provided there is an appropriate alternative mechanism for documenting that informed consent was obtained.

The IRB may allow broad consent to be obtained in lieu of informed consent only with respect to the storage, maintenance, and secondary research uses of identifiable private information and identifiable biospecimens.

The IRB shall notify investigators (or the requesting institution, if applicable) in writing of its decision to approve or disapprove the proposed research activity, or if modifications are required to obtain IRB approval of the research project. If the IRB's decision is to disapprove the research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing within 60 days of its decision.

When the IRB determines that specialized expertise or competence would assist in review of complex issues, it will seek input from recognized and established personnel or competent staff from recognized and established institutions. The expert opinion will be taken under advisement by the IRB, but will not be dispositive, nor count as a vote.

Unless an IRB determines otherwise, continuing review of research is not required in the following circumstances: (i) research eligible for expedited review in accordance with 46.110. (ii) research reviewed by the IRB in accordance with the limited IRB review (iii) research that has progressed to the point that it involves only one or both of the following, which are part of the IRB-approved study: (a) data analysis, including analysis of identifiable private information or identifiable biospecimens, or (b) accessing follow-up clinical data from procedures that subjects would undergo as part of clinical.

Section 5.3 Review of Approved Research

The IRB shall conduct continuing review of research which it has approved at intervals of not less than once per year, or more often as appropriate to the degree of risk. Periodic review of the research activity is necessary to determine whether the risk/benefit ratio has shifted, whether there are unanticipated findings involving risks to subjects, and whether any new information regarding the risks and benefits should be provided to subjects.

The IRB shall have authority to observe or have a third party observe the consent process and the research as determined by the IRB.

Section 5.4 Expedited Review Procedures

The IRB may provide expedited review for certain kinds of research involving no more than minimal risk and if the research falls within the categories of research as set forth in the January 26, 1987 Federal Register, 46 CFR 8392, as amended from time to time (see Attachment A) and the separate Expedited Review Policy and Procedures (see Attachment L).

An expedited review process may be used for continuing review of a research project only for minimal risk changes (or minor changes involving minimal risk) to the protocol or consent form. For guidance on minimal risk changes, see Attachment A. The periodic or annual reviews of research projects, or any project that initially required full review, must still go through the full IRB.

Under an expedited review procedure, the review may be carried out by the IRB Chairperson or by one or more experienced reviewers designated by the Chairperson from IRB members. The reviewers may exercise all the authorities of the IRB except that they may not disapprove the research. A research activity may be

disapproved only after review in accordance with the non-expedited review procedure set forth in Section 5.2.

Each member of the IRB shall be kept advised of research proposals that have been approved under the expedited review procedures.

The IRB Human Protections Administrator and one other IRB staff member, shall review incoming requests for approval to determine which research projects or modifications thereto may be eligible for expedited review.

Section 5.5 Criteria for IRB Approval of Research

In order to approve research or modifications thereto, the IRB shall determine that all of the following requirements are satisfied:

a. Risks to subjects are minimized by (i) using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes;

b. Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result. In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research). The IRB should not consider possible long-range effects of applying knowledge gained in the research as among those research risks that fall within the purview of its responsibility;

c. Selection of subjects is equitable. In making this assessment, the IRB should take into account the purposes of the research and the setting in which the research will be conducted, and should be particularly cognizant of the special problems of research that involves a category of subjects who are vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons;

d. Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by Section 5.6;

e. Informed consent will be appropriately documented or appropriately waived, in accordance with and to the extent required by Section 5.7;

f. Where appropriate, the research plan makes adequate provision for monitoring the data collected to insure the safety of subjects;

g. Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data;

h. Where some or all of the subjects are likely to be vulnerable to coercion on undue influence, such as children, mentally disabled persons, or persons who are economically or educationally disadvantaged, appropriate additional safeguards have been included in the study to protect the rights and welfare of these subjects;

i. That the proposed research complies with the "NIH/ADAMHA Policy Concerning Inclusion of Women in Study Populations," NIH Guide Vol. 19, No. 31, August 24, 1990, p. 18. This policy contains the requirement that "clinical research findings should be of benefit to all persons at risk of the disease regardless of gender." Also the proposed research must be in compliance with "NIH Guide for Grants and Contracts, September 25, 1998, January 15, 1988, and June 16, 1989" regarding the similar requirements that the research benefit all minorities at risk equally;

j. The IRB should determine that no coercive practices are used to recruit subjects for the research; and

k. The IRB must feel confident that the investigator has the qualifications, and the facilities to carry out the proposed research.

Section 5.6 General Requirements for Informed Consent

Except in the case of exempt research, or when waiver of informed consent is allowed, no investigator may involve a human being as a subject in research covered by this policy unless the investigator has obtained the legally effective informed consent of the subject or the subject's legally authorized representative. An investigator shall seek such consent only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence. The information that is given to the subject or the representative shall be in language understandable to the subject or the representative. The prospective subject or the legally authorized representative must be provided with the information that a reasonable person would want to have in order to make an informed decision about whether to participate, and an opportunity to discuss that information. No informed consent, whether oral or written, may include any exculpatory language through which that subject or the representative is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the investigator, the sponsor, the Institution or its agents from liability for negligence.

Broad consent may be obtained in lieu of informed consent obtained only with respect to the storage, maintenance, and secondary research uses of identifiable private information and identifiable biospecimens.

a. Basic elements of informed consent. Except as provided in subsection (c) or (d), in seeking informed consent, the following information shall be provided to each subject or the legally authorized representative;

1. A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental;

2. A description of any reasonably foreseeable risks or discomforts to the subject;

3. A description of any benefits to the subject or to others which may reasonably be expected from the research;

4. A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;

5. A statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained;

6. For research involving more than minimal risk, an explanation as to whether there shall be any compensation, and an explanation as to whether any medical treatments are available if injury occurs, and if so, what they consist of, or where further information may be obtained;

7. An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research related injuryto the subject;

8. A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled;

9. A statement authorizing the release of information in accordance with HIPAA and 42 CFR. Part 2;

10. A statement concerning exceptions to the Certificate of Confidentiality; and

11. One of the following statements about any research that involves the collection of identifiable private information or identifiable biospecimens: (i) A statement that identifiers might be removed from the identifiable private information or identifiable biospecimens and that, after such removal, the information or biospecimens could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative, if this might be a possibility; or (ii) A statement that the subject's information or biospecimens collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.

b. Additional elements of informed consent. When appropriate, one or more of the following elements of information shall also be provided to each subject:

1. A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or may become pregnant) which are currently unforeseeable;

2. Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's or the legally authorized representative's consent;

3. Any additional costs to the subject that may result from participation in the research;

4. The consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject;

5. A statement that significant new findings developed during the course of the research which may relate to the subject's willingness to continue participation will be provided to the subject; and

6. The approximate number of subjects involved in the study.

7. A statement that the subject's biospecimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit;

8. A statement regarding whether clinically relevant research results, including individual research results, will be disclosed to subjects, and if so, under what conditions; and

9. For research involving biospecimens, whether the research will (if known) or might include whole genome sequencing (*i.e.,* sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen).

The IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent set forth in subsection (a) and/or (b), or waive the requirement to obtain informed consent provided the IRB finds and documents that: (i)The research or demonstration project is to be conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or otherwise examine: (A) Public benefit or service programs; (B) Procedures for obtaining benefits or services under those programs; (C) Possible changes in or alternatives to those programs or procedures; or (D) Possible changes in methods or levels of payment for benefits or services under those programs; and (ii) The research could not practicably be carried out without the waiver or alteration. If an individual was asked to provide broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens, and refused to consent, an IRB cannot waive consent for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.

c. The IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent set forth in subsection (a) and/or (b), or waive the requirements to obtain informed consent provided the IRB finds and documents that:

1. The research involves no more than minimal risk to the subjects; and

2. The research could not practicably be carried out without the requested waiver or alteration;

3. If the research involves using identifiable private information or identifiable biospecimens, the research could not practicably be carried out without using such information or biospecimens in an identifiable format;

4. The waiver or alteration will not adversely affect the rights and welfare of the subjects; and

5. Whenever appropriate, the subjects will be provided with additional pertinent information after participation.

d. If the subject or the legally authorized representative is asked to provide broad consent, the following shall be provided to each subject or the subject's legally authorized representative: a description of any reasonably foreseeable risks or discomforts to the subject; a description of any benefits to the subject or to others that may reasonably be expected from the research; (1) a statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained; a statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled; a statement that the subject's biospecimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit; and for research involving biospecimens, whether the research will (if known) or might include whole genome sequencing (*i.e.,* sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen); (2) A general description of the types of research that may be conducted with the identifiable private information or identifiable biospecimens. This description must include sufficient information such that a reasonable person would expect that the broad consent would permit the types of research conducted; (3) A description of the identifiable private information or identifiable biospecimens that might be used in research, whether sharing of identifiable private information or identifiable biospecimens might occur, and the types of institutions or researchers that might conduct research with the identifiable private information or identifiable biospecimens; (4) A description of the period of time that the identifiable private information or identifiable biospecimens may be stored and maintained (which period of time could be indefinite), and a description of the period of time that the identifiable private information or identifiable biospecimens may be used for research purposes (which period of time could be indefinite); (5) Unless the subject or legally authorized representative will be provided details about specific research studies, a statement that they will not be informed of the details of any specific research studies that might be conducted using the subject's identifiable private information or identifiable biospecimens, including the purposes of the research, and that they might have chosen not to consent to some of those specific research studies; (6) Unless it is known that clinically relevant research results, including individual research results, will be disclosed to the subject in all circumstances, a statement that such results may not be disclosed to the subject; and (7) An explanation of whom to contact for answers to questions about the subject's rights and about storage and use of the subject's identifiable private information or identifiable biospecimens, and whom to contact in the event of a research-related harm. If an individual was asked to provide broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens, and refused to consent, an IRB cannot waive consent for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.

e. An IRB may approve a research proposal in which an investigator will obtain information or

biospecimens for the purpose of screening, recruiting, or determining the eligibility of prospective subjects without the informed consent of the prospective subject or the subject's legally authorized representative, if either of the following conditions are met: (1) The investigator will obtain information through oral or written communication with the prospective subject or legally authorized representative, or (2) The investigator will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable biospecimens.

f. For each clinical trial conducted or supported by a Federal department or agency, one IRB-approved informed consent form used to enroll subjects must be posted by the awardee or the Federal department or agency component conducting the trial on a publicly available Federal Web site that will be established as a repository for such informed consent forms. If the Federal department or agency supporting or conducting the clinical trial determines that certain information should not be made publicly available on a Federal Web site (*e.g.* confidential commercial information), such Federal department or agency may permit or require redactions to the information posted. The informed consent form must be posted on the Federal Web site after the clinical trial is closed to recruitment, and no later than 60 days after the last study visit by any subject, as required by the protocol.

g. The informed consent requirements in this policy are not intended to preempt any applicable federal, state, or local laws (including tribal laws passed by the official governing body of an American Indian or Alaska Native tribe) which require additional information to be disclosed in order for informed consent to be legally effective.

h. Nothing in this policy is intended to limit the authority of a physician to provide emergency medical care, to the extent the physician is permitted to do so under applicable federal, state, or local law (including tribal laws passed by the official governing body of an American Indian or Alaska Native tribe).

Section 5.7 Documentation of Informed Consent

a. Except as provided in paragraph (c) of this section, informed consent shall be documented by the use of a written consent form approved by the IRB and signed (including in an electronic format) by the subject or the subject's legally authorized representative. A written copy shall be given to the person signing the informed consent form.

b. Except as provided in paragraph (c) of this section, the consent form may be either of the following:

1. A written consent document that embodies the elements of informed consent required by Section 5.6. The investigator shall give either the subject or the subject's legally authorized representative adequate opportunity to read the informed consent form before it is signed; alternatively, this form may be read to the subject or the subject's legally authorized representative.

2. A "short form" written consent document stating that the elements of informed consent required by Section 5.6 have been presented orally to the subject or the subject's legally authorized representative and that the required key information was presented first to the subject, before other information, if any, was provided. When this method is used, there shall be a witness to the oral presentation. Also, the IRB shall approve a written summary of what is to be said to the subject or the representative. Only the “short form” itself is to be signed by the subject or the representative. However, the witness shall sign both the short form and a copy of the summary, and the person actually obtaining consent shall sign a copy of the summary. A copy of the summary shall be given to the subject or the representative, in addition to a copy of the short form.

c. The IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds any of the following:

1. That the only record linking the subject and the research would be the informed consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject (or legally authorized representative) will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern;

2. That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context; or

3. If the subjects or legally authorized representatives are members of a distinct cultural group or community in which signing forms is not the norm, that the research presents no more than minimal risk of harm to subjects and provided there is an appropriate alternative mechanism for documenting that informed consent was obtained.

In cases where the documentation requirement is waived, the IRB shall require the investigator to provide subjects or legally authorized representatives with a written statement regarding the research.

Section 5.8 Suspension or Termination of IRB Approval of Research

The IRB shall have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of the reasons for the IRB's action and shall be reported promptly to the investigator, appropriate Institution officials, and any and all funding bodies.

Section 5.9 Cooperative Research

Cooperative research projects are those projects, normally supported through grants, contracts, or similar arrangements, which involve institutions in addition to the grantee or prime contractor (such as a contractor with the grantee, or a subcontractor with the prime contractor). In the conduct of cooperative research projects, each institution is responsible for safeguarding the rights and welfare of human subjects and for complying with this policy.

Any institution located in the United States that is engaged in cooperative research must rely upon approval by a single IRB for that portion of the research that is conducted in the United States. The reviewing IRB will be identified by the Federal department or agency supporting or conducting the research or proposed by the lead institution subject to the acceptance of the Federal department or agency supporting the research.

The following research is not subject to this provision: (i) Cooperative research for which more than single IRB review is required by law (including tribal law passed by the official governing body of an American Indian or Alaska Native tribe); or (ii) Research for which any Federal department or agency supporting or conducting the research determines and documents that the use of a single IRB is not appropriate for the particular context.

An institution participating in a cooperative project may enter into a joint review arrangement, rely on the review of another IRB, or make similar arrangements for avoiding duplication of effort.

If the Institution will be involved in a Research Protocol with a collaborating independent investigator or institutional investigator that does not routinely conduct human subjects research, the Institution may extend the applicability of the FWA to cover the collaborating investigators in accordance with the “Guidance on Extension of an FWA to cover Collaborating Individual Investigators and Introduction of the Individual Investigator Agreement”, January 31, 2005 (see Attachment H).

Section 5.10 Protection of Children

a. Exempt Research

All exemptions regarding research activities described above in Section 1.5 apply to research involving children, except for the exemption for research involving survey or interview procedures or observations of

public behavior. This exemption does not apply to research involving children, unless the research involves observation of public behavior when the investigators do not participate in the activities being observed.

b. Research Not Involving Greater Than Minimal Risk

If the IRB determines that no greater than minimal risk to children is presented, then the IRB must determine that adequate provisions have been made for soliciting the assent of the children and the permission of their parents or guardians, as described below.

c. Research Involving Greater Than Minimal Risk but Presenting the Prospect of Direct Benefit to the Subjects

If the IRB determines that more than minimal risk to children is presented by an intervention or procedure that holds out the prospect of direct benefit for the individual subject, or by a monitoring procedure that is likely to contribute to the subject's well-being, then the IRB must determine that:

1. The risk is justified by the anticipated benefit to the subjects:

2. The relation of the anticipated benefit to the risk is at least as favorable to the subjects as that presented by available alternative approaches; and

3. Adequate provisions are made for soliciting assent of the children and permission of their parents or guardians, as described below in paragraphs (f) and/or (g).

d. Research Involving Greater Than Minimal Risk and No Prospect of Direct Benefit to Individual Subjects, but Likely to Yield Generalizable Knowledge About the Subject's Disorder or Condition

If the IRB determines that more than minimal risk to children is presented by an intervention or procedure that does not hold out the prospect of direct benefit for the individual subject, or by a monitoring procedure which is not likely to contribute to the well-being of the subject, then the IRB must determine that:

1. The risk presents a minor increase over minimal risk;

2. The intervention or procedure presents experiences to subjects that are reasonable commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations;

3. The intervention or procedure is likely to yield generalizable knowledge about the subjects' disorder or condition which is of vital importance for the understanding or amelioration of the subjects' disorder or condition; and

4. Adequate provisions are made for soliciting assent of the children and permission of their parents or guardians, as described below in paragraph(s) (f) and/or (g).

e. Research Not Meeting the Criteria of Categories A-D

If the IRB determines that the research does not meet the criteria of categories a-d above, but finds that the research presents a reasonable opportunity to further the understanding, prevention or alleviation of a serious problem affecting the health or welfare of children, it may refer the protocol to HHS for review. The research may proceed only if the Secretary, HHS, or his or her designee, after consulting with a panel of experts in pertinent disciplines, and following an opportunity for public review and comment, determines either that:

1. The research in fact satisfies the criteria of categories a-d; or

2. The research meets the following conditions:

- The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children;
- The research will be conducted in accordance with sound ethical principles; and
- Adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians.

If the IRB determines that the research does not meet the criteria of categories a-d above, but does meet the requirements for review by the Secretary, HHS, the IRB may request that OHRP, on behalf of the Secretary, conduct a review (known as a "407" review). The IRB will submit the following documents and/or information to OHRP in written and electronic (if available) forms to assist OHRP in their determination of whether a 407 review should proceed:

1. IRB documentation of required findings that the proposed research does not meet the criteria of categories a-d above, but presents a reasonable opportunity to understand, prevent or alleviate a serious problem affecting the health or welfare of children;
2. The name of the institution, institution assurance number and IRB name;
3. The institutional contact name, title, phone number, fax number, mailing address and e-mail address;
4. Title of the protocol and name of principal investigator;
5. HHS application number and name of funding agency;
6. Relevant HHS grant application or proposal;
7. Most current version of parental permission/assent documents submitted to and reviewed by the IRB and modified by the principal investigator of required by the IRB; and
8. Relevant IRB minutes and correspondence.

Hard copy versions of materials should be sent to:

Office for Human Research Protections Department of

Health and Human Services

1101 Wootton Parkway, Suite 200

Rockville, MD 20852

For further information, refer to the OHRP Guidance entitled "Special Protections for Children as Research Subjects", May 26, 2005 (see Attachment I).

f. Requirements for Assent by Children

The IRB must determine that adequate provisions are made for soliciting the assent of the children, when in the judgment of the IRB the children are capable of providing assent.

In determining whether children are capable of providing assent, the IRB must take into account the ages, maturity, and psychological state of the children involved. This judgment may be made for all children to be involved in research under a particular protocol, or for each child, as the IRB deems appropriate.

If the IRB determines that the capability of some or all of the children is so limited that they cannot reasonably be consulted or that the intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health and well-being of the children and is available only in the context of the research, the assent of the children is not a necessary condition for proceeding with the research.

Even if the IRB determines that the subjects are capable of assenting, the IRB may still waive the assent requirement under the same circumstances in which consent may be waived in accordance with Section 5.6(d).

If the IRB determines that assent is required, it must also determine whether and how assent must be documented.

g. Requirements for Permission by Parents or Guardians

The IRB must determine that adequate provisions are made for soliciting the permission of each child's parents or guardians. Where parental permission is to be obtained, it must be in accordance with the general requirements of informed consent as described in Section 5.6. It also must be documented in accordance with documentation requirements as described in Section 5.7.

Where parental permission is to be obtained, the IRB may find that the permission of one parent is sufficient for research not involving greater than minimal risk or research involving greater than minimal risk but presenting the prospect of direct benefit to the individual subjects.

Where parental permission is to be obtained, and the research involves greater than minimal risk and no prospect of direct benefit to individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition, permission is to be obtained from both parents.

However, permission may be obtained from one parent if one parent is deceased, unknown, incompetent, or not reasonably available, or when only one parent has legal responsibility for the care and custody of the child.

The IRB may waive the parental permission/informed consent requirement in accordance with the provisions for waiver of informed consent as described in Section 5.6(d).

The IRB may also waive the parental permission/informed consent requirement if it determines that a research protocol is designed for conditions or for a subject population for which parental or guardian permission is not a reasonable requirement to protect the subjects (for example, neglected or abused children).

However, the IRB may waive the parental permission/informed consent requirements only if an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and provided further that the waiver is not inconsistent with Federal, state or local law. The choice of an appropriate mechanism would depend upon the nature and purpose of the activities described in the protocol, the risk and anticipated benefit to the research subjects, and their age, maturity, status, and condition.

Section 5.11 DCFS Wards

Children who are wards of the state or any other agency, institution, or entity can be included in research approved under §46.406 or §46.407 only if such research is: (1) Related to their status as wards; or (2) Conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.

If the research is approved, the IRB shall require appointment of an advocate for each child who is a ward, in addition to any other individual acting on behalf of the child as guardian or in loco parentis. One individual may

serve as advocate for more than one child. The advocate shall be an individual who has the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except in the role as advocate or member of the IRB) with the research, the investigator(s), or the guardian organization.

In accordance with the Illinois Department of Children and Family Services ("DCFS") policy, any research performed on DCFS wards must be approved in advance by the DCFS IRB, in addition to this Institution's IRB. DCFS also requires in any research, including research that involves minimal risks, the written consent of the DCFS guardian and the consent of the child.

Section 5.12 Protection of Prisoners

Additional safeguards for the protection of prisoners involved in human subjects research shall be adhered to in accordance with 45 CFR 46.301-306, including making the seven required findings under 45 CFR 46.305(a) (refer also to the "OHRP Guidance on the Involvement of Prisoners in Research" (see Attachment J)).

Section 5.13 Protection of Pregnant Women and Fetuses

Additional safeguards for the protection of pregnant women and fetuses involved in human subjects research shall be adhered to in accordance with 45 CFR 46.201-207.

Pregnant women or fetuses may be involved in research if all of the following conditions are met:

(a) Where scientifically appropriate, preclinical studies, including studies on pregnant animals, and clinical studies, including studies on nonpregnant women, have been conducted and provide data for assessing potential risks to pregnant women and fetuses;

(b) The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus; or, if there is no such prospect of benefit, the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means;

(c) Any risk is the least possible for achieving the objectives of the research;

(d) If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, or no prospect of benefit for the woman nor the fetus when risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means, her consent is obtained in accord with the informed consent requirement in accordance with the provisions for waiver of informed consent as described in Section 5.6.;

(e) If the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accord with the informed consent requirement as described in Section 5.6, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest.

(f) Each individual providing consent under paragraph (d) or (e) of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;

(g) For children as defined in Section 2.3 who are pregnant, assent and permission are obtained in accord with the provisions of Section 5.10;

(h) No inducements, monetary or otherwise, will be offered to terminate a pregnancy;

(i) Individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy; and

(j) Individuals engaged in the research will have no part in determining the viability of a neonate.

Neonates of uncertain viability and nonviable neonates may be involved in research if all of the following conditions are met:

(1) Where scientifically appropriate, preclinical and clinical studies have been conducted and provide data for assessing potential risks to neonates.

(2) Each individual providing consent under paragraph (2) or (5) of this section is fully informed regarding the reasonably foreseeable impact of the research on the neonate.

(3) Individuals engaged in the research will have no part in determining the viability of a neonate.

(4) The requirements of paragraph (b) or (c) of this section have been met as applicable.

Until it has been ascertained whether or not a neonate is viable, a neonate may not be involved in research covered by this subpart unless the following additional conditions are met:

(1) The IRB determines that:

(i) The research holds out the prospect of enhancing the probability of survival of the neonate to the point of viability, and any risk is the least possible for achieving that objective, or

(ii) The purpose of the research is the development of important biomedical knowledge which cannot be obtained by other means and there will be no added risk to the neonate resulting from the research; and

(2) The legally effective informed consent of either parent of the neonate or, if neither parent is able to consent because of unavailability, incompetence, or temporary incapacity, the legally effective informed consent of either parent's legally authorized representative is obtained in accord with subpart A, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.

After delivery nonviable neonate may not be involved in research unless all of the following additional conditions are met:

(1) Vital functions of the neonate will not be artificially maintained;

(2) The research will not terminate the heartbeat or respiration of the neonate;

(3) There will be no added risk to the neonate resulting from the research;

(4) The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means; and

(5) The legally effective informed consent of both parents of the neonate is obtained in accord with subpart A of this part, except that the waiver and alteration provisions of § 46.116(c) and (d) do not apply. However, if either parent is unable to consent because of unavailability, incompetence, or

temporary incapacity, the informed consent of one parent of a nonviable neonate will suffice to meet the requirements, except that the consent of the father need not be obtained if the pregnancy resulted from rape or incest. The consent of a legally authorized representative of either or both of the parents of a nonviable neonate will not suffice to meet the requirements.

(k) Viable neonates. A neonate, after delivery, that has been determined to be viable may be included in research only to the extent permitted by and in accord with the requirements of subparts A and D.

Research involving, after delivery, the placenta; the dead fetus; macerated fetal material; or cells, tissue, or organs excised from a dead fetus, shall be conducted only in accord with any applicable Federal, State, or local laws and regulations regarding such activities.

If information associated with material described in the above paragraph is recorded for research purposes in a manner that living individuals can be identified, directly or through identifiers linked to those individuals, those individuals are research subjects and all pertinent subparts are applicable.

ARTICLE 6 APPLICATION PROCESS

Section 6.1 New Submissions

The following Chestnut IRB application must be submitted for any proposed study prior to start-up and includes the following elements (see Attachment B):

a. General Information: this section provides information regarding project title; funding sources; estimated project duration; and estimated start date. It must list the Principal Investigator and all Co-Investigators.

b. Research Description : this section provides space for an abstract of a lengthy protocol which describes the research project and includes the following sections:

- Hypotheses/objectives
- Intervention (if applicable)
- Sample Size and Characteristics
- Setting
- Instrumentation
- Measurement Frequency
- Research Design
- Statistical Analysis Plan
- Study Design
- Subject Identification
- Data Source
- Procedures to Keep Data Confidential
- Special Subject Groups

- Source of Subjects
- Payment for Treatment Costs
- Plans for Participant Recruitment
- Participant Payment
- Availability of Alternative Treatments
- Names and Titles of All Persons Obtaining Informed Consent
- Informed Consent Training
- Potential Risks and Steps Taken to Minimize Risks
- Potential Benefits
- Good Clinical Practice (GCP) Certification
- Adverse Event Reporting
- Data Safety and Monitoring Plan
- Test Article Summary (for drug studies only)
- Financial Interests

c. Consent Form: the consent form should be in the form of the Institution's standard boilerplate consent forms (see Attachment C). Detailed information about how to write an adequate consent form is contained in Sections 5.6 and 5.7.

Following its review of the proposal, the IRB may take one of the following actions:

a. Approval: a valid approval consists of the receipt of an approved consent form and an official approval letter.

b. Contingent Approval: approval may be contingent upon changes in the consent form, changes in the method of handling data, or other changes the IRB feels necessary. The approval letter is withheld until the IRB is satisfied such conditions have been met by the investigator. A revised consent form must be submitted in a format exactly as it will be presented to the patient.

c. Protocol Tabled: the protocol may be tabled if the IRB feels that there are major questions or concerns which must be addressed before it can approve the research. In this case, the protocol must be placed before the IRB again once these questions are answered.

d. Disapproval: the IRB may withhold approval for the research. The investigator is free to appeal the decision to the IRB, which may choose to consult experts outside the Institution, the OHRP, or other IRBs for guidance.

e. Formal Withdrawal by Principal Investigator: the IRB may permit the investigator to withdraw a proposal that has already been scheduled for formal review if the investigator (or IRB) believes that the submission is incomplete, and therefore insufficient for IRB review under current federal guidelines.

Section 6.2 Procedures for Filing Amendments

Any change in the conduct of the research or in the study consent form must be approved by the IRB before it can be implemented. The following documentation is required for review of amendments:

a. Request to amend previously approved project form (see Attachment D) This form requires the following information:

- Principal Investigator
- Project Title
- Description of Proposed Changes (including rationale and any changes in risk level)

b. If applicable, edited version of the application form in "track changes".

c. If applicable, edited version of previously approved consent forms or other materials in "track changes".

d. If applicable, a letter from the primary IRB that approves the change(s)

Section 6.3 Procedures to Assure Continuing Protocol Review

The following procedures must be followed for continuing review of approved research as described in Section 5.3. The Federal Regulations require that an IRB conduct continuing review of human subject protocols at intervals appropriate to the degree of risk, but not less than 365 days after the original approval date, except as specified below. Therefore, IRB approval is given for a maximum one-year period from the date of review; any project which is not determined to be exempt from review must be reviewed on an annual basis, at least. The necessary documentation for annual review must be submitted sufficiently in advance of the expiration date to allow the protocol to be reviewed at a regularly scheduled IRB meeting. The IRB shall review, at a minimum:

a. A status report on the progress of the research (see Attachment E) that includes:

- Brief abstract of the project
- Detailed description of any problems that developed in relation to the protection of human subjects

  Changes in protocol or data management that could affect protection of human subjects and measures taken to ensure their protection
- Number of subjects enrolled to date
- If all subjects completed all study interventions, last date that subjects received any study intervention
- Description of any adverse outcomes of the research
- Description of any adverse events that occurred incidental to the research
- If the study is a clinical trial funded by NIH and/or if the study is a clinical trial of medication or a medical device, list names, titles, and dates of Good Clinical Practice (GCP) for all investigators and personnel responsible for clinical study coordination, data collection, and data management
- Brief description of preliminary results

Any IRB member, upon request, may have access to the complete protocol file and relevant minutes (refer also to the OHRP "Guidance on Continuing Review", July 11, 2002; see Attachment K).

Unless an IRB determines otherwise, continuing review of research is not required in the following circumstances: (i) Research eligible for expedited review; (ii) Research reviewed by the IRB in accordance with the limited IRB review (review to determine exempt status); (iii) Research that has progressed to the point that it involves only one or both of the following, which are part of the IRB-approved study: (A) Data analysis, including analysis of identifiable private information or identifiable biospecimens, or (B) Accessing follow-up clinical data from procedures that subjects would undergo as part of clinical care.

Section 6.4 Procedures to Closeout Projects

A closeout report is required for all IRB approved studies and takes the place of an Annual Report (or sooner if has not been one year since the last report).

a. A closeout report on the research (see Attachment F) that includes:

- Brief abstract of the project
- Detailed description of any problems that developed in relation to the protection of human subjects
- Changes in protocol or data management that could affect protection of human subjects and measures taken to ensure their protection
- Number of subjects enrolled to date
- If all subjects completed all study interventions, last date that subjects received any study intervention
- Description of any adverse outcomes of the research
- Description of any adverse events that occurred incidental to the research
- If the study is a clinical trial funded by NIH and/or if the study is a clinical trial of medication or a medical device, list names, titles, and dates of Good Clinical Practice (GCP) for all investigators and personnel responsible for clinical study coordination, data collection, and data management
- A brief description of main findings

ARTICLE 7 CONFIDENTIALITY

Section 7.1 Confidentiality of IRB Activities

Members of the IRB should be sensitive to the actions of the IRB and the discussion during the review of protocols at each meeting. IRB members should not independently disclose or discuss written or verbal information submitted to the IRB or activities of the IRB without clearance from the IRB Chairperson or the Human Subjects Protections Administrator. Reviewers are encouraged to contact the principal investigator prior to the meeting to clarify issues regarding the protocol and/or consent form.

Section 7.2 Confidentiality of Research Data

Confidentiality of research data shall be kept in accordance with 42 CFR Part 2A and HIPAA (45 CFR 160 and 164).

Section 7.3 Confidentiality of Research Subjects

Confidentiality of research subjects shall be kept in accordance with 42 CFR Part 2, HIPAA (45 C.F.R. 160 and 164) and state mental health confidentiality laws and regulations.

Section 8.1 Assurances to Funding Agency

Assurances must include the following information, at a minimum:

a. A statement of principles governing the Institution in the discharge of its responsibilities for protecting the rights and welfare of human subjects of research conducted at or sponsored by the institution, regardless of whether the Institution is subject to Federal Regulation. This may include an appropriate existing code, declaration, or statement of ethical principles, or a statement formulated by the institution itself. Cite the Belmont Report.

b. Designation of one or more IRBs established in accordance with the Federal Regulations, and which provisions are made for meeting space and sufficient staff to support the IRB's review and recordkeeping duties.

c. A list of IRB members identified by name; earned degrees; representative capacity; indications of experience such as board certifications, licenses, etc., sufficient to describe each members' chief anticipated contributions to IRB deliberations; and any employment or other relationship between each member and the Institution, for example: full-time employee, part-time employee, board member, paid or unpaid consultant. Changes in IRB membership must be reported to the federal department or agency head.

d. Written procedures which the IRB will follow:

    1. For conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and the Institution.

    2. For determining which projects require review more often than annually and which projects need verification from sources other than the investigators that no material changes have occurred since previous IRB review.

    3. For ensuring prompt reporting to the IRB of proposed changes in a research activity, and for ensuring that such changes in approved research, during the period for which IRB approval has already been given, may not be initiated without IRB review and approval except when necessary to eliminate apparent immediate hazards to the subject.

e. Written procedures for ensuring prompt reporting to the IRB, to appropriate Institution officials, and to federal department or agency heads of:

    1. Any unanticipated problems involving risks to subjects or others or any serious or continuing noncompliance with the Federal Regulations (or IRB policy and procedure) or requirements or determinations of the IRB.

    2. Any suspension or termination.

CHESTNUT HEALTH SYSTEMS

Attachment A

Office for Human Research Protections (OHRP) - Categories of Research

Categories of Research That May Be Reviewed by the Institutional Review Board (IRB) through an Expedited Review Procedure[1]

Applicability

A. Research activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the following categories, may be reviewed by the IRB through the expedited review procedure authorized by 45 CFR 46.110 and 21 CFR 56.110. The activities listed should not be deemed to be of minimal risk simply because they are included on this list. Inclusion on this list merely means that the activity is eligible for review through the expedited review procedure when the specific circumstances of the proposed research involve no more than minimal risk to human subjects.

B. The categories in this list apply regardless of the age of subjects, except as noted.

C. The expedited review procedure may not be used where identification of the subjects and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.

D. The expedited review procedure may not be used for classified research involving human subjects.

E. IRBs are reminded that the standard requirements for informed consent (or its waiver, alteration, or exception) apply regardless of the type of review--expedited or convened--utilized by the IRB.

F. Categories one (1) through seven (7) pertain to both initial and continuing IRB review.

Research Categories

1. Clinical studies of drugs and medical devices only when condition (a) or (b) is met.

    a. Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.)

    b. Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

2. Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:

a. From healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or

b. From other adults and children[2], considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

3. Prospective collection of biological specimens for research purposes by noninvasive means.

   Examples: (a) hair and nail clippings in a non-disfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gum base or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.

4. Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.)

   Examples: (a) physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject=s privacy; (b) weighing or testing sensory acuity; (c) magnetic resonance imaging; (d) electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, Doppler blood flow, and echocardiography; (e) moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

5 Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis). (Note: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(4). This listing refers only to research that is not exempt.)

6. Collection of data from voice, video, digital, or image recordings made for research purposes.

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (Note: Some research in this category may be exempt from the HHS

regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.)

8. Continuing review of research previously approved by the convened IRB as follows:

    a. Where (i) the research is permanently closed to the enrollment of new subjects; (ii) all subjects have completed all research-related interventions; and (iii) the research remains active only for long-term follow-up of subjects; or

    b. Where no subjects have been enrolled and no additional risks have been identified; or

    c. Where the remaining research activities are limited to data analysis.

9. Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories two (2) through eight (8) do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

---

[1] An expedited review procedure consists of a review of research involving human subjects by the IRB chairperson or by one or more experienced reviewers designated by the chairperson from among members of the IRB in accordance with the requirements set forth in 45 CFR 46.110.

[2] Children are defined in the HHS regulations as "persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted." 45 CFR 46.402(a).

Source: 63 FR 60364-60367, November 9, 1998.

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Attachment B

IRB APPLICATION

Email the completed IRB application, informed consent and other consent documents, locator forms, measurement forms, and all other documents that participants will be asked to complete to Kelli Wright at kwright@chestnut.org.

If you have any questions regarding the completion of this form, email Kelli Wright at kwright@chestnut.org.

Respond to all items. Type "NA" if not applicable.

SECTION A: GENERAL INFORMATION

1. Project Title:

2. Funding Source(s):

3. Estimated Project Duration:

4. Estimated Start Date:

5. Principal Investigator Information
   a. Last Name:
   b. First Name:
   c. Degree:
   d. Organization:
   e. Street Address:
   f. City/State/Zip:
   g. Telephone:
   h. Email:

6. Co-Investigator Information

   Co-Investigator #1
   a. Last Name:
   b. First Name:
   c. Degree:
   d. Telephone:
   e. Email:

   Co-Investigator #2
   a. Last Name:
   b. First Name:
   c. Degree:
   d. Telephone:
   e. Email:

SECTION B: RESEARCH DESCRIPTION

7. Hypotheses/Objectives:

8. Intervention (if applicable):

9. Sample Size and Characteristics:

10. Setting:

11. Instrumentation (list all instruments and tools to be used and submit with this form):

12. Measurement Frequency:

13. Research Design:

14. Statistical Analysis Plan:

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SECTION C: HUMAN SUBJECT PROTOCOL

15. Study Design (check all that apply):
    - ☐ Retrospective (data already exist; e.g., record review)
    - ☐ Prospective (data do not currently exist)
    - ☐ Randomized
    - ☐ Subjects blinded
    - ☐ Other – please explain:

16. Subject Identification (check all that apply):
    - ☐ The data used for this research is free of identifying information (such as name, pseudonym, treatment record number, linked code)
    - ☐ The data is coded but not linked to a subject identifier
    - ☐ The data is coded but the subjects' identities could be obtained if needed
    - ☐ The data contains references to the subjects' identities
    - ☐ Other – please explain:

17. Data Source (check all that apply):
    - ☐ Information in the public domain (e.g., newspaper)
    - ☐ Treatment records
    - ☐ Questionnaire/survey or interview
    - ☐ Laboratory samples (e.g., urine)

18. Describe procedures to keep collected data confidential:

19. Special Subject Groups (check all that apply):
    - ☐ Pregnant
    - ☐ Children/adolescents
    - ☐ Prisoners

20. Source of Subjects (check all that apply):
    - ☐ Chestnut Health Systems patients
    - ☐ Other – please explain:

21. Who will pay for treatment costs? (check one)
    - ☐ Funding agency
    - ☐ Participant/insurance
    - ☐ Other – please explain:
    - ☐ Not applicable

22. Explain plans for participant recruitment:

23. Total participant payment amount:

24. Are alternative treatments available to the patients/subjects? (check one)
    - ☐ Not applicable
    - ☐ No
    - ☐ Yes – please explain:

25. List the names and titles of all persons obtaining informed consent:

26. Describe training for persons obtaining informed consent:

27. List any potential risks involved (e.g., unauthorized disclosure of confidential data, drug reaction):

28. Describe steps taken to minimize risk (e.g., certificate of confidentiality, ID codes, record security):

29. Describe how the subjects and/or society will benefit from this study:

30. Good Clinical Practice (GCP) Certification: Is this study a clinical trial funded by NIH and/or is this study a clinical trial of medication or a medical device?
    - ☐ No
    - ☐ Yes – List the names and titles of all investigators and personnel responsible for clinical study coordination, data collection, and data management. All individuals listed must have completed the GCP certification program at National Drug Abuse Treatment Clinical Trials Network (https://gcp.nihtraining.com/) within the past 3 years. GCP certification documentation must be included as part of the IRB submission for this project.

31. Adverse Event Reporting: All studies are to report unanticipated events to the IRB's Human Protections Administrator within 2 business days of PI notification. Unanticipated events are events that are not consistent with the foreseeable risk associated with research procedures or are not expected in the natural progression of any underlying condition of the sample. All deaths are considered unanticipated events. Reports should be made to the Human Protections Administrator by sending a copy of a completed Adverse Event Report (Adverse Event report forms for a DSMP may be used or the Adverse Event Form Template located at Y: http://chestnut.org/LI/Institutional-Review-Board).

    a. Is there is a Data Safety and Monitoring Plan (DSMP) for this study?
        - ☐ No

☐ Yes – Include a copy of the DSMP with your IRB application

32. (For Drug Studies Only) Test Article Summary:
    a. Drug (check all that apply)
        ☐ Drug is FDA-approved to use for any indication
        ☐ Drug is FDA-approved to use for this research study indication
        ☐ Drug is FDA-approved to test in this research study

        a1. If any of the above boxes are checked, provide IND#:

    b. Device (check all that apply)
        ☐ Device is FDA-approved to use for any indication
        ☐ Device is FDA-approved to use for this research indication
        ☐ Device is FDA-approved to test in this research study

        b1. If any of the above boxes are checked, provide IND# or IDE#:

    c. Radioactive substances
        ☐ Yes
        ☐ No

33. Financial interests: Indicate below if any investigators or any members of their immediate families have any relationships, commitments, or activities with the sponsor of this research that might present or appear to present a conflict of interest with regard to the outcome of the research. If you have questions about conflict of interest, contact Dr. Mark Godley, Human Subjects Protections Administrator, at 309-451-7800.

    ☐ Ownership, equity, or stock options
        ☐ Has been disclosed to Chestnut Health Systems
        ☐ Has not been disclosed to Chestnut Health Systems

    ☐ Personal compensation such as royalties, consulting fees, etc.
        ☐ Has been disclosed to Chestnut Health Systems
        ☐ Has not been disclosed to Chestnut Health Systems

    ☐ Intellectual property such as patents, trademarks, copyright, licensing, etc.
        ☐ Has been disclosed to Chestnut Health Systems
        ☐ Has not been disclosed to Chestnut Health Systems

    ☐ Other conflict of interest – please explain:
        ☐ Has been disclosed to Chestnut Health Systems
        ☐ Has not been disclosed to Chestnut Health Systems

    ☐ No conflicts exist

Signature of Principal Investigator: _____ Date: _____

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Attachment C

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH

Title of Project: _____

Principal Investigator: _____

You have been invited to participate in a research project. The process by which you decide whether or not to participate in the project is called informed consent. We will explain the research project to you, and you will have the opportunity to ask any questions you might have about it before you make your decision. If you decide to participate, you will sign this form and a copy will be given to you.

What is the project about and how long will it last?

[Insert description of purposes and goals of project and summary of research design, including: research techniques used, what the participant will be required to do (interviews, surveys, calls, etc.), types of information sought, timetable, randomization, etc.]

Will I be paid for my participation?

[Insert description of payments, if applicable]

What are you asking me to agree to?

If you agree to participate today, you will be asked to: (a) sign this informed consent, *(b) sign authorization(s) to allow other people or organizations to provide information about you to us (c) complete a Locator Form to help us find you for follow-up purposes and (d) [insert other, such as complete a base line interview].* The data will only be used for research purposes.

Below is a short summary of several things we want to make sure you understand and agree with. At the end you will be asked whether you agree or "consent" to all of them.

Consent to Participate in Interviews

I understand that if I participate in the project I will be asked to complete interviews as follows: [Insert schedule of interviews.] I also understand that I have the right to refuse to answer any question, to skip any interview and to drop out of the project whenever I want.

Consent to be Audio-Taped

I understand that if I participate in the project the interviews will be audio-taped so that members of the research team can review how well the staff are doing their job. These tapes will be reviewed to rate how closely staff followed the protocol, to give staff feedback and to train staff how to do a better job in the future. If I have something very private to say, I have the right to tell the staff to turn off the tape. To further protect me, the tapes will only have my research ID number on them and they will be destroyed ____ years after the project has been completed.

Consent to be Photographed

I understand that if I participate in this project, I will be photographed and the photograph will be attached to the Follow-up Locator Form. These photographs will help the researchers verify that the person they are interviewing at the follow-up interview is in fact me, and not someone else. This photograph may also be used to identify and locate me for follow-up interview purposes, and it may be shown to individuals to help locate me. These individuals will only be told the researchers are trying to locate me for a health project in which I have agreed to participate. At the end of the project, a member of the research team will either return the pictures to me or destroy them.

Consent for Other Testing

[Insert description of urine, blood or other type of testing.] The results of the testing will be completely confidential to the extent allowed by law and used only for research purposes. My participation in testing is voluntary and I am still eligible to participate in the project even if I decide not to participate with the testing.

Consent to be Re-Contacted

If we receive additional funding, we may want to contact you again in the coming years to see how you are doing. If we do so, each time we will identify ourselves, explain what we are doing and ask for your permission to make further contact.

Specific Authorizations

I understand that if I participate in the project, you will ask me to sign specific authorization(s) to allow the research team to locate me and to get data about me. Information about this project and purpose do not appear on these authorizations in order to protect my privacy. This data will only be used for research and I can refuse to sign any or all of these authorizations and still participate.

HOW WILL MY INFORMATION BE PROTECTED?

Records created as part of this research project are kept confidential and are protected by federal laws regarding the confidentiality of substance abuse treatment records as well as the Health Insurance Portability and Accountability Act. Disclosure of your records is only done consistent with all applicable law. Research staff are required to report suspicion of child neglect or child abuse and medical information in cases of medical emergency and will report circumstances in which a client may be a risk to themselves or others. Additional information related to the protection of your confidential information can be found in Chestnut Health Systems, Inc.'s Notice of Privacy Practices, which is available upon request.

We have taken several steps to protect your information. These are: a) all staff have been trained to understand the need for privacy *and have signed a statement agreeing with the terms of this consent and to keep your answers (locator data excluded) completely separate from the records that identify who you are*, 2) the information about your identity and all the data with your answers are kept in two separate files that are only linked through a research ID, 3) records are stored in locked, secure research offices, 4) only data on groups of people is reported, *and 5) a federal certificate of confidentiality has been obtained to keep us from being forced to disclose information that may identify you in any federal, state or local civil, criminal, administrative, legislative or other proceeding.*

There are some exceptions to this Certificate of Confidentiality that we are required to disclose to you. First, it does not prevent the federal government from reviewing our records for the purpose of auditing our books or evaluating federally-funded projects. Second, it requires us to give you back a copy of the information we have collected about you if you ask for it in writing. Third, it does not

prevent us from sharing information if we believe you are about to harm yourself or someone else or if you have been involved in harming a child. We are also required to offer you a copy of the Certificate of Confidentiality if you want it. You should understand that a Certificate of Confidentiality does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If an insurer, employer, or other person obtains your written authorization to receive research information, then the researchers may not use the Certificate to withhold that information.

What are the risks of the project?

As previously disclosed, the risk to you is that your personal information will be disclosed to outside persons unconnected with the research. Accidental disclosure, though possible, is unlikely because of the steps that we take to protect the confidentiality of your information. *[Describe any other risks from the project.]*

Are there any benefits to me or to others if I participate?

All participants may benefit from the knowledge that they are participating in a project to help people with substance use disorders. Society will benefit from a better understanding of the subject matter. You will also be paid for your time as described above. *[Describe any other benefits.]*

HOW WILL MY INFORMATION BE USED?

[Insert description of who will have access to the information, including counselors, other researchers, courts, etc.]

Can I choose whether or not to participate in this project?

Yes. You are completely free to decline to participate in this project now or later should you agree to participate now. If you do decline to participate you are still eligible to apply for any treatment services offered by this or other agencies. A refusal to participate does not affect your eligibility for services or right to benefits.

Whom do I call if I have questions or problems?

For questions about the research or to withdraw from the research project, contact the Principal Investigator at [Insert Number].

For questions about your rights in a research project or about a research-related injury, call [Insert Name and Number]

When does this consent expire?

This consent will expire on: [Insert expiration date.]

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PROJECT ASSURANCE OF CONSENT

This project has been explained to me. I have had the opportunity to ask questions concerning any and all aspects of the project. I am aware that I can refuse to answer any question without having to explain why. I am aware that I may choose not to participate or to withdraw from this project at any time without penalty. I acknowledge that no guarantee or assurance has been given by anyone as to the results to be obtained. Confidentiality of records related to my involvement in this project will be maintained in accordance with federal law. I understand that if I do not sign this form, then I cannot participate in the project.

I understand that my right to access my information created or obtained in the course of research that includes treatment may be temporarily suspended for as long as the research is in progress. My right of access will be reinstated upon completion of the research.

I hereby agree _____/ do not _____ agree (check one) to participate in the above-described research project and to the use and disclosure of my information for research purposes. Should I withdraw from the project, I agree that any information obtained prior to my withdrawal may continue to be used to maintain the integrity of the research project.

I will be given a copy of this informed consent for my records.

_____

Name of Research Participant (Please Print)

_____

Signature of Research Participant Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

____ Ineligible ____ Refused

(Reason_____)

_____

Signature of Staff/Witness

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Attachment D

CHESTNUT HEALTH SYSTEMS IRB
REQUEST TO AMEND PREVIOUSLY APPROVED PROJECT

Principal Investigator:

Project Title:

Date This Form was Completed:

All modifications must be reviewed and approved prior to implementation.

Please supply the following:

1) An edited version of Chestnut's IRB application in "track changes" that was previously approved and clearly shows the proposed changes where indicated. The application included the following documents: Title Page, Research Description, and Human Subjects Protocol.
2) An edited version of updated consent forms or other materials in "track changes" that were previously approved and clearly show the proposed changes where indicated.
3) A letter from the primary IRB that approves the changes submitted on this form if Chestnut's IRB is not primary.

Describe the requested change(s) and clearly reference materials submitted with this form.

Provide a rationale for the proposed change(s).

Do the proposed changes involve changes in level of risk to the physical, emotional, or psychological well-being of participants (including the loss of confidentiality)? If yes, provide justification.

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Attachment E

CHESTNUT HEALTH SYSTEMS
IRB RESEARCH PROGRESS REPORT

Project title: **Grant # (if applicable):**

1. **Provide a brief abstract of the project (limited to one paragraph).**

2. **Provide a detailed description of any problems which have developed in relation to the protection of human subjects. In the event that none have developed, you should state that there have been no problems in this regard.**

3. **List any changes in your protocol or data management which could affect protection of human subjects and measures being taken to ensure their protection.**

4. **Provide the number of subjects enrolled to date.**

5. **Have all subjects completed all study interventions? If yes, specify last date that subject received any study intervention.**

6. **List any adverse outcomes of the research itself.**

7. **List any adverse events that occurred incidental to the research.**

8. **Is this study a clinical trial funded by NIH and/or is this study a clinical trial of medication or a medical device?** ☐ Yes ☐ No

   If yes, list the names, titles, and dates of GCP certification for all investigators and personnel responsible for clinical study coordination, data collection, and data management:

   All individuals listed above must have completed the GCP certification program at National Drug Abuse Treatment Clinical Trials Network (https:\\gcp.nihtraining.com) within the past 3 years.

   Documentation for all staff who renewed certification or began work on the project since the last report must be included as part of the IRB progress report for this project.

9. **If preliminary results of the research have been obtained, give a brief description of them.**

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Attachment F

CHESTNUT HEALTH SYSTEMS
IRB RESEARCH CLOSEOUT REPORT

Project title: **Grant # (if applicable):**

1. **Provide a brief abstract of the project (limited to one paragraph).**

2. **Provide a detailed description of any problems which have developed in relation to the protection of human subjects. In the event that none have developed, you should state that there have been no problems in this regard.**

3. **List any changes in your protocol or data management which could affect protection of human subjects and measures being taken to ensure their protection.**

4. **Provide the number of subjects enrolled to date.**

5. **Have all subjects completed all study interventions? If yes, specify last date that subject received any study intervention.**

6. **List any adverse outcomes of the research itself.**

7. **List any adverse events that occurred incidental to the research.**

8. **Is this study a clinical trial funded by NIH and/or is this study a clinical trial of medication or a medical device?** ☐ Yes ☐ No

   If yes, list the names, titles, and dates of GCP certification for all investigators and personnel responsible for clinical study coordination, data collection, and data management:

   All individuals listed above must have completed the GCP certification program at National Drug Abuse Treatment Clinical Trials Network (https:\\gcp.nihtraining.com) within the past 3 years.

   Documentation for all staff who renewed certification or began work on the project since the last report must be included as part of the IRB progress report for this project.

9. **If results of the research have been obtained, give a brief description of them or send along a copy of the final report/manuscript report main findings.**

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Attachment G

Office for Human Research Protections (OHRP)

Guidance on Reporting Incidents to OHRP

NOTE: THIS GUIDANCE REPLACES OHRP'S MAY 27, 2005 GUIDANCE ENTITLED "GUIDANCE ON REPORTING INCIDENTS TO OHRP" This guidance has been updated to clarify what information regarding serious or continuing noncompliance by the institutional review board needs to be reported, to include an e-mail address to report incidents to OHRP, and to update OHRP's contact information.

This guidance represents OHRP's current thinking on this topic and should be viewed as recommendations unless specific regulatory requirements are cited. The use of the word *must* in OHRP guidance means that something is required under HHS regulations at 45 CFR part 46. The use of the word *should* in OHRP guidance means that something is recommended or suggested, but not required. An institution may use an alternative approach if the approach satisfies the requirements of the HHS regulations at 45 CFR part 46. OHRP is available to discuss alternative approaches at 240-453-6900 or 866-447-4777.

Date: June 20, 2011

Scope:

This document provides guidance about procedures institutions may use to file incident reports with OHRP. Incident reports include reports of unanticipated problems involving risks to subjects or others; serious or continuing noncompliance with Department of Health and Human Services (HHS) regulations at 45 CFR part 46 or the requirements or determinations of the institutional review board (IRB); and suspension or termination of IRB approval. In particular, OHRP offers guidance on the following topics:

I. Applicability of incident reporting requirements;
II. Information to be included in incident reports;
III. Time frame for reporting incidents;
IV. OHRP focus on corrective actions when reviewing incident reports;
V. OHRP's response to incident reports;
VI. Where to send incident reports; and

VII. Additional guidance.

Target Audience: IRBs, institutional officials and institutions that may be responsible for review, oversight, or conduct of human subjects research covered by an OHRP-approved assurance.

Regulatory Background:

HHS regulations at 45 CFR 46.103(a) and (b)(5) require that institutions have written procedures to ensure that the following incidents related to regulatory requirements pertaining to research conducted under an OHRP- approved assurance are promptly reported to OHRP:

a. Any unanticipated problems involving risks to subjects or others;
b. Any serious or continuing noncompliance with this policy or the requirements or determinations of the IRB; and
c. Any suspension or termination of IRB approval.

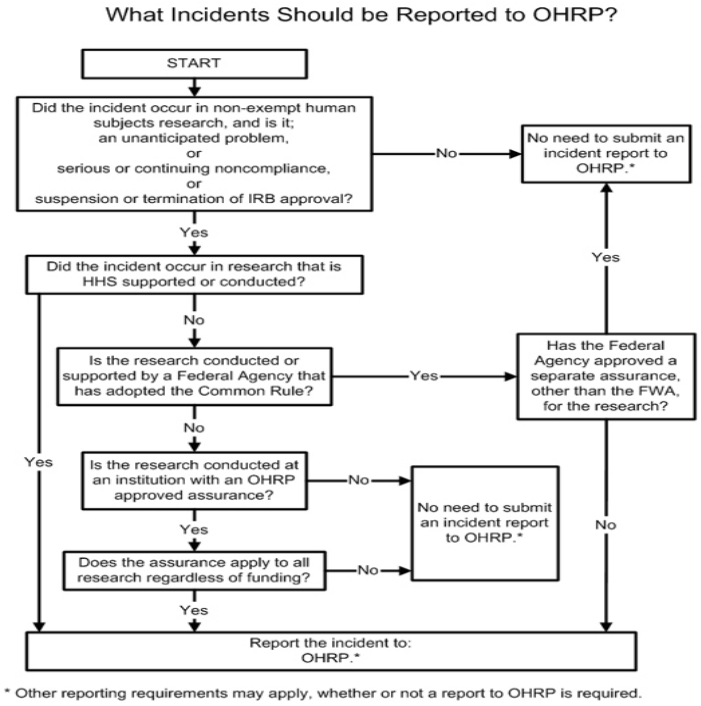
Guidance:

I. Applicability of incident reporting requirements

In general, these reporting requirements apply to all nonexempt human subjects research that is:

(a) conducted or supported by HHS;
(b) conducted or supported by any non-HHS federal department or agency that has adopted the Common Rule and is covered by a Federalwide Assurance (FWA) determined to be appropriate for such research; or
(c) covered by an FWA, regardless of funding source.

Federal departments or agencies other than HHS that have adopted the Common Rule may determine that the FWA is not appropriate for certain research that they conduct or support. OHRP notes that these incident reporting requirements are **not** applicable to such research. In such cases, the institution should contact the non-HHS department or agency that supports the research about reporting requirements. See the decision chart below.



II. Information to be included in incident reports

To fulfill the regulatory requirements for reporting incidents, OHRP would consider it acceptable for an institution to comply with written procedures specifying that the following information be included in an incident report submitted to OHRP:

A. For unanticipated problems involving risks to subjects or others:

- Name of the institution (e.g., university, hospital, foundation, school, etc) conducting the research;
- Title of the research project and/or grant proposal in which the problem occurred;
- Name of the principal investigator on the protocol;
- Number of the research project assigned by the IRB and the number of any applicable federal award(s) (grant, contract, or cooperative agreement);
- A detailed description of the problem; and
- Actions the institution is taking or plans to take to address the problem (e.g., revise the protocol, suspend subject enrollment, terminate the research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.).

B. For serious or continuing noncompliance:

- Name of the institution (e.g., university, hospital, foundation, school, etc) conducting the research;
- Title of the research project and/or grant proposal in which the noncompliance occurred, or, for IRB or institutional noncompliance, the IRB or institution involved;
- Name of the principal investigator on the protocol, if applicable;
- Number of the research project assigned by the IRB and the number of any applicable federal award(s) (grant, contract, or cooperative agreement);
- A detailed description of the noncompliance; and
- Actions the institution is taking or plans to take to address the noncompliance (e.g., educate the investigator, educate all research staff, educate the IRB or institutional official, develop or revise IRB written procedures, suspend the protocol, suspend the investigator, conduct random audits of the investigator or all investigators, etc.).

C. For suspension or termination:

- Name of the institution (e.g., university, hospital, foundation, school, etc.) conducting the research;
- Title of the research project and/or grant proposal that was suspended or terminated;
- Name of the principal investigator on the protocol;
- Number of the research project assigned by the IRB that was suspended or terminated and the number of any applicable federal award(s) (grant, contract, or cooperative agreement);
- A detailed description of the reason for the suspension or termination; and
- The actions the institution is taking or plans to take to address the suspension or termination (e.g., investigate alleged noncompliance, educate the investigator, educate all research staff, require monitoring of the investigator or the research project, etc.).

III. Time frame for reporting incidents

The regulations at 45 CFR 46.103(a) and (b)(5) do not specify a time frame for reporting, except to say this must be done "promptly." For a more serious incident, this may mean reporting to OHRP within days. For a less serious incident, a few weeks may be sufficient. It may be appropriate to send an initial report, and indicate that a follow-up or final report will follow by the earlier of:

- A specific date; or
- When an investigation has been completed or a corrective action plan has been implemented.

IV. OHRP focus on corrective actions when reviewing incident reports

When reviewing a report of an unanticipated problem, OHRP assesses most closely the adequacy of the actions taken by the institution to address the problem. Likewise, when reviewing reports of non-compliance or suspension or termination of IRB approval, OHRP assesses most closely the adequacy of the corrective actions taken by the institution. In particular, OHRP assesses whether or not the corrective actions will help ensure that the incident will not happen again, with the investigator or protocol in question, with any other investigator or protocol, or with the IRB. Therefore, OHRP recommends that, when appropriate, corrective actions be applied institution-wide.

V. OHRP response to incident reports

After receiving and evaluating an incident report from an institution, OHRP will respond in writing and will either state that the report was adequate or request additional information. For questions on reporting, please contact the Director of the Division of Compliance Oversight, 240-453-6900 or 866-447-4777.

VI. Where to send incident reports

Please send reports (PDF or Word documents preferred) to the following email address: **IRPT.OS@hhs.gov**

VII. Additional guidance

Please see OHRP guidance on continuing review regarding the distinction between suspension and expiration of IRB approval by clicking here and OHRP guidance on unanticipated problems by clicking here.

CHESTNUT HEALTH SYSTEMS

Attachment H

Guidance on Extension of an FWA to Cover Collaborating Individual Investigators and Introduction of the Individual Investigator Agreement

Date: January 31, 2005

Scope: This document describes a permissible mechanism under which an institution holding an Office for Human Research Protections (OHRP)-approved Federalwide Assurance (FWA) (hereafter referred to as the ***assured institution***) may extend – for one or more research protocols – the applicability of its FWA to cover two types of collaborating individual investigators: collaborating **independent** investigators and collaborating **institutional** investigators.

This mechanism would be permitted for **any Department of Health and Human Services (HHS) conducted or supported human subjects research when the research is being conducted under the direction and supervision of a principal investigator from the assured institution**. This mechanism provides an alternative to establishing additional FWAs for numerous institutions that do not hold FWAs (hereafter referred to as ***non-assured institutions***) and do not routinely conduct human subjects research.

Any non-assured institution may choose to submit an assurance to OHRP for approval rather than agree to the use of this mechanism that extends another institution's FWA to cover a collaborating institutional investigator employed by the non-assured institution. Please note that if HHS-conducted or -supported human subjects research activities routinely occur at a non-assured institution, the institution should obtain an OHRP-approved FWA because this guidance does not apply. Also, **if the non-assured institution is the primary awardee for an HHS-supported award providing support for non-exempt human subjects research, the institution must obtain its own OHRP-approved FWA.** If an institution is uncertain about the need for its own FWA, it should consult with OHRP.

This document also introduces a new sample agreement called the Individual Investigator Agreement, which allows for the flexibility offered in this guidance and which will replace all prior sample investigator agreements developed by OHRP.

Target Audience: This document primarily is intended to assist institutional review board (IRB) administrators, research administrators, IRB chairpersons and members, investigators, institutional officials, and funding agencies that may be responsible for review or oversight of human subjects research conducted or supported by HHS.

Regulatory Background

HHS regulations at 45 CFR 46.103(a) require that each institution engaged in HHS-conducted or -supported human subjects research provide written assurance, satisfactory to HHS, that it will comply with the requirements of the HHS regulations for the protection of human subjects, unless the research is exempt under 45 CFR 46.101(b). HHS regulations at 45 CFR 46.103(b) require that each institution engaged in HHS-conducted or -supported human subjects research certify to the HHS funding agency that the research has been approved by an IRB designated in the assurance.

Two Types of Collaborating Individual Investigators

OHRP notes that some human subjects' research conducted by an assured institution may involve the following two types of collaborating individual investigators:

1. A collaborating **independent** investigator is:

a. Not otherwise an employee or agent of the assured institution;

b. Conducting collaborative research activities outside the facilities of the **assured** institution; and

c. Not acting as an employee of **any** institution with respect to his or her involvement in the research being conducted by the assured institution.

2. A collaborating **institutional** investigator is:

a. Not otherwise an employee or agent of the **assured** institution;

b. Conducting collaborative research activities outside the facilities of the **assured** institution;

c. Acting as an employee or agent of a **non-assured** institution with respect to his or her involvement in the research being conducted by the **assured** institution; and

d. Employed by, or acting as an agent of, a ***non-assured institution*** that does not routinely conduct human subjects research.

Prior to January 31, 2005, the effective date of this guidance document, assurance options for collaborating **independent** investigators included (1) the Unaffiliated Investigator Agreement (UIA), for collaborating independent investigators engaged in research activities in collaboration with FWA institutions and who are not acting as employees of any institution with respect to the research activities; (2) the Non-Institutional Investigator Agreement (NIA), for collaborating independent investigators solely involved in Cooperative Protocol Research Programs; and (3) the Agreement for Independent Investigators (AII), for collaborating independent investigators involved in any other HHS-conducted or -supported human subjects research not covered by a UIA or NIA. Now, the Individual Investigator Agreement, or another similar agreement developed by an assured institution, will be the sole assurance option for collaborating **independent** investigators.

Prior to this guidance, OHRP had not established a routine formal mechanism for an assured institution to extend the applicability of its FWA to cover collaborating **institutional** investigators.

Introduction Of The Individual Investigator Agreement

Effective January 31, 2005, OHRP has replaced the UIA, NIA, and AII with the sample Individual Investigator Agreement, which will provide greater flexibility and simplicity. Previously executed AIIs, NIAs, and UIAs may remain in effect until all applicable research that has already been initiated is completed or until the previous agreement has been replaced by an new Individual Investigator Agreement or other written agreement developed by an assured institution.

The new sample Individual Investigator Agreement may be used by an assured institution to extend – for one or more research protocols – the applicability of its FWA to cover either collaborating **independent** investigators or collaborating **institutional** investigators.

The sample Individual Investigator Agreement may be found on the OHRP website at http://www.hhs.gov/ohrp/policy/unaflsup.rtf. Institutions also may develop their own agreements for individual investigators, provided the conditions below are met.

Conditions For Extending An FWA To Cover Collaborating Individual Investigators

OHRP will permit an assured institution to extend its FWA to cover a collaborating **independent** or **institutional** investigator provided all of the following conditions are satisfied:

1. The principal investigator at the assured institution directs and appropriately supervises all of the collaborative research activities to be performed by the collaborating individual investigator outside the assured institution.

2. The extension of the coverage of the FWA is put in place by use of an appropriate written agreement, such as the sample Individual Investigator Agreement, for each collaborating individual investigator who will be engaged in the research being conducted by the assured institution. **The assured institution must maintain the Individual Investigator Agreement,** or other written agreement used by the assured institution, **on file and provide copies to OHRP upon request.**

3. For collaborating **institutional** investigators, the appropriate authorities at the non-assured institution state in writing that the conduct of the research is permitted at their institution.

4. The assured institution and the responsible IRB designated under the FWA approve the extension of the assurance through either the Individual Investigator Agreement or other written agreement used by the assured institution.

5. The following documents are made available to the collaborating individual investigator: (a) *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (see http://www.hhs.gov/ohrp/policy/belmont.html) or other internationally recognized equivalent (see section B.1. of the Terms of the Federalwide Assurance (FWA) for International (Non-U.S.) Institutions on the OHRP website at http://www.hhs.gov/ohrp/assurances/assurances/filasurt.html); (b) the HHS regulations for the protection of human subjects at 45 CFR part 46 (see http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html) or other procedural standards designated by a non-U.S. institution under its FWA (see section B.3. of the Terms of the Federalwide Assurance (FWA) for International (Non-U.S.) Institutions on the OHRP website at http://www.hhs.gov/ohrp/assurances/assurances/filasurt.html); (c) the FWA and applicable Terms of the FWA for the assured institution; and (d) the relevant institutional policies and procedures for the protection of human subjects of the assured institution.

6. The collaborating individual investigator understands and accepts the responsibility to comply with the standards and requirements stipulated in the documents referenced in the preceding paragraph and to protect the rights and welfare of human subjects involved in research conducted under the Individual Investigator Agreement or other written agreement used by the assured institution.

7. The collaborating individual investigator agrees to comply with all other applicable federal, international, state, and local laws, regulations, and policies that may provide additional protections for human subjects participating in research conducted under the Individual Investigator Agreement or other written agreement used by the assured institution.

8. The collaborating individual investigator agrees to abide by all determinations of the Institutional Review Board (IRB)/Independent Ethics Committee (IEC) designated under the FWA of the assured institution and agrees to accept the final authority and decisions of the IRB/IEC, including but not limited to directives to terminate participation in designated research activities conducted under the Individual Investigator Agreement or other written agreement used by the assured institution.

9. The collaborating individual investigator agrees to complete any educational training required by the assured institution and/or the IRB/IEC prior to initiating research covered under the Individual Investigator Agreement or other written agreement used by the assured institution.

10. The collaborating individual investigator agrees not to enroll subjects in research under the Individual Investigator Agreement or other agreement used by the assured institution, prior to the research being reviewed and approved by the IRB/IEC.

11. The collaborating individual investigator agrees to report promptly to the IRB/IEC any proposed changes in the research conducted under the Individual Investigator Agreement or other agreement used by the assured institution. The collaborating institutional investigator agrees not to initiate changes in the research without prior IRB/IEC review and approval, except where necessary to eliminate apparent immediate hazards to subjects.

12. The collaborating individual investigator agrees to report immediately to the IRB/IEC any unanticipated problems involving risks to subjects or others in research covered under the Individual Investigator Agreement or other agreement used by the assured institution.

13. The collaborating individual investigator, when responsible for enrolling subjects, agrees to obtain, document, and maintain records of informed consent for each such subject or each subject's legally authorized representative as required under HHS regulations at 45 CFR part 46 (or any other international or national procedural standards selected in the FWA for the institution referenced above) and stipulated by the IRB/IEC.

14. The collaborating individual investigator acknowledges and agrees to cooperate with the IRB/IEC's in its initial and continuing review, record keeping, reporting, and certification for the research covered by the Individual Investigator Agreement, or other agreement used by the assured institution. The collaborating institutional investigator agrees to provide all information requested by the IRB/IEC in a timely fashion.

If you have specific questions about how to apply this guidance, please contact OHRP by phone at (866) 447-4777 (toll-free within the U.S.), (301) 496-7005, or by e-mail at ohrp@hhs.gov

CHESTNUT HEALTH SYSTEMS

Attachment I

Special Protections for Children as Research Subjects

When a proposed research study involves children and is supported or conducted by HHS, the research institution's Institutional Review Board (IRB) must take into consideration the special regulatory requirements that provide additional protection for the children who would be involved in the research. If the proposed research involves FDA-regulated products, then FDA's parallel regulations apply.

FAQs on Research with Children

By regulatory definition, children are persons who have not attained the legal age for consent to treatments or procedures involved in the research, under applicable law of the jurisdiction in which the research will be conducted. Generally the law considers any person under 18 years old to be a child.

When reviewing research with children as subjects, in addition to ensuring adherence to the general regulatory requirements of 45 CFR part 46, Subpart A, the IRB also must consider the potential benefits, risks, and discomforts of the research to children and assess the justification for their inclusion in the research. In assessing the risks and potential benefits, the IRB should consider the circumstances of the children to be enrolled in the study-for example their health status, age, and ability to understand what is involved in the research-as well as potential benefits to subjects, other children with the same disease or condition, or society as a whole.

For any protocol involving children, the IRB must determine which of the four categories of research apply to that study, if any. OHRP recommends that the IRB document the rationale for this choice.

The HHS regulations at 45 CFR part 46, subpart D permit IRBs to approve three categories of research involving children as subjects:

45 CFR 46.404 **- Research not involving greater than minimal risk to the children.**

To approve this category of research, the IRB must make the following determinations:

- The research presents no greater than minimal risk to the children; ***and***
- Adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians, as set forth in HHS regulations at 45 CFR 46.408.

45 CFR 46.405 - Research involving greater than minimal risk but presenting the prospect of direct benefit to the individual child subjects involved in the research.

To approve research in this category, the IRB must make the following determinations:

- The risk is justified by the anticipated benefits to the subjects;
- The relation of the anticipated benefit to the risk presented by the study is at least as favorable to the subjects as that provided by available alternative approaches; ***and***
- Adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians, as set forth in HHS regulations at 45 CFR 46.408.

45 CFR 46.406 - Research involving greater than minimal risk and no prospect of direct benefit to the individual child subjects involved in the research, but likely to yield generalizable knowledge about the subject's disorder or condition.

In order to approve research in this category, the IRB must make the following determinations:

- The risk of the research represents a minor increase over minimal risk;

- The intervention or procedure presents experiences to the child subjects that are reasonably commensurate with those inherent in their actual, or expected medical, dental, psychological, social, or educational situations;
- The intervention or procedure is likely to yield generalizable knowledge about the subject's disorder or condition which is of vital importance for the understanding or amelioration of the disorder or condition; ***and***
- Adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians, as set forth in HHS regulations at 45 CFR 46.408.

A fourth category of research requires a special level of HHS review beyond that provided by the IRB.

45 CFR 46.407 - Research that the IRB believes does not meet the conditions of 45 CFR 46.404, 46.405, or 46.406, but finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children.

If the IRB believes that the research does not meet the requirements of 45 CFR 46.404, 46.405, or 46.406, but finds that it presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children, it may refer the protocol to HHS for review. The research may proceed only if the Secretary, HHS, or his or her designee, after consulting with a panel of experts in pertinent disciplines (e.g., science, medicine, education, ethics, law) and following an opportunity for public review and comment, determines either: (1) that the research in fact satisfies the conditions of 45 CFR 46.404, 46.405, or 46.406, or (2) the following:

- The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children;
- The research will be conducted in accordance with sound ethical principles; ***and***
- Adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians, as set forth in HHS regulations at 45 CFR 46.408.

For more information on the HHS 45 CFR 46.407 review process see OHRP Guidance, Children Involved as Subjects in Research: Guidance on the HHS 45 CFR 46.407 ("407") Review Process [PDF - 37.5KB]

Attachment J

Office for Human Research Protections (OHRP)

NOTE: THIS GUIDANCE REPLACES THE FOLLOWING OHRP GUIDANCE: "OHRP Guidance on Approving Research Involving Prisoners" (May 19, 2000) **THIS GUIDANCE HAS BEEN UPDATED FOR FORMAT AND TO PROVIDE ADDITIONAL GUIDANCE ON RESPONSIBILITIES OF IRBs AND INSTITUTIONS REQUIRED UNDER SUBPART C**

Office for Human Research Protections

Department of Health and Human Services

OHRP Guidance on the Involvement of Prisoners in Research

Date: May 23, 2003

Scope: This document describes the requirements of Department of Health and Human Services (HHS) regulations at 45 CFR part 46, subpart C, which provides additional protections to prisoners involved as subjects in HHS-conducted or supported research.

Target Audience: Research institutions, institutional review boards (IRBs), investigators, and sponsors

For further information contact: OHRP Prisoner Research Contact Person at (301) 496-7005 (phone); (301) 402-0527 (fax)

A. General Regulatory Background

HHS regulations at 45 CFR part 46, subpart C provide additional protections pertaining to biomedical and behavioral research involving prisoners as subjects. The regulations are applicable to all biomedical and behavioral research conducted or supported by HHS. See 45 CFR 46.301. It is important to note that the regulations provide that "biomedical or behavioral research conducted or supported by HHS shall not involve prisoners as subjects" unless the research is specifically authorized within the subpart. See 45 CFR 46.306(b).

In the preamble to the final subpart C rule, the drafters noted: "In fact, most testimony before the Commission opposed the use of prisoners in any form of medical research not intended to benefit the individual prisoner." 43 Fed. Reg. 53652,53653 (November 16, 1978). HHS did determine that some limited research would be permissible but not "until additional and more stringent review procedures are conducted." Id. at page 53652.

B. Subpart C applies where any subject is or becomes a prisoner.

The provisions of subpart C apply to any research conducted or supported by HHS in which prisoners are subjects. This includes situations where a human subject becomes a prisoner after the research has commenced. As the Purpose section of the regulation notes: "Inasmuch as prisoners may be under constraints because of their incarceration which could affect their ability to make a truly voluntary and uncoerced decision whether or not to participate as subjects in research, it is the purpose of this subpart to provide additional safeguards for the protection of prisoners involved in activities to which this subpart is applicable." 45 CFR 46.302. These concerns apply whether the research involves individuals who are prisoners at the time of enrollment in the research or who become prisoners after they become enrolled in the research. In the latter situation, it is unlikely that review of the research and the consent document contemplated the constraints imposed by incarceration.

C. What does the definition of prisoner encompass?

"Prisoner" is defined by HHS regulations at 45 CFR part 46.303(c) as "any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced

to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures which provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing."

D. Special Composition of IRB

In addition to satisfying the requirements of 45 CFR 46.116 and 46.117, when an IRB reviews a protocol involving prisoners as subjects that is conducted or supported by HHS, the composition of the IRB must satisfy the following requirements of HHS regulations at 45 CFR 46.304(a) and (b):

- A majority of the IRB (exclusive of prisoner members) shall have no association with the prison(s) involved, apart from their membership on the IRB.
- At least one member of the IRB must be a prisoner, or a prisoner representative with appropriate background and experience to serve in that capacity, except that where a particular research project is reviewed by more than one IRB, only one IRB need satisfy this requirement.

In the absence of choosing someone who is a prisoner or has been a prisoner, the IRB should choose a prisoner representative who has a close working knowledge, understanding and appreciation of prison conditions from the perspective of the prisoner.

In addition, the IRB must notify OHRP of any change in the IRB roster occasioned by the addition of a prisoner or a prisoner representative, as required by HHS regulations at 45 CFR 46.103(b)(3). IRBs should be alert to the impact of roster changes on quorum requirements under HHS regulations at 45 CFR 46.108(b).

If a protocol involving prisoners as subjects is to be reviewed by more than one IRB, only one IRB must satisfy the requirement that at least one member of the IRB be a prisoner or a prisoner representative.

For research involving prisoners as subjects, the IRB must meet the special composition requirements of 45 CFR 46.304 for all types of review of the protocol, including initial review, continuing review, review of protocol amendments, and review of reports of unanticipated problems involving risks to subjects.

E. Additional duties of the IRB where prisoners are involved.

When an IRB is reviewing a protocol in which a prisoner is a subject, the IRB must make, in addition to other requirements under 45 CFR 46, subpart A, seven additional findings under 45 CFR 46.305(a), as follows:

1. The research under review represents one of the categories of research permissible under 45 CFR 46.306(a)(2);
2. Any possible advantages accruing to the prisoner through his or her participation in the research, when compared to the general living conditions, medical care, quality of food, amenities and opportunity for earnings in the prison, are not of such a magnitude that his or her ability to weigh the risks of the research against the value of such advantages in the limited choice environment of the prison is impaired;
3. The risks involved in the research are commensurate with risks that would be accepted by nonprisoner volunteers;
4. Procedures for the selection of subjects within the prison are fair to all prisoners and immune from arbitrary intervention by prison authorities or prisoners. Unless the principal investigator

provides to the IRB justification in writing for following some other procedures, control subjects must be selected randomly from the group of available prisoners who meet the characteristics needed for that particular research project;

5. The information is presented in language which is understandable to the subject population;
6. Adequate assurance exists that parole boards will not take into account a prisoner's participation in the research in making decisions regarding parole, and each prisoner is clearly informed in advance that participation in the research will have no effect on his or her parole; and
7. Where the IRB finds there may be a need for follow-up examination or care of participants after the end of their participation, adequate provision has been made for such examination or care, taking into account the varying lengths of individual prisoners' sentences, and for informing participants of this fact.

F. Permitted research involving prisoners.

For research conducted or supported by HHS to involve prisoners, two actions must occur:

1. The institution engaged in the research must certify to the Secretary (through OHRP) that the IRB designated under its assurance of compliance has reviewed and approved the research under 45 CFR 46.305; and
2. The Secretary (through OHRP) must determine that the proposed research falls within the categories of research permissible under 45 CFR 46.306(a)(2). The categories of permissible research are the following:

   i. Study of the possible causes, effects, and processes of incarceration, and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;

      (Note that the definition of minimal risk for prisoner research at 45 CFR 46.303(d) differs from the definition of minimal risk for other research, contained in 45 CFR 46, subpart A, 45 CFR 46.102(i)) [See Section J.7 of this document]

   ii. Study of prisons as institutional structures or of prisoners as incarcerated persons, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;

   iii. Research on conditions particularly affecting prisoners as a class (for example, vaccine trials and other research on hepatitis which is much more prevalent in prisons than elsewhere; and research on social and psychological problems such as alcoholism, drug addiction, and sexual assaults) provided that the study may proceed only after the Secretary (through OHRP) has consulted with appropriate experts including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of his intent to approve such research; or

   iv. Research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subject. In cases in which those studies require the assignment of prisoners in a manner consistent with protocols approved by the IRB to control groups which may not benefit from the research, the study may proceed only after the Secretary (through OHRP) has consulted with appropriate experts including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of his intent to approve such research.

G. Responsibilities of IRBs: Documentation of IRB Findings Required Under Subpart C

Pursuant to HHS regulations at 45 CFR 46.115(a), an institution or, when appropriate, an IRB, shall prepare and maintain adequate documentation of IRB activities. For the purposes of subpart C, the IRB activities include making the specific findings required under HHS regulations at 45 CFR 46.305(a). OHRP would consider documentation of protocol-specific information justifying each IRB finding required under 45 CFR 46.305(a) to be one way of adequately documenting the IRB activities required under subpart C.

H. Responsibilities of Institutions

Pursuant to HHS regulations at 45 CFR 46.115(a), an institution must maintain adequate documentation of IRB activities. These records must be made accessible to authorized representatives of HHS, at reasonable times and in a reasonable manner, under HHS regulations at 45 CFR 46.115(b). OHRP recommends that one way for an institution responsible for the conduct of the proposed research to adequately document the IRB review of the research:

- The curriculum vitae of the prisoner or prisoner representative serving on the IRB.
- A record of the determination of the IRB regarding the seven additional findings required under HHS regulations at 45 CFR 46.305(a).

Under 45 CFR 46.305(c), the institution responsible for conducting research involving prisoners that is supported by HHS shall certify to the Secretary (through OHRP) that the IRB has made the seven findings required under 45 CFR 46.305(a). The institution must send to OHRP a certification letter to this effect, which should also include the name and address of the institution and specifically identify the research protocol in question and any relevant HHS grant application or protocol. HHS conducted or supported research involving prisoners as subjects may not proceed until OHRP issues its approval in writing to the institution on behalf of the Secretary under 45 CFR 46.306(a)(2).

Under its authority at 45 CFR 46.115(b), OHRP requires that the institution responsible for the conduct of the proposed research also submit to OHRP a copy of the research proposal so that OHRP can determine whether the proposed research involves one of the categories of research permissible under 45 CFR 46.306(a)(2), and if so, which one. The term "research proposal" includes the IRB-approved protocol, any relevant HHS grant application or proposal, any IRB application forms required by the IRB, and any other information requested or required by the IRB to be considered during initial IRB review.

Prisoner research certification letters should be emailed to subpartc@hhs.gov

I. Responsibilities of OHRP

Following receipt of the research proposal, OHRP will determine which, if any, of the four categories of research permissible under HHS regulations at 45 CFR 306(a)(2) the proposed research meets. OHRP will consult with appropriate experts with respect to certain research that falls under paragraphs (iii) and (iv) of 45 CFR 46.306(a)(2).

When applicable, OHRP also will publish in the Federal Register a notice of intent to approve such research. HHS conducted or supported research involving prisoners as subjects may not proceed until OHRP issues its approval in writing to the institution on behalf of the Secretary under 45 CFR 46.306(a)(2).

J. Frequently Asked Questions

1. Does subpart C apply only where the research targets prisoners as subjects?

Answer: No, subpart C applies whenever any human subject in a research protocol subject to 45 CFR part 46 becomes a prisoner at any time during the study.

2. What should an investigator do if a subject becomes a prisoner after enrollment in research?

Answer: The investigator should report this situation to the IRB immediately.

3. What should be done when a subject becomes a prisoner after enrollment in a study which was not reviewed and approved by the IRB in accordance with the requirements of subpart C?

Answer: When a previously enrolled research subject becomes a prisoner and the relevant research protocol was NOT reviewed and approved by the institutional review board (IRB) in accordance with the requirements of HHS regulations at 45 CFR part 46, subpart C, the principal investigator should promptly notify the IRB of this event. All research interactions and interventions with, and obtaining identifiable private information about, the now-incarcerated prisoner-subject must cease until the requirements of subpart C have been satisfied with respect to the relevant protocol.

NOTE: OHRP has allowed one important exception. In special circumstances in which the principal investigator asserts that it is in the best interests of the subject to remain in the research study while incarcerated, the IRB Chairperson may determine that the subject may continue to participate in the research until the requirements of subpart C are satisfied.

Upon receipt of notification that a previously enrolled research subject has become a prisoner, the IRB should promptly re-review the protocol in accordance with the requirements of subpart C if the principal investigator wishes to have the prisoner subject continue to participate in the research.

It is important that the IRB remind the principal investigator that, except in the special circumstances noted above, all research interactions and interventions with, and obtaining identifiable private information about, the now-incarcerated prisoner-subject must cease until all of the requirements of subpart C have been satisfied with respect to the relevant protocol.

4. Is an adolescent (e.g., age 14) detained in a juvenile detention facility a prisoner?

Answer: Yes. In addition to subpart C, most likely subpart D would also apply.

5. Can research involving prisoners be expedited?

Answer: Yes, however, OHRP recommends that the convened IRB review research involving prisoners as human subjects.

6. Do the exemptions apply to research involving prisoners?

Answer: The exemptions at 45 CFR 46.101(b) do not apply to research involving prisoners. See 45 CFR 46.101(i), footnote 1.

7. What is the definition of minimal risk for prisoner research?

Answer: The definition of minimal risk for research involving prisoners can be found at 45 CFR 46.303(d). This definition, promulgated in 1978, differs from the definition of minimal risk in subpart A of 45 CFR 46. See 45 CFR 46. 102(i).

For research involving prisoners, the definition of minimal risk requires reference to physical or psychological harm, as opposed to harm or discomfort, to risks normally encountered in the daily lives, or routine medical, dental or psychological examination of healthy persons.

Definition of Minimal Risk in Prisoner Research 45 CFR 46.303(d)	Definition of Minimal Risk in 45 CFR part 46, subpart A, 45 CFR 46.102(i)
"Minimal risk" is the probability and magnitude of **physical or psychological** harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of **healthy persons**.	"Minimal risk means that the probability and magnitude of **harm or discomfort anticipated** in the research **are not greater** in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

Last revised: June 25, 2004

CHESTNUT HEALTH SYSTEMS

Attachment K

Office for Human Research Protections (OHRP)

NOTE: THIS GUIDANCE SUPERSEDES OHRP'S JANUARY 15, 2007 GUIDANCE ENTITILED "GUIDANCE ON CONTINUING REVIEW."

Office for Human Research Protections

Department of Health and Human Services

Guidance on IRB Continuing Review of Research

This guidance represents the Office for Human Research Protections' (OHRP's) current thinking on this topic. OHRP guidance should be viewed as recommendations unless specific regulatory requirements are cited. The use of the word *must* in OHRP guidance means that something is required under the Department of Health and Human Services (HHS) regulations at 45 CFR part 46. The use of the word *should* in OHRP guidance means that something is recommended or suggested, but not required. An institution may use an alternative approach if the approach satisfies the requirements of 45 CFR part 46. OHRP is available to discuss alternative approaches by telephone at 240-453-6900 or 866-447-4777, or by email at ohrp@hhs.gov.

Date: November 10, 2010

Scope: This guidance document applies to research involving human subjects that is conducted or supported by HHS. It provides guidance on the HHS regulations for the protection of human research subjects at 45 CFR part 46 related to institutional review board (IRB) continuing review of research. In particular, the guidance addresses the following topics:

A. Introduction

B. Key IRB Considerations When Evaluating Research Undergoing Continuing Review

1. Criteria for IRB Approval of Research Undergoing Continuing Review
2. Risk Assessment and Monitoring
3. Evaluating the Adequacy of the Informed Consent Process
4. Evaluating Investigator and Institutional Issues
5. Evaluating Research Progress

C. Process for Conducting Continuing Review

1. Key Procedural Requirements for Continuing Review Conducted by the IRB at Convened Meetings
2. Key Procedural Requirements for Continuing Review Conducted Under an Expedited Review Procedure
3. Written Procedures for Conducting Continuing Review
4. Submission of Documents to the IRB
5. Distribution and Availability of Documents for Review by IRB Members
6. Primary Reviewers
7. Involvement of IRB Staff in Preliminary Review
8. Procedures for Continuing Review Deliberations During IRB Meetings
9. Approving Research with Conditions at the Time of Continuing Review

10. Additional Considerations Regarding Continuing Review Using an Expedited Review Procedure

11. Using a Different IRB to Conduct Continuing Review

D. Additional Considerations for Continuing Review of Multicenter Research Projects

1. Multiple Institutions Relying on Local IRBs for Continuing Review

2. Implementation of Cooperative IRB Review Arrangements for Continuing Review, Including Use of Central IRB Procedures

E. When Expedited Review Procedures may be Used by an IRB for Continuing Review

1. General Considerations

2. Expedited Review Category (8)

3. Expedited Review Category (9)

F. Determining the Frequency of Continuing Review

G. Determining the Effective Date of Initial IRB Approval and the Dates for Continuing Review

1. General Considerations

2. Determining the *First* Continuing Review Date for Research Reviewed by the IRB at a Convened Meeting at the Time of Initial Review and Approved for One Year

3. Determining the Date for the *Second and All Subsequent* Continuing Reviews for Research Reviewed by the IRB at Convened Meeting and Approved for One Year Intervals, Including how to Maintain a Fixed Anniversary Date for the Expiration of Annual IRB Approvals

4. Determining the Continuing Review Date for Research Reviewed by the IRB at a Convened Meeting and Approved for Less Than One Year and for Research Reviewed by the IRB Under an Expedited Review Procedure

H. Lapses in IRB Approval

I. Communicating the IRB's Continuing Review Determination to Investigators and the Institution

J. Suspension or Termination of IRB Approval of Research or Disapproval of Research at the Time of Continuing Review

K. Identifying the Point When Continuing Review is no Longer Necessary

L. Continuing Review is Not Required for Exempt Human Subjects Research Projects

Target Audience: IRBs, investigators, HHS funding agencies, and others that may be responsible for the review, conduct, or oversight of human subjects research conducted or supported by HHS.

Regulatory Background:

The HHS regulations for the protection of human subjects at 45 CFR part 46 have several provisions pertinent to continuing review of research, including the following:

- An institution (or when appropriate an IRB) must prepare and maintain – and the IRB must follow – written procedures for:
  - Conducting continuing review of research and for reporting its findings and actions to the investigator and the institution;
  - Determining which projects require review more often than annually;

  - Determining which projects need verification from sources other than the investigators that no material changes in the research have occurred since the previous IRB review; and
  - Ensuring prompt reporting to the IRB of proposed changes in a research activity and for ensuring that changes in approved research, during the period for which IRB approval has already been given, may not be initiated without IRB review and approval except when necessary to eliminate apparent immediate hazards to the human subjects (45 CFR 46.103(b)(4), 46.108(a), and 46.115(a)(6)).
- No IRB may have a member participate in the IRB's continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB (45 CFR 46.107(e)).
- Except when an expedited review procedure is used, continuing review of research must occur at convened meetings at which a majority of the IRB members are present, including at least one member whose primary concerns are in nonscientific areas. In order for research undergoing continuing review to be approved, it must receive the approval of a majority of those members present at the meeting (45 CFR 46.108(b)).
- *IRB approval* means the determination of the IRB that the research has been reviewed and may be conducted at an institution within the constraints set forth by the IRB and by other institutional and federal requirements (45 CFR 46.102(h)).
- An IRB must conduct continuing review of research at intervals appropriate to the degree of risk, but not less than once per year (45 CFR 46.109(e)).
- An IRB may use an expedited review procedure to conduct continuing review of research for some or all of the research appearing on the list of research eligible for expedited review (see http://www.hhs.gov/ohrp/policy/expedited98.html) and found by the reviewer(s) to involve no more than minimal risk. Under an expedited review procedure, the review may be carried out by the IRB chairperson or by one or more experienced reviewers designated by the IRB chairperson from among the members of the IRB. In reviewing the research, the reviewers may exercise all of the authorities of the IRB except that the reviewers may not disapprove the research. For any research approved under an expedited review procedure at the time of continuing review, all members must be advised of such approvals. OHRP may restrict, suspend, terminate, or choose not to authorize an IRB's use of the expedited review procedure (45 CFR 46.110).
- In order to approve research, the IRB must determine that all of the requirements of 45 CFR 46.111 are satisfied. In addition, for research involving pregnant women, fetuses or neonates; prisoners; or children, the IRB must determine that the research satisfies the requirements of subpart B, C, or D, respectively, of 45 CFR part 46.
- An institution, or when appropriate an IRB, must prepare and maintain adequate documentation of IRB activities, including the following:
  - Copies of all research proposals reviewed, scientific evaluations, if any, that accompany the proposals, approved sample consent documents, progress reports submitted by investigators, and reports of injuries to subjects;
  - Minutes of IRB meetings which shall be in sufficient detail to show attendance at the meetings; actions taken by the IRB; the vote on these actions including the number of members voting for, against, and abstaining; the basis for requiring changes in or disapproving research; and a written summary of the discussion of any controverted issues and their resolution;
  - Records of continuing review activities;

- Copies of all correspondence between the IRB and the investigators;
- Written procedures for the IRB in the same detail as required in 45 CFR 46.103(b)(4) and (5); and
- Statements of significant new findings provided to subjects, as required by 45 CFR 46.116(b)(5) (45 CFR 46.115(a)).

Guidance:

A. Introduction

This guidance is intended to assist IRBs in carrying out their continuing review responsibilities under 45 CFR part 46 by providing recommendations regarding, among other things, the approval criteria, process, and frequency for continuing review to assure the protection of the rights and welfare of human subjects participating in research. The guidance also is intended to help investigators and others involved in the review, conduct, or oversight of research better understand their responsibilities related to continuing review.

An institution (or when appropriate an IRB) must prepare and maintain written procedures for conducting continuing review (45 CFR 46.103(b)(4)). The purpose of these written procedures is to ensure that IRBs have a framework for periodically reviewing the conduct of research by investigators. While a research project is ongoing, the IRB reviews and considers proposed changes to the research as they are received, including protocol and consent form amendments. They also periodically receive and review reports of unanticipated problems involving risks to subjects or others (hereinafter referred to as “unanticipated problems”) and other information about the research. In general, IRB review of a proposed change to a research project or a report of unanticipated problems during the period for which approval is authorized does not constitute continuing review of the project as a whole. Although an IRB may become familiar with various individual aspects of the research project’s conduct, such familiarity does not relieve the IRB of the responsibility to conduct continuing review at least annually, which provides an opportunity to reassess the totality of the project and assure that, among other things, risks to subjects are being minimized and are still reasonable in relation to anticipated benefits, if any, to the subjects and the knowledge that is expected to result.

B. Key IRB Considerations When Evaluating Research Undergoing Continuing Review

1. Criteria for IRB Approval of Research Undergoing Continuing Review

HHS regulations set forth the criteria for IRB approval of research (45 CFR 46.111, 46.204-207, 46.305, and 46.404-409). These criteria apply to both initial review and continuing review of research and provide the framework for the IRB’s evaluation of research. In order to re-approve research at the time of continuing review, the IRB must determine that all of following requirements are satisfied:

- Risks to subjects are minimized (i) by using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes (45 CFR 46.111(a)(1));
- Risks to subjects are reasonable in relation to anticipated benefits, if any, to the subjects and the importance of the knowledge that may reasonably be expected to result (45 CFR 46.111(a)(2));

- Selection of subjects is equitable (45 CFR 46.111(a)(3));
- Informed consent will be sought from each prospective subject or the subject's legally authorized representative, and appropriately documented in accordance with, and to the extent required by, HHS regulations at 45 CFR 46.116 and 46.117, respectively (45 CFR 46.111(a)(4) and (5));
- When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects (45 CFR 46.111(a)(6));
- When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data (45 CFR 46.111(a)(7));
- Appropriate safeguards are included to protect subjects likely to be vulnerable to coercion or undue influence (45 CFR 46.111(b)); and
- When the research involves pregnant women, fetuses, or neonates; prisoners; or children, the research satisfies the additional requirements for IRB approval under HHS regulations at subpart B, C, or D, respectively, of 45 CFR part 46.

When conducting continuing review, the IRB should start with the working presumption that the research, as previously approved, does satisfy all of the above criteria. The IRB should focus on whether there is any new information provided by the investigator, or otherwise available to the IRB, that would alter the IRB's prior determinations, particularly with respect to the IRB's prior evaluation of the potential benefits or risks to the subjects. The IRB also should assess whether there is any new information that would necessitate revision of the protocol and/or the informed consent document. IRBs have the authority to disapprove or require modifications in (to secure re-approval of) a research activity that does not meet the above criteria (45 CFR 46.109(a)). If research does not satisfy all of the above criteria, the IRB must require changes that would result in research satisfying these criteria, defer taking action, or disapprove the research.

When conducting continuing review and evaluating whether research continues to satisfy the criteria for IRB approval of research, IRBs should pay particular attention to the following four aspects of the research:

- Risk assessment and monitoring;
- Adequacy of the process for obtaining informed consent;
- Investigator and institutional issues; and
- Research progress.

2. Risk Assessment and Monitoring

One of the most important considerations for the IRB at the time of continuing review is whether there is any new information provided by the investigator, or otherwise available to the IRB, that would alter the IRB's previous conclusion that (1) the risks to subjects are minimized, and (2) the risks to subjects are reasonable in relation to anticipated benefits, if any, to the subjects and the importance of the knowledge that may reasonably be expected to result (45 CFR 46.111(a)(1) and (2)). The IRB's continuing review procedures should ensure that the IRB will consider relevant information received since the date of the last IRB review and approval of the research project from the investigator, any monitoring entity (e.g., the research sponsor, a coordinating or statistical center, an independent medical monitor, a data and safety monitoring board (DSMB), or a data monitoring committee (DMC)), or any other source. Information regarding any unanticipated problems that have occurred since the previous IRB review in most cases will be pertinent to the

IRB's determinations at the time of continuing review regarding the risk-benefit relationship of the research (see OHRP's *Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events* at http://www.hhs.gov/ohrp/policy/advevntguid.html).

It also may be appropriate for the IRB at the time of continuing review to confirm that any provisions under the previously approved protocol for monitoring the research data to ensure safety of subjects (45 CFR 46.111(a)(6)) have been implemented and are working as intended (e.g., the IRB could require that the investigator provide a report from the monitoring entity described in the IRB-approved protocol).

3. Evaluating the Adequacy of the Informed Consent Process

At the time of continuing review, the IRB should review a copy of the sample informed consent document submitted by the investigator to verify that the investigator is using the most recently approved version and that the document contains the most accurate, up-to-date information about the research. OHRP recommends that IRBs consider using methods that will allow the IRB to readily recognize the most current version of the IRB-approved informed consent document, for example, using date stamps, version numbers, or initialing and dating documents to indicate when a version was approved.

Likewise, if the IRB waived the requirement for the investigator to obtain a signed consent form for some or all subjects (45 CFR 46.117(c)), the IRB should assess the accuracy of the content of the information being provided to subjects orally and of any written statement regarding the research that is being provided to subjects.

When reviewing an informed consent document, the IRB must ensure that the currently approved or proposed consent document adequately addresses the elements of informed consent required under 45 CFR 46.116(a) and (b). The IRB should be particularly attentive to whether the informed consent document provides an accurate and up-to-date description of the reasonably foreseeable risks and discomforts of the research to the subjects (45 CFR 46.116(a)(2)) and any appropriate alternative procedures or courses of treatment that might be advantageous to the subject (45 CFR 46.116(a)(4)).

The IRB also should assess whether there is any new information presented by the investigator or others (for example, subjects or other individuals who have observed the investigator obtaining subjects' informed consent) that raises concerns about the circumstances under which informed consent is being obtained. For example, the IRB should assess whether there is any new information indicating that the investigator may not be obtaining informed consent under circumstances that provide subjects with sufficient opportunity to consider whether or not to participate or that minimize the possibility of coercion or undue influence (see 45 CFR 46.116).

As part of the process for obtaining informed consent, subjects must be provided, when appropriate, with a statement that significant new findings developed during the course of the research which may relate to the subjects' willingness to continue participation will be provided to the subjects (45 CFR 46.116(b)(5)). Continuing review provides the IRB with an opportunity to determine whether there is any new information that should be considered to represent such a significant new finding and therefore be communicated to subjects who have already enrolled in the research (e.g., important new toxicity information or new adverse event information related to the research interventions that is identified during analysis of the research data; or new information regarding alternative treatments that have become available and may be advantageous to the subjects).

4. Evaluating Investigator and Institutional Issues

When appropriate, the reviewing IRB should consider issues regarding the investigator and the institution(s) where the research is being conducted during its continuing review, such as the following:

- Changes in the investigator's situation or qualifications (e.g., suspension of hospital privileges, change in medical license status, or increase in number of research studies conducted by the investigator);
- Evaluation, investigation, and resolution of any complaints related to the investigator's conduct of the research;
- Changes in the acceptability of the proposed research in terms of institutional commitments (e.g., personnel and financial resources, adequacy of facilities) and applicable regulations, State and local law, or standards of professional conduct or practice; and
- Reports from any third party observations of the research carried out under 45 CFR 46.109(e).

5. Evaluating Research Progress

This section discusses three considerations for when the IRB evaluates the progress of a research study.

Confirmation that Continuing Review Information is Consistent with the IRB-approved Protocol

The IRB should confirm that the information provided by the investigator at the time of continuing review is consistent with the research protocol previously approved by the IRB. If this information suggests that the investigator is not conducting the research in accordance with either the IRB-approved protocol or the requirements or determinations of the IRB, the IRB should either defer re-approving the research or re-approve the research for a limited period of time (e.g., one month) and seek an explanation from the investigator regarding the apparent discrepancies.

Total Subject Enrollment

As part of its initial review of a research project, the IRB typically will have approved a protocol that includes the expected total number of subjects to be enrolled by the investigator and the expected rate of enrollment. Evaluating information about the number of subjects enrolled in the research at the time of continuing review may allow the IRB to ascertain whether enrollment is consistent with the planned number of subjects described in the IRB-approved protocol. A marked difference between the actual and expected rates of enrollment may indicate a problem with the research project that requires further evaluation, including whether the research project is likely to provide sufficient data to answer the scientific question(s) being posed.

Subject Withdrawals

Subjects may discontinue their participation in research at any point for various reasons (e.g., serious adverse events, conflicts with the investigators, transportation problems, etc.).

The IRB's continuing review procedures in general should provide for review of:

- The number of subjects who discontinued their participation; and
- A summary of the reasons for the withdrawals, if known.

IRB review of this information may shed light on problems related to the conduct of the research. For example, a high rate of subject withdrawal secondary to serious adverse events may indicate that the risks of the research are greater than expected and may lead the IRB to conclude that the research should not be approved for continuation because the risks to subjects are not being minimized or are not reasonable in relation to the anticipated benefits to the subjects and the

importance of the knowledge that may reasonably be expected to result (45 CFR 46.111(a)(1) and (2)).

C. Process for Conducting Continuing Review

1. Key Procedural Requirements for Continuing Review Conducted by the IRB at Convened Meetings

Continuing review must take place at a convened meeting at which a majority of the IRB members are present, including at least one member whose primary concerns are in nonscientific areas, unless the research qualifies for review under an expedited review procedure (45 CFR 46.108(b)). In order for research undergoing continuing review to be approved by the IRB at a convened meeting, it must receive the approval of a majority of those members present at the meeting (45 CFR 46.108(b)). Should the quorum fail during a meeting (e.g., loss of a majority through exclusion (i.e., recusal) of members with conflicting interests or early departures of members, or absence of a nonscientist member), the IRB may not take further actions or votes for research projects undergoing continuing review unless the quorum can be restored (45 CFR 46.108(b)).

The IRB must ensure that no member participates in the IRB's continuing review of any research project in which the member has a conflicting interest, except to provide information requested by the IRB (46 CFR 46.107(e)).

For each research project undergoing continuing review, the minutes of IRB meetings must be in sufficient detail to show actions taken by the IRB; the vote on these actions, including the number of members voting for, against, and abstaining; the basis for requiring changes in or disapproving the research; and a summary of the discussion of controverted issues and their resolution. (45 CFR 46.115(a)(2)). OHRP recommends that the recusal of IRB members because of a conflicting interest also be documented when recording votes on IRB actions. The following examples demonstrate one acceptable format for documenting in the minutes the votes on actions taken by the IRB on research projects undergoing continuing review:

- Total = 15; Vote: For-14, Opposed-0, Abstained-1.
- Total = 14 (1 member recused and did not vote); Vote: For-12, Opposed-2, Abstained-0.

2. Key Procedural Requirements for Continuing Review Conducted Under an Expedited Review Procedure

When continuing review of research is conducted under an expedited review procedure, the review must be conducted by the IRB chairperson or one or more experienced reviewers designated by the IRB chairperson from among the IRB members (45 CFR 46.110(b)). The IRB must have procedures in place to ensure that no IRB member participates in the expedited review of research in which the member has a conflicting interest, except to provide information requested by the chairperson or his/her designee(s) (46 CFR 46.107(e)). The IRB chairperson or IRB members designated by the chairperson only can approve or require modification in (to secure approval of) research, but may not disapprove research using the expedited procedures (45 CFR 46.110(b)). Disapproval of a research project at the time of continuing review can only occur after review by the IRB at a convened meeting, not by the expedited review process. All IRB members must be advised of research that has been approved under an expedited review procedure (45 CFR 46.110(c)).

See section E below for additional guidance regarding when an expedited review procedure may be used to conduct continuing review.

3. Written Procedures for Conducting Continuing Review

An institution (or when appropriate an IRB) must prepare and maintain – and the IRB must follow – written procedures for the continuing review of research (45 CFR 46.103(b)(4), 46.108(a), and 46.115(a)(6)). OHRP recommends that written procedures for continuing review describe the following:

- The procedures for informing investigators about their responsibilities related to continuing review under the HHS regulations at 45 CFR part 46 and the IRB's own policies and procedures on continuing review requirements;
- The list of documents to be submitted by investigators at the time of continuing review, the time frame for submitting these documents to the IRB, and the procedure for requesting these documents from the investigator (see sections C.4 and G below for further guidance);
- The list of specific documents distributed or made available to primary reviewers (if applicable) and to all other IRB members (see sections C.4 and C.5 below for further guidance);
- Any primary reviewer system used (see section C.6 below for further guidance);
- Any process (e.g., an administrative review process by IRB staff or a subcommittee review procedure) that may be used to supplement the IRB's continuing review (see section C.7 below for further guidance);
- For research requiring continuing review at a convened meeting, the timing of document distribution prior to IRB meetings;
- The range of possible IRB actions taken on research projects undergoing continuing review (see section C.9 below for further guidance);
- How continuing review under an expedited review procedure is conducted and how expedited approval actions are communicated to all IRB members;
- The procedures for:
    - Communicating to investigators IRB actions regarding continuing review of research and any changes or clarifications required by the IRB as a condition of IRB approval; and
    - Reviewing and acting upon investigators' responses to the IRB's requests for changes or clarifications;
- Which institutional office(s) and official(s) are notified of IRB findings and actions regarding continuing review and how notification to each is accomplished;
- The procedures for how the IRB determines the effective date of IRB approval following initial review of a research study and communicates this effective date and the initial period of approval to the investigator (see section G below for guidance regarding how to determine the effective date of initial IRB approval);
- The procedures for how the IRB determines continuing review dates for a research study (including whether the IRB follows a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals) and communicates the period of approval following continuing review to the investigator (see section G below for guidance regarding how to determine continuing review dates);
- A procedure for how the IRB determines which protocols require review more often than annually, including specific criteria used to make these determinations (e.g., an IRB may set a shorter approval period for high-risk protocols or protocols with a high risk:potential benefit ratio; see section F below for additional guidance on determining the frequency of continuing review); and

- A procedure for how the IRB determines which projects need verification from sources other than the investigators (e.g., an independent study audit) that no material changes have occurred since previous IRB review, including specific criteria used to make these determinations (e.g., such criteria could include some or all of the following: (a) randomly selected projects; (b) complex projects involving unusual levels or types of risk to subjects; (c) projects conducted by investigators who previously have failed to comply with the requirements of the HHS regulations at 45 CFR part 46 or the requirements or determinations of the IRB; and (d) projects where concern about possible material changes occurring without IRB approval have been raised based upon information provided in continuing review reports or from other sources).

4. Submission of Documents to the IRB

Investigators are responsible for fulfilling requirements associated with continuing review in time for the IRB to carry out continuing review prior to the expiration date of the current IRB approval. In particular, investigators are responsible for submitting sufficient materials and information for the IRB to meet its regulatory obligations, and should follow the institutional policies and procedures for continuing IRB review of research that are required by 45 CFR 46.103(b)(4) and referenced in the institution's OHRP-approved Federalwide Assurance (FWA). OHRP recommends that institutions have written procedures for continuing review that require investigators to submit the following documents, as applicable, if not already available to the IRB as part of the existing IRB records for the research:

- A brief project summary (this could be included as part of a progress report described in the next bullet, provided as a separate document, or be addressed by referencing other documents made available to the IRB, including the informed consent document(s));
- A progress report that includes the following:
  - The number of subjects accrued (for multicenter research studies, the number of subjects accrued at the local institution and the number accrued study-wide, if available, should be provided);
  - A brief summary of any amendments to the research approved by the IRB since the IRB's initial review or the last continuing review;
  - Any new and relevant information, published or unpublished, since the last IRB review, especially information about risks associated with the research (note that OHRP does not expect the IRB to perform an independent review of the relevant scientific literature related to a particular research project undergoing continuing review; this responsibility rests with the investigators and any monitoring entity for the research);
  - A summary of both any unanticipated problems and available information regarding adverse events (the amount of detail provided in such a summary will vary depending on the type of research being conducted; in many cases, such a summary could be a brief statement that there have been no unanticipated problems and that adverse events have occurred at the expected frequency and level of severity as documented in the research protocol, the informed consent document, and investigator's brochure (if applicable); see OHRP's *Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events* at http://www.hhs.gov/ohrp/policy/advevntguid.html);
  - A summary of any withdrawal of subjects from the research since the last IRB review, and the reasons for withdrawal, if known; and

  - A summary of any complaints about the research from subjects or others since the last IRB review;
- The latest version of the IRB-approved protocol and sample informed consent document(s);
- Any proposed modifications to the informed consent document or protocol;
- For FDA-regulated research, the current Investigator's Brochure, if available, including any modifications; and
- Any other significant information related to subject risk, such as the most recent report from any DSMB or DMC monitoring the research, if available. Even when the DSMB or DMC has identified no problems during its review and simply recommended continuation of the research study as designed, it may be useful for the IRB to be informed of this recommendation.

In developing procedures for continuing review, the IRB might consider use of templates, checklists, or other tools to standardize the request for information or list of materials to be provided to the IRB by investigators at the time of continuing review.

5. Distribution and Availability of Documents for Review by IRB Members

An IRB that is conducting continuing review of research should be familiar with, and have access to, all IRB records related the research, including those associated with the initial review and approval and any other previous reviews, including ad hoc and scheduled continuing reviews and any reviews of amendments to the research or unanticipated problems. For continuing review of research at a convened meeting, IRB members should receive appropriate materials sufficiently in advance of the meeting to allow adequate time for review.

OHRP recommends that for continuing review of a research study not eligible for expedited review all IRB members receive and review copies of the progress report described in the preceding section and the current IRB-approved informed consent document or any newly proposed consent document. At least one member of the IRB (e.g., a primary reviewer; see next section) should have available, for review as needed, the complete IRB file, including the complete protocol, relevant IRB meeting minutes, and any additional documents submitted by the investigator with the continuing review progress report. The complete IRB file also should be made available upon request to any IRB member prior to the meeting at which the research is to be reviewed and should be accessible during the meeting to allow members to resolve any questions that may arise during the IRB's deliberations.

When conducting continuing review of research under an expedited review procedure, the IRB chairperson (or designated IRB member(s)) should receive and review copies of the progress report described in the preceding section, the current IRB-approved informed consent document, and any newly proposed consent document, and have available, for review as needed, all of the above-referenced documentation, including the complete IRB protocol file.

6. Primary Reviewers

IRBs may adopt a variety of procedures to reduce burdens and allow the IRB to efficiently accomplish its continuing review workload. One such commonly-adopted procedure is the use of primary reviewers for continuing review of research at convened IRB meetings. Typically, primary reviewers are members of the IRB with appropriate expertise designated to perform primary review of IRB records related to research undergoing continuing review, provide an oral or written summary to the other IRB members, and lead the discussion at the convened IRB meeting. The primary reviewer's summary might highlight any critical issues for consideration by the IRB, identify any key changes being proposed by the investigator, and include recommendations for action by the IRB. A

typical primary reviewer's summary might note that no issues of concern have arisen since the prior IRB review, no changes are being proposed by the investigator, adverse events are of the type and frequency expected, the research appears to satisfy all criteria required for approval under 45 CFR 46.111 (and subparts B, C, and D when applicable), and the primary reviewer recommends approval without any stipulated changes.

7. Involvement of IRB Staff in Preliminary Review

Appropriately trained IRB staff members, regardless of whether they are members of the IRB, may perform preliminary reviews of continuing review documents and complete IRB files in order to facilitate the continuing review of research by the IRB. As part of this preliminary review, IRB staff may perform the following functions, among others:

- Confirm that all documents required by the IRB have been submitted by the investigator;
- Assess whether the information and documents submitted by the investigator are consistent with the research protocol previously approved by the IRB;
- Confirm that the informed consent document submitted by the investigator matches the current IRB-approved informed consent document;
- Aid the IRB in identifying important issues and concerns that the IRB may wish to consider; and
- Provide technical assistance and guidance to the IRB at convened meetings and to the IRB chairperson (or designated IRB member(s)) during an expedited review process.

IRB staff members who are *not* IRB members may not be delegated responsibility for making the determinations that must be made by the IRB at the time of continuing review (see sections B, C.1 and C.2 above) and may not approve research on behalf of the IRB (45 CFR 46.109).

8. Procedures for Continuing Review Deliberations During IRB Meetings

Research studies undergoing continuing review by the IRB at convened meetings should be considered and discussed individually. Furthermore, OHRP recommends that the IRB act and vote on research studies individually. If an IRB adopts a procedure under which the IRB votes on groups of studies (sometimes called "block voting") undergoing continuing review, such a procedure must provide IRB members with the ability to vote "yes" on some studies, "no" on others, and abstain on others (45 CFR 46.108(b)).

As previously noted, no IRB member may participate in the review of research in which the member has a conflicting interest, except to provide information requested by the IRB (45 CFR 46.107(e)). Individual consideration of, and voting on actions related to, research projects during continuing review will help to ensure that members with a conflicting interest related to a particular study do not participate in the IRB's continuing review of that study, except to provide information requested by the IRB.

OHRP recommends that minutes of IRB meetings document by name any member who had a conflicting interest in a research study and therefore was excluded (i.e., recused) from participation in the IRB's continuing review of that study, except to provide any information requested by the IRB. OHRP further recommends that, except when requested by the IRB to be present to provide information, IRB members absent themselves from the meeting room when the IRB conducts continuing reviews of research in which they have a conflicting interest, and that such also be noted in the minutes of the IRB meeting.

When conducting continuing review of a research project, the IRB, at its discretion, may invite individuals with competence in special areas to assist in the review of issues which require expertise

beyond or in addition to that available to the IRB. The input of such expert consultants may be provided through (a) submission of written reports to the IRB prior to the IRB meeting at which a research project for which consultation was sought is to be reviewed and/or (b) the attendance and participation (either in person or by telephone or videoconference) of the expert consultants in the deliberations at the IRB meeting. These individuals may not vote with the IRB (45 CFR 46.107(f)), and their attendance at an IRB meeting must be documented in the minutes of the IRB meeting if they attend the meeting (45 CFR 46.115(a)(2)). OHRP recommends that the minutes of the meeting also document the role any expert consultant played in the IRB's review.

The amount of time the IRB spends on the continuing review of a particular research project at a convened meeting will vary depending on the nature and complexity of the research, the amount and type of new information presented to the IRB by the investigator, and whether the investigator is seeking approval of substantive changes to the research protocol or informed consent document. For many research projects, continuing review can be fairly straightforward, and the IRB should be able to complete its deliberations and approve the research within a brief period of time.

For example, consider the continuing review by the IRB of a randomized clinical trial for which the investigator reports the following:

- The research is proceeding in accordance with the IRB-approved protocol;
- The rate of subject enrollment is as expected;
- There have been no unanticipated problems;
- The rate and pattern of adverse events is as expected;
- No subjects have complained about the conduct of the research or withdrawn from the research;
- There is no new published or unpublished information that would alter the IRB's prior determinations, particularly with respect to the IRB's prior evaluation of the potential benefits and risks to the subjects and the informed consent process; and
- No changes to the protocol or informed consent document are needed.

In the absence of any concern about the research being raised by the IRB member assigned to be the primary reviewer or by any other IRB member present at the IRB meeting, the IRB should be able to complete its continuing review deliberations for such a research project within a brief period of time. In this example, deliberations that included the following brief series of steps would be sufficient:

- The primary reviewer provides a brief synopsis of the research and a statement that:
    - No concerning issues have arisen since the prior IRB review and approval;
    - No changes to the project are being proposed by the investigator;
    - Adverse events in subjects have been of the type and frequency expected;
    - The research appears to continue to satisfy all criteria for approval under the regulations at 45 CFR 46.111 (and subparts B, C, and D, when applicable); and
    - The reviewer recommends approval without any conditions.
- The IRB chairperson calls for a motion on the project;
- The primary reviewer makes a motion to approve the research without conditions and another member seconds the motion;
- The IRB chairperson makes a request for discussion by the IRB members; and

- Following any discussion, the IRB chairperson calls for a vote on the motion to approve the project without conditions.

On the other hand, consider the continuing review of a randomized clinical trial for which the investigator reports the following:

- The rate of serious adverse events occurring in subjects is significantly higher than expected;
- A recently completed research project reported in the literature identified previously unrecognized risks for the same experimental intervention being tested in the clinical investigator undergoing continuing review;
- The investigator is proposing several substantive revisions to the protocol in response to the new risk information, including the addition of new exclusion criteria and new safety monitoring procedures for subjects; and
- The investigator is proposing substantive changes to the informed consent document to add a description of the new information regarding reasonably foreseeable risks.

In these circumstances the IRB would need to spend significantly more time at the convened meeting on its continuing review of the research as it carefully reassesses whether the risks to subjects still are minimized and reasonable in relation to the to anticipated benefits, if any, to the subjects and the knowledge that is expected to result, given the new information presented by the investigator. The IRB also would need to assess whether the changes to the protocol and informed consent document proposed by the investigator are appropriate and adequate, or whether additional changes should be required.

9. Approving Research with Conditions at the Time of Continuing Review

Given the authorities that IRBs have under HHS regulations at 45 CFR 46.109(a), when conducting either initial or continuing review of a research study, an IRB can take any of the following actions:

- Approve the research study either (a) as submitted without any conditions, or (b) with conditions;
- Require modifications to secure approval and defer or table the research study for further review at a future date after the required modifications are submitted by the investigator (see section H for a discussion of how to handle lapses in IRB approval); or
- Disapprove the research study.

With respect to the first action listed above, by *IRB approval with conditions* (sometimes also referred to as “conditional approval” or “contingent approval”) in the context of continuing review, OHRP means that at the time when the IRB reviews and re-approves a research study, the IRB as a condition of approval requires that the investigator (a) make specified changes to the research protocol or informed consent document(s), (b) confirm specific assumptions or understandings on the part of the IRB regarding how the research will be conducted, or (c) submit additional documents, such that, based on the assumption that the conditions are satisfied, the IRB is able to make all of the determinations required for approval under the HHS regulations at 45 CFR 46.111 and, if applicable, subparts B, C, or D of 45 CFR part 46. With respect to research reviewed and approved with conditions by the IRB at a convened meeting, note that because the IRB is able to make all these determinations, the IRB may designate the IRB chairperson (and/or other individual(s) with appropriate expertise or qualifications) to review responsive materials from the investigator and determine that the conditions have been satisfied, and further review by the IRB at a subsequent convened meeting would not be necessary.

When approving research with conditions at the time of continuing review, the IRB should be careful

to specify whether any conditions need to be satisfied before an investigator can continue particular research activities related to those conditions. For example, if at the time of continuing review, the IRB requires the investigator to change the research protocol to include a specific new procedure for screening prospective subjects, the IRB could approve the research with the following condition: research activities involving currently enrolled subjects may continue, but no new subjects may be enrolled until a designated IRB member reviews a revised protocol and verifies that the protocol includes the new screening procedure. Note that OHRP would not consider such a suspension of subject enrollment at the time of continuing review to be a suspension of IRB approval that needs to be reported to appropriate institutional officials, the head (or designee) of the agency conducting or supporting the research, or OHRP under HHS regulations at 45 CFR 46.103(a) and 46.103(b)(5).

For guidance regarding how to determine the effective date of initial IRB approval and the subsequent continuing review dates, see section G below. For additional guidance on IRB approval of research with conditions, see OHRP's *Guidance on IRB Approval of Research with Conditions* at http://www.hhs.gov/ohrp/policy/conditionalapproval2010.html.

10. Additional Considerations Regarding Continuing Review Using an Expedited Review Procedure

When conducting continuing review under an expedited review procedure, the IRB chairperson or other member(s) designated by the chairperson, at their discretion, may invite individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available to the IRB (45 CFR 46.107(f)). OHRP recommends that in such cases the IRB records document the involvement of such expert consultants in the expedited review. However, only the IRB chairperson or experienced IRB members designated by the chairperson may carry out continuing review and approve research under the expedited review procedure.

An IRB administrator or staff member who is also an experienced member of the IRB may be designated by the IRB chairperson to conduct continuing review of research under an expedited review procedure.

OHRP also recommends that documentation for continuing reviews conducted under an expedited review procedure include:

- The specific categories permitting the expedited review; and
- Documentation of the review and action taken by the IRB Chairperson or designated reviewer.

See section E below for additional guidance regarding when an expedited review procedure may be used to conduct continuing review and recommendations regarding using an expedited review procedure to conduct continuing review when the only remaining human subjects research activities are limited to data analysis.

11. Using a Different IRB to Conduct Continuing Review

The IRB that conducted the initial review of a research project may be best suited to conduct continuing review of that project because of its familiarity with the research. However, an IRB other than the one that conducted the initial or other prior reviews of a research project may conduct continuing review of the project, as long as the IRB conducting the continuing review has members with appropriate experience and expertise and access to all prior relevant IRB records.

OHRP is aware that some institutions have designated one or more IRBs for the sole purpose of conducting continuing review. Such a practice is permissible under the HHS regulations for the protection of human subjects at 45 CFR part 46, as long as such IRBs satisfy the IRB membership

requirements under 45 CFR 46.107 and fulfill the regulatory requirements for conducting continuing review referenced in this document.

D. Additional Considerations for Continuing Review of Multicenter Research Projects

When the HHS human subjects protection regulations at 45 CFR part 46 were first issued in 1974, the single investigator-single institution project was the norm, and reporting requirements to IRBs were almost entirely and appropriately fulfilled by the investigator, who was in a position to know about all aspects of the research project. Since that time, research projects involving multiple institutions (hereafter referred to as "multicenter research projects") have become commonplace. Although an individual investigator at a particular institution involved in a multicenter research project informs the local IRB at that institution about events related to subjects enrolled at that institution, the investigator and IRB are not likely to be well-informed about the progress of the research project across all institutions involved in the research. Consequently, IRB review and oversight of such research has become more challenging.

1. Multiple Institutions Relying on Local IRBs for Continuing Review

For many multicenter research projects, most institutions involved in the research choose to rely upon an internal IRB operated by the institution (hereinafter referred to as a "local IRB") for both initial and continuing review of such projects.

As noted above in section C.4, OHRP recommends that institutions have written procedures for continuing review that require investigators to submit to the IRB at the time of continuing review a progress report that includes, among other things, summaries of any unanticipated problems, available information regarding adverse events, and any withdrawals of subjects or complaints about the research from subjects or others since the last IRB review. For continuing review of multicenter research at a particular institution, OHRP recommends that the local investigator include in the progress report a summary of such events for subjects who participated at that institution.

OHRP recognizes that local investigators participating in multicenter research projects usually are unable to prepare a meaningful summary of project-wide information, including information on adverse events, subject withdrawals, and complaints about the research, for their local IRBs because such project-wide information is not readily available to them. In such circumstances, when the research project is subject to oversight by a monitoring entity (e.g., the research sponsor, a coordinating or statistical center, or a DSMB/DMC), OHRP recommends that at the time of continuing review local investigators submit to their local IRBs the most current report from the monitoring entity, if available. Such monitoring entities are in the unique position of having information for the entire project that may assist the IRBs in reviewing the research and protecting subjects. OHRP further recommends that such reports include the following:

- A statement indicating what information (e.g., project-wide adverse events, subject withdrawals, complaints about the research, interim findings, and any recent literature that may be relevant to the research) was reviewed by the monitoring entity;
- The date of the review; and
- The monitoring entity's assessment of the information reviewed.

The local IRB has authority to require that such a report be submitted by the investigator and also may ask the monitoring entity directly to provide such a report (45 CFR 46.102(h) and 46.109(a)).

As discussed in section B.5 above, the IRB should evaluate information about the number of subjects enrolled in the research at the time of continuing review because a marked difference between the actual and expected rates of enrollment may indicate a problem with the project that

requires further evaluation. When the local IRB at one institution is evaluating subject enrollment based on information provided by the local investigator, it may discover a much lower than expected rate of enrollment at that institution. In the absence of project-wide data being available to the IRB, such information may be indicative of lagging enrollment at that one local institution or at all institutions. In these circumstances, the local IRB should consider seeking additional information regarding project-wide enrollment. Project-wide enrollment data may indicate that there is sufficient rationale to continue the research project at the local institution despite low local enrollment because project-wide enrollment is progressing at the expected rate. Similar considerations would also apply to the local IRB's review of local subject withdrawals.

For any particular institution that chooses to rely upon a local IRB, continuing review of a multicenter research project by the local IRB at that institution must occur at least annually as long as the institution remains engaged in human subjects research activities involving the project (45 CFR 46.109(e)). Once the institution is no longer engaged in human subjects research activities under the project, there is no need for continuing review by the local IRB, even if human subjects research activities are occurring at other institutions. For example, consider a multicenter clinical trial in which the following conditions exist with respect to institution A:

- The research is permanently closed to enrollment at the institution;
- All subjects enrolled at the institution have completed all-research related interventions and interactions, including interventions and interactions related to collection of long-term follow-up data;
- No additional identifiable private information about the subjects is being obtained by investigator at the institution; and
- The statistical center at another institution will conduct the analysis of all study data that includes identifiable private information about the subjects enrolled at institution A.

In these circumstances, the local IRB for institution A does not need to conduct any additional continuing review of the research project. This is the case even if the overall study results base has not been locked, such that there is the possibility that the statistical center at the other institution may query the investigators at institution A about previously collected data about the subjects enrolled at institution A. (Note that once the study results base for a study has been locked, no further changes can be made to the data set, and the only remaining activity is analysis of aggregate data.)

On the other hand, the local IRBs relied upon by other institutions where investigators continue to enroll subjects, intervene or interact with subjects, obtain identifiable private information about subjects, or analyze identifiable private information in accordance with the IRB-approved protocol would need to conduct continuing review of the research project at least annually.

2. Implementation of Cooperative IRB Review Arrangements for Continuing Review, Including Use of Central IRB Procedures

In the conduct of multicenter research projects, each institution engaged in the project is responsible for safeguarding the rights and welfare of human subjects and for complying with the requirements of 45 CFR part 46 (45 CFR 46.114). For multicenter research projects, an institution participating in the project may enter into a joint IRB review arrangement, rely on the review of a qualified IRB at another participating institution, or make similar cooperative IRB review arrangements for avoiding duplication of effort (45 CFR 46.114). These cooperative IRB review arrangements can be used for both initial and continuing review. OHRP encourages institutions engaged in multicenter research projects to utilize cooperative IRB review arrangements whenever it is appropriate and feasible to do so.

When an institution holding an OHRP-approved FWA relies upon an IRB operated by another institution or organization (i.e., an "external IRB") to review HHS-conducted or -supported research, the institution holding the FWA must execute an IRB Authorization Agreement (see http://www.hhs.gov/ohrp/assurances/forms/iprotsup.rtf) with the institution or organization operating the IRB (45 CFR 46.103(a) and 46.103(b)(2)); also see the Terms of the FWA at http://www.hhs.gov/ohrp/assurances/assurances/filasurt.html#sectiona). Furthermore, when review responsibilities for a multicenter research project are shared across multiple IRBs under a cooperative review arrangement, OHRP recommends that the IRB Authorization Agreements or other written documents identify the responsibilities covered by the agreement and who is responsible for them.

It is important to note that each institution holding an OHRP-approved FWA has a responsibility to ensure that the IRBs upon which it relies collectively possess sufficient knowledge of the local research context for the research that they review on behalf of the institution.

Cooperative IRB review arrangements for a multicenter research project may vary with respect to how continuing review will be carried out. For example, all institutions engaged in a multicenter research project could designate the same IRB to conduct all aspects of continuing review on behalf of all institutions. Alternatively, all institutions engaged in a multicenter research project could assign the same IRB the primary responsibility for continuing review of the research with respect to the assessment of project-wide information, but assign responsibility for assessment of local issues to each institution's local IRB. In both examples, the IRB that all institutions rely upon either partially or completely is commonly referred to as a "central IRB."

During its continuing review of a multicenter research project, a central IRB typically is responsible for reviewing a standard, project-wide protocol and the model/template informed consent document(s) that are distributed to investigators at all institutions engaged in the research. Depending on the nature of the cooperative IRB review arrangement, a central IRB at the time of continuing review also may be responsible for reviewing and approving the actual informed consent documents in use at one or more (or even all) institutions. If a central IRB conducting continuing review is responsible for the assessment of local issues, the central IRB should supplement its procedures as appropriate to ensure that local issues are addressed. For example, a central IRB should ask the local investigators or institutional officials for each institution relying on the central IRB to provide information related to subject withdrawals or complaints about the research. A central IRB's review of this information may shed light on problems related to the conduct of the research at a particular institution.

Whenever multiple institutions rely upon a central IRB to conduct continuing review of a multicenter research project that is overseen by a monitoring entity (e.g., the research sponsor, a coordinating or statistical center, or a DSMB/DMC the project sponsor), OHRP recommends that the central IRB obtain a report describing project-wide information from that monitoring entity. Such monitoring entities are in the unique position of having information for the entire project that may assist the IRB in reviewing the research project and protecting subjects. The central IRB has authority to require that such a report be submitted by the investigators and also may ask the monitoring entity directly to provide such a report (45 CFR 46.102(h) and 46.109(a)). OHRP recommends that such reports include the same information as noted in section D.1 above.

E. When Expedited Review Procedures May Be Used by an IRB for Continuing Review

- **General Considerations**

IRBs may use an expedited review procedure to conduct continuing review of research projects that:

- Involve only procedures described in one or more of the nine categories of research activities published in the Federal Register (see 63 FR 60364-60367, November 9, 1998, also available at http://www.hhs.gov/ohrp/policy/expedited98.html); and
- Are found by the reviewers to involve no more than minimal risk to the subjects (45 CFR 46.110(b)).

Expedited review categories (1) to (7) apply to both initial and continuing review, whereas expedited review categories (8) and (9) apply only to continuing review.

In general, a research study that was eligible for initial review under an expedited review procedure will qualify for an expedited review procedure at the time of continuing review. However, IRBs should be aware that a research study previously approved under an expedited review procedure in some circumstances will need to undergo continuing review by the IRB at a convened meeting. For example, the investigator at the time of continuing review may propose changes to the research project that involve the addition of activities that do not fall within the scope of any of the categories of research activities eligible for an expedited review procedure.

Likewise, a research project that was *not* eligible for initial review under an expedited review procedure usually will *not* qualify for an expedited review procedure at the time of continuing review, except in the following limited circumstances:

- The research project involves only activities described by expedited review categories (8) or (9); or
- Research project previously approved by the IRB at a convened meeting progresses to the stage where all of the remaining human subjects research activities involve no more than minimal risk to the subjects and fall within the scope of one or more of expedited review categories (2) through (7).

2. Expedited Review Category (8)

Under category (8), an expedited review procedure may be used for the continuing review of research previously approved by the IRB at a convened meeting as follows:

(a) Where (i) the research is permanently closed to the enrollment of new subjects; (ii) all subjects have completed all research-related interventions; and (iii) the research remains active only for long-term follow-up of subjects; **OR**
(b) Where no subjects have been enrolled and no additional risks have been identified; **OR**

- Where the remaining research activities are limited to data analysis.

For a multicenter research project, an expedited review procedure may be used by the IRB for a particular institution whenever the conditions of category (8)(a), (b), or (c) are satisfied for that institution. As a result, for some institutions involved in the conduct of a multicenter research project, the IRBs reviewing the project may need to conduct continuing review of the project at a convened meeting, whereas for other institutions, the IRBs may conduct continuing review using an expedited review procedure under category (8).

Expedited review category (8)(a) and the meaning of "long-term follow-up"

Under expedited review category (8)(a), OHRP interprets "long-term follow-up" to include:

- Research *interactions* that involve no more than minimal risk to subjects (e.g., quality of life surveys); and

- Collection of follow-up data from procedures or interventions that would have been done as part of routine clinical practice to monitor a subject for disease progression or recurrence, regardless of whether the procedures or interventions are described in the research protocol.

In contrast, OHRP interprets "long-term follow-up" to exclude:

- Research *interventions* that would not have been performed for clinical purposes, even if the research interventions involve no more than minimal risk.

However, some research studies that are not eligible for expedited review under category (8)(a) at the time of continuing review may be eligible for expedited review under one of the other expedited review categories. For example, if a research project's only remaining activity involves long-term follow-up of subjects by drawing 15 ml of blood once annually for a test that is not part of routine clinical practice, such research would not be eligible for expedited review under category (8)(a), but might be eligible for expedited review under category (2).

Expedited review category (8)(b)

With respect to category (8)(b), while the criterion that "no subjects have been enrolled" is interpreted by OHRP to mean that no subjects have ever been enrolled at a particular institution, the criterion that "no additional risks have been identified" is interpreted to mean that neither the investigator nor the IRB at a particular institution has identified any additional risks from any institution engaged in the research project or from any other relevant source since the IRB's most recent prior review.

Expedited review category (8)(c) and data analysis

OHRP considers a research study to continue to involve *human subjects* as long as the investigators conducting the research continue to obtain: (1) data about the subjects of the research through intervention or interaction with them; or (2) identifiable private information about the subjects of the research (45 CFR 46.102(f)). OHRP interprets *obtaining identifiable private information* to include an investigator's use, study, or analysis of identifiable private information. Therefore, as long as a non-exempt human subjects research study continues to involve use, study, or analysis of identifiable private information by the investigators, the research continues to involve human subjects and must undergo continuing review by an IRB at least annually (45 CFR 46.109(e)), even if the participation of all subjects in a research project has been completed or discontinued. OHRP notes that simply maintaining individually identifiable private information without using, studying, or analyzing such information is not human subjects research and thus does not require continuing review.

Under expedited review category 8(c), an IRB may use an expedited review procedure to conduct continuing review when the only remaining human subjects research activity is the analysis of data that includes identifiable private information and the IRB chairperson (or another experienced IRB member designated by the chairperson) determines that this activity involves no more than minimal risk. OHRP expects that in nearly all cases such research activities will involve no more than minimal risk and therefore be eligible for IRB review under an expedited review procedure.

OHRP notes that the process for conducting continuing review of research under expedited review category (8)(c) can be accomplished through a simple, abbreviated process. For example, the investigator, as part of the continuing review process, could provide to the IRB the following statement regarding the research: "the study only involves data analysis, which is proceeding in accordance with the IRB-approved research protocol, and there are no problems to report." This statement could be provided by email or as part of a standard continuing review application form. Upon receipt of such a statement from the investigator, the IRB chairperson, or other member(s) designated by the chairperson, under the expedited review procedure may approve the continuation of the research project for another year without further deliberation or review.

For a multicenter research project, only the institution engaged in the ongoing data analysis activities (e.g., the institution operating the coordinating center or statistical center for the research project) needs to ensure that continuing review of the research by an IRB upon which the institution relies under its FWA occurs at least annually. Furthermore, when the data analysis activities progress to the point when they no longer involve analysis of identifiable private information (e.g., the overall study results base has been locked and the only remaining activity is analysis of aggregate data), further continuing review of the research is no longer required.

3. Expedited Review Category (9)

Under category (9), an expedited review procedure may be used for the continuing review of research previously approved by the IRB at a convened meeting that meets the following conditions:

- The research is not conducted under an investigational new drug application (IND) or an investigational device exemption (IDE);
- Expedited review categories (2) through (8) do not apply to the research;
- The IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk to the subjects; and
- No additional risks of the research have been identified

With regard to the third condition, the IRB at a convened meeting must have determined that either (a) the research project as a whole involved no more than minimal risk, or (b) the remaining research activities involving human subjects present no more than minimal risk to the subjects. This determination, particularly with respect to (a), could occur as early as the convened IRB meeting at which the IRB conducted its initial review.

With regard to multicenter research projects, the fourth condition that “no additional risks have been identified” is interpreted by OHRP to mean that neither the investigator nor the IRB at a particular institution has identified any additional risks from any institution engaged in the research project or from any other relevant source since the IRB’s most recent prior review.

The following are two examples of research eligible for expedited review under category (9):

- A research study is designed to evaluate the effects of urban pollution on pulmonary status in healthy adults. The study is not conducted under an IND or IDE. The subjects are healthy adult volunteers living in urban settings who are asked to undergo monthly surveys regarding outdoor exercise activities and pulmonary symptoms, annual pulmonary function tests measured by routine spirometry procedures, and a single chest x-rays five years after enrollment. At the time of initial review, the IRB reviewed and approved the research at a convened meeting and determined and documented that the research involves no more than minimal risk. Because of the single chest x-ray five years after enrollment, the research at the time of initial review did not qualify for review under expedited review categories (1) through (7); in particular, category (4) explicitly excludes procedures involving x-rays. At the time of the first continuing review, the IRB chairperson (or another experienced reviewer designated by the IRB chairperson from among the IRB members) determines that the research continues to involve no more than minimal risk and that there have been no additional risks identified since the initial review. Therefore, the research study may undergo continuing review under expedited review under category (9).
- A research study is designed to evaluate the fluctuations in inflammatory cytokines in the serum of adult patients with newly diagnosed rheumatoid arthritis. The study is not conducted under an IND or IDE, and management of the subject’s rheumatoid arthritis is determined clinically by the subject’s primary rheumatologist and not by the investigator. The subjects are

asked to undergo collection of 30 ml of blood by venipuncture 4 times per week for 6 weeks for measurement of serum inflammatory cytokines. The investigator plans to enroll 30 subjects per year for 3 years. At the time of initial review, the IRB reviewed and approved the research at a convened meeting and determined and documented that the research involves no more than minimal risk. Because of the frequency of blood collection, the research did not qualify at the time of initial review for review under expedited review categories (1) through (7); in particular, the frequency of blood draws exceeds that permitted under category (2). At the time of the first continuing review, the IRB chairperson (or another experienced reviewer designated by the IRB chairperson from among the IRB members) determines that the research continues to involve no more than minimal risk and that there have been no additional risks identified since the initial review. Therefore, the research may undergo continuing review under expedited review under category (9).

For additional guidance on the process for conducting continuing review of research eligible for review under an expedited review procedure, see section C above.

F. Determining the Frequency of Continuing Review

The IRB must conduct continuing review of research at intervals appropriate to the degree of risk, but not less often than once a year (45 CFR 46.109(e)). In addition, the IRB must have and follow written procedures for conducting continuing review and for determining which projects require review more often than annually (45 CFR 46.103(b)(4) and 46.108(a)).

The IRB should decide the frequency of continuing review for each research project necessary to ensure the continued protection of the rights and welfare of research subjects. More frequent review (i.e., more frequently than once per year) may be appropriate, for example, when the risks to subjects warrants more frequent reassessment. OHRP recommends that the IRB consider factors such as the following when deciding on an appropriate interval for continuing review and that these factors be outlined in the IRB's written procedures for deciding the frequency of continuing review:

- The nature of any risks posed by the research project;
- The degree of uncertainty regarding the risks involved;
- The vulnerability of the subject population;
- The experience of the investigators in conducting research;
- The IRB's previous experience with the investigators (e.g., compliance history, previous problems with the investigator obtaining informed consent, or prior complaints from subjects about the investigator);
- The projected rate of enrollment; and
- Whether the research project involve novel interventions.

At the time of initial approval of a research project, the IRB should specify the duration of the approval period and the interval by which continuing review must occur (e.g., 4 months, 6 months, or 1 year) in order for the research to continue. OHRP notes that in addition to specifying a time interval, the IRB also may specify a subject enrollment number as a threshold for determining when continuing review is to occur. For example, at the time of initial review and approval of a high-risk clinical trial, the IRB might require that continuing review occur either in 6 months or after 5 subjects have been enrolled, whichever occurs first. OHRP also recommends that the minutes of IRB meetings clearly document the approval period (continuing review interval).

Similarly, OHRP recommends that at the time of continuing review the IRB consider whether the current frequency of continuing review for the research study is adequate or should be adjusted. For

example, if the IRB initially approved a research study for a period of a year and at the first annual continuing review determined that the risks posed to the subjects have increased significantly, the IRB might re-approve the project after determining that the criteria for approval under 45 CFR 46.111 remain satisfied, but require that the next continuing review occur in 6 months.

The IRB's determinations regarding the approval of research and the required interval for continuing review must be communicated to the investigator in writing (45 CFR 46.103(b)(4) and 46.109(d)).

G. Determining the Effective Date of Initial IRB Approval and the Dates for Continuing Review

1. General Considerations

The IRB's written procedures should describe how the IRB (a) determines the effective date of IRB approval following initial review of a research study; (b) determines the continuing review dates for a research study; and (c) communicates these dates and the periods of approval to the investigator.

In general, IRB review of a proposed change to a research project during the period for which approval is authorized does not constitute continuing review of the project as a whole, and thus does not extend the date by which continuing review must occur (e.g., beyond one year from the effective date of the initial approval or the most recent continuing review approval).

Except when an expedited review procedure is used, the IRB must review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concerns are in nonscientific areas (45 CFR 46.108(b)). In order for the research to be approved by the IRB at a convened meeting, it must receive the approval of a majority of those members present at the meeting (45 CFR 46.108(b)). Therefore, for research not eligible for expedited review, approval by the IRB at the time of initial or continuing review must occur at a convened meeting of the IRB.

2. Determining the *First* Continuing Review Date for Research Reviewed by the IRB at a Convened Meeting at the Time of Initial Review and Approved for One Year

*When the IRB Reviews and Approves Research **Without Conditions** at a Convened Meeting*

When an IRB conducts the initial review of a research project at a convened meeting and approves the research for one year *without* requiring either (a) changes to the protocol or informed consent document(s), or (b) submission of clarifications or additional documents, the effective date of the initial approval is the date of that IRB meeting. In such circumstances, the expiration date of the initial approval period and the date by which the **first** continuing review must occur may be as late as one year after the date of the IRB meeting at which the research project initially was approved (45 CFR 46.109(e)). An example of this scenario is provided in the Appendix (see scenario A).

*When the IRB Reviews and Approves Research **With Conditions** at a Convened IRB Meeting Without Requiring Further Review at a Subsequent Convened Meeting*

A much more common scenario is when an IRB conducting the initial review of a research project at a convened meeting takes the following set of actions:

- Approves the project for one year;
- As a condition of approval, requires either (a) changes to the protocol or informed consent document(s), or (b) submission of confirmations of specific assumptions or understandings on the part of the IRB or additional documents; and

- Directs that the IRB chairperson (or other individual(s) designated by the IRB) to review and determine on behalf of the IRB whether the changes, clarifications, and/or additional documents to be submitted by the investigator(s) are satisfactory (see OHRP's *Guidance on IRB Approval of Research with Conditions* at http://www.hhs.gov/ohrp/policy/conditionalapproval2010.html).

Under this scenario, further review by the IRB at a subsequent convened meeting is not necessary in order for the initial approval to become effective, and the effective date of the initial approval is the date on which the IRB chairperson (or any other individual(s) designated by the IRB) has reviewed and accepted as satisfactory all changes to the protocol or informed consent documents, or any other responsive materials, required by the IRB from the investigator. In such circumstances, the expiration date of the initial approval period, which is the date by which the first continuing review must occur, may be as late as one year after that effective date of initial IRB approval (45 CFR 46.109(e)). OHRP notes that the first continuing review in these circumstances may occur earlier; for example, for logistical reasons an IRB may choose to set the expiration date of the initial approval period at one year from the date of the IRB meeting at which the research project initially was approved with conditions. Examples of these scenarios are provided in the Appendix (see scenarios B1-B3).

The IRB records must include documentation of the date when the IRB chairperson (or other individual(s) designated by the IRB) determined that all conditions of IRB approval have been satisfied and the approval becomes effective, and the expiration date of the initial IRB approval (i.e., the date by which the first continuing review must occur) (45 CFR 46.102(h) and 46.115(a)).

In circumstances where an IRB at a convened meeting approves a research study with conditions, OHRP recommends the following:

- The IRB should consider implementing administrative procedures to minimize the time between the IRB's review and approval of the research study at the convened meeting and the investigator's submission of revised protocol or informed consent documents or any other responsive materials requested by the IRB (e.g., the IRB might require, if appropriate, that (a) the investigator submit such materials within 1, 3, or 6 months of the IRB meeting, and (b) if the investigator misses such a deadline, the research study be reviewed again by the IRB at another convened meeting upon receipt of the responsive materials from the investigator); and
- When responding after a prolonged period of time to the IRB's request for either (a) changes to the protocol or informed consent document(s), or (b) submission of clarifications or additional documents, the investigator should inform the IRB of any new information (e.g., new information about risks of the research interventions) the investigator has become aware of since the convened IRB meeting that might alter the IRB's determinations under 45 CFR 46.111 and, if applicable, subparts B, C, and D of 45 CFR part 46.

3. Determining the Date for the *Second and all Subsequent* Continuing Reviews for Research Reviewed by the IRB at Convened Meetings and Approved for One Year Intervals, Including How to Maintain a Fixed Anniversary Date for the Expiration of Annual IRB Approvals

An IRB must conduct continuing review of research at intervals appropriate to the degree of risk, but not less than once per year (45 CFR 46.109(e)). Given this requirement, it is important to recognize that the use of the "effective date" of IRB approval (i.e., the date on which the IRB chairperson or any other individual(s) designated by the IRB has determined that the conditions of approval have been satisfied) – as opposed to the date of the convened meeting at which the IRB approved a research study with conditions as described in the section G.2 above – to determine the latest permissible date for continuing review *only applies to the first continuing review*. For all subsequent continuing reviews of a research study, since there will be an on-going approved study, *the date of the convened meeting* when the IRB conducts continuing review and approves the study (with or without conditions) determines the latest permissible date of the next continuing review.

OHRP notes that when the IRB approves research with conditions at the time of continuing review before the expiration date of the preceding IRB approval period, IRB approval does not lapse even if the investigator needs additional time – beyond the date on which the preceding IRB approval would have expired – to satisfy some or all of the IRB's conditions (see section C.9 above for additional guidance on approval of research with conditions at the time of continuing review and section H below for additional guidance on lapses in IRB approval).

OHRP recognizes the logistical advantages of keeping the expiration date of the IRB approval period constant from year to year throughout the life of a research project. Therefore, when (a) the IRB grants approval for one year at the time of each continuing review, and (b) the IRB performs continuing review and re-approves (with or without conditions) the research within 30 days *before* the IRB approval period expires, the IRB may retain the anniversary of the expiration date of the initial IRB approval as the expiration date of each subsequent one-year approval period. For example, if an IRB conducts initial review of a research project and approves it without conditions on October 1, 2009 for one year, the IRB may conduct its first continuing review anytime between September 1 and October 1, 2010, and re-approve the research for another one-year period that expires on October 1, 2011. The same timing may be applied to each subsequent continuing review until the research activities involving human subjects are completed. Institutions that adopt a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals should include a description of this procedure in their written IRB procedures (see section C.3 above for additional guidance on written IRB procedures for conducting continuing review).

Determining the dates for continuing reviews after the first continuing review should be straightforward. The Appendix includes several scenarios that provide further clarification regarding how to implement this guidance in circumstances where the IRB approves research at the time of continuing review at a convened meeting either with or without conditions (see scenarios C1-C7).

4. Determining the Continuing Review Date for Research Reviewed by the IRB at a Convened Meeting and Approved for Less Than One Year and for Research Reviewed by the IRB Under an Expedited Review Procedure

The same guidelines for determining the continuing review dates as discussed in sections G.2 and G.3 above would apply when the IRB determines that a research project must undergo continuing review more often than annually (see section F above) and when the IRB reviews and approves research under an expedited review procedure (45 CFR 46.110). Examples of both types of scenarios are provided in the Appendix (see scenarios D1-D3 for research reviewed more often than annually and scenarios E1-E2 for research reviewed under an expedited review procedure).

H. Lapses in IRB Approval

As previously noted, continuing review of research must occur at intervals appropriate to the degree of risk, but not less frequently than once per year (45 CFR 46.109(e)). OHRP recommends that the IRB establish written procedures for informing investigators of the HHS regulations at 45 CFR part 46 and the IRB's own policies and procedures on continuing review requirements. This applies whether the research projects are reviewed by the IRB at a convened meeting or under an expedited review procedure.

OHRP recommends that the IRB and the investigator plan ahead to ensure that continuing review and re-approval of research occurs prior to the end of the approval period specified by the IRB. OHRP further recommends that the IRB's written procedures provide for sufficient advance notice to the investigator to ensure that the requirements for continuing review are met by the date on which approval would expire. The IRB should develop administrative procedures, such as computerized tracking systems, to minimize any unintended expiration of IRB approval. OHRP cautions, however,

that if investigators submit materials for continuing review too far in advance of the expiration date of IRB approval, the materials may not reflect the current status of the research by the time that continuing review actually takes place. Therefore, OHRP recommends that the IRB work to link as closely in time as possible:

- The receipt by the IRB of continuing review materials;
- The review of those materials by the IRB; and
- The impending expiration date for IRB approval.

OHRP notes that it is the responsibility of investigators to provide in a timely manner the information needed by the IRB to perform its continuing review functions, and any reminder notices regarding the need to do so from the IRB to investigators are a courtesy.

The HHS regulations at 45 CFR part 46 make no provision for any grace period extending the conduct of research beyond the expiration date of IRB approval. A lapse in IRB approval of research occurs whenever an investigator has failed to provide continuing review information to the IRB or the IRB has not conducted continuing review and re-approved the research – with or without conditions – by the expiration date of IRB approval. In such circumstances, all research activities involving human subjects must stop after IRB approval expired, *unless* it is determined to be in the best interests of already enrolled subjects to continue participating in the research. Enrollment of new subjects cannot occur after the expiration of IRB approval. Continuing participation of already enrolled subjects in a research project during the period when IRB approval has lapsed may be appropriate, for example, when the research interventions hold out the prospect of direct benefit to the subjects or when withholding those interventions poses increased risk to the subjects (see section J below for additional guidance).

The determination regarding whether it is in the best interests of already enrolled subjects to continue to participate in the research after IRB approval has expired may be made initially by the investigator, possibly in consultation with the subjects' treating physicians (if the investigator is not the subjects' treating physician), but the investigator as soon as possible should submit a request for confirmation that the IRB agrees with this determination. The determination by the IRB may be made by the IRB chairperson, by another IRB member or group of IRB members designated by the IRB chairperson, or at a convened meeting of the IRB. Furthermore, this determination may be made for all enrolled subjects as a group or for each individual subject. If the investigator or IRB determines that it is not in the best interests of already enrolled subjects to continue to participate, investigators must stop all human subjects research activities, including intervening or interacting with subjects and obtaining or analyzing identifiable private information about human subjects (45 CFR 46.109(a) and (e)).

When IRB approval of an ongoing research project lapses and the investigator wants to continue the project, the IRB should complete continuing review for the project as soon as possible. Investigators may resume the human subjects research activity once continuing review and approval by the IRB has occurred. OHRP recommends that the IRB document why the lapse in IRB approval occurred, and, if appropriate, any corrective actions that the investigator, institution, or IRB is taking to prevent any such lapse of approval of the project from occurring again in the future.

Furthermore, when IRB approval of an ongoing research project lapses and the IRB subsequently re-approves the project, the IRB may approve the project for one year and establish a new anniversary date for the expiration date of subsequent approval periods, or the IRB may re-approve the project for a period of less than 1 year so as to retain the original anniversary date on which prior approval periods expired (see scenario C7 in the Appendix).

When continuing review of a research project does not occur prior to the end of the approval period specified by the IRB, IRB approval expires automatically. OHRP does not consider such an

expiration of IRB approval to be a suspension or termination of IRB approval. Therefore, such expirations of IRB approval do not need to be reported to OHRP as suspensions or terminations of IRB approval under the HHS regulations at 45 CFR 46.103(a) and 46.103(b)(5). However, if the IRB notes a pattern of non-compliance with the requirements for continuing review (e.g., an investigator repeatedly or deliberately neglects to submit materials for continuing review in a timely fashion or the IRB itself is frequently not meeting the continuing review dates), the IRB should determine whether such a pattern represents serious or continuing noncompliance that needs to be reported to appropriate institutional officials, the HHS agency that supported the research, and OHRP (45 CFR 46.103(b)(5).

I. Communicating the IRB's Continuing Review Determination to Investigators and the Institution

The IRB must notify the investigator and the institution in writing of its decision to approve or disapprove proposed research, or of modifications required to secure IRB approval of the research (45 CFR 46.103(b)(4) and 46.109(d)). Furthermore, if the IRB decides to disapprove research, it must include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing (45 CFR 46.109(d)). These notification requirements apply to both initial and continuing review. Therefore, after an IRB completes its continuing review of a research project, the IRB must provide written notification informing the investigator of the IRB's determination (e.g., approval, requiring modification(s) to secure approval, or disapproval). OHRP also recommends that the IRB notify any sponsor or coordinating center of a study (possibly through the investigator) of any decision to disapprove the research and the reasons for its disapproval determination.

For research projects that are approved to continue, the IRB's notification to the investigator must clearly state the period of time for which the project is approved, any conditions of the IRB's approval, and the date by which the next continuing review must occur (45 CFR 46.103(b)(4) and 46.109(d))(see section G above for additional guidance on how to determine the effective date of initial IRB approval and continuing review dates). OHRP also recommends that written IRB procedures related to continuing review describe which institutional office(s) and official(s) are notified of IRB findings and actions regarding continuing review and how notification to each is accomplished.

J. Suspension or Termination of IRB Approval of Research or Disapproval of Research at the Time of Continuing Review

The IRB has the authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that is associated with unexpected serious harm to subjects (45 CFR 46.113). A suspension or termination of IRB approval of research may occur at anytime during the period for which IRB approval had already been given.

For a multicenter research project for which many or all institutions engaged in the research project choose to rely upon their local IRBs for review of the project, a local IRB's decision at one institution to suspend or terminate its approval of the research only applies to the conduct of the research project at that institution. On the other hand, if all institutions engaged in a multicenter research project rely upon a central IRB for review of the project, the central IRB could suspend or terminate its approval of the research either at one institution because of a unique problem regarding the conduct of the research at that institution or at all institutions because of a study-wide problem.

Suspension of IRB approval may be appropriate when a significant issue is first identified and while the IRB investigates the matter. For example, if there is an allegation of serious noncompliance by an investigator or a human subject safety issue that needs further investigation and evaluation, the

IRB may decide to suspend its approval of the research project while the allegation or issue is undergoing evaluation. In addition, the IRB may consider whether it is appropriate to notify subjects about the suspension and the reasons for it, and if so, when the subjects should be notified, given that complete information may not be available.

Any suspension or termination of IRB approval must be promptly reported to the investigator, appropriate institutional officials, the HHS agency that supported the research, and OHRP (45 CFR 46.103(b)(5) and 46.113)). Such reports must include the reasons for the IRB's action (45 CFR 46.113).

IRBs must follow written procedures for ensuring such reporting (45 CFR 46.108(a)). When reporting the suspension or termination of IRB approval of a research project to OHRP, OHRP recommends that the report include the following information:

- The name of the institution(s) (e.g., university, hospital, foundation, school, etc.) conducting the research project;
- The title of the research project and the title of any related grant, contract, or cooperative agreement;
- The name of the principal investigator for the research project;
- The number of the research project assigned by the IRB and the number of the applicable HHS award(s) (grant, contract, or cooperative agreement);
- A detailed description of the reason for the suspension or termination; and
- The actions the institution is taking or plans to take to address the suspension or termination (e.g., investigate alleged noncompliance, educate the investigator, educate all research staff, require monitoring of the investigator or the research project, etc.)

When an IRB (a) suspends or terminates its approval during the period for which IRB approval had already been given or (b) disapproves a research project at the time of continuing review, the IRB should establish procedures to ensure that the rights and welfare of currently enrolled subjects are protected, subjects are not put at risk, and subjects receive appropriate care, if indicated, during the period of suspension or following the cessation of the research. This is particularly important in the context of clinical trials. For example, the IRB, in consultation with the investigator and the subjects' treating physicians (if not the investigator), may need to determine whether it is in the best interests of currently enrolled subjects to (a) continue receiving the interventions that were being administered to subjects under the research project, (b) be transferred to another institution engaged in the research so that participation of the subjects in the research may continue, or (c) be transitioned to medical management outside of the research context. Continuation of subjects on interventions that were being administered under the research project may be appropriate at least temporarily, for example, when those interventions hold out the prospect of direct benefit to the subjects or when withholding those interventions poses increased risk to the subjects. If the IRB decides that already enrolled subjects should continue to receive the interventions that were being administered to subjects under the research project, data collection (especially safety information) should also continue for such subjects.

K. Identifying the Point When Continuing Review is no Longer Necessary

Continuing review and re-approval of a research project at least annually is required so long as the project continues to involve human subjects. OHRP considers a research project to continue to involve human subjects as long as the investigators conducting the research continue to obtain:

- Data about the subjects of the research through intervention or interaction with them; or

- Identifiable private information about the subjects of the research.

With respect to *obtaining identifiable private information*, OHRP considers this to include obtaining identifiable biological specimens originating from living individuals. *Furthermore, OHRP considers obtaining identifiable private information to include*:

- Collecting or receiving identifiable private information (including identifiable biological specimens) from any source (i.e., not already in the possession of the investigator);
- Collecting identifiable private information by observing or recording private behavior without interacting or intervening with the human subjects; and
- Using, studying, or analyzing identifiable private information (including identifiable biological specimens), even if the information was already in the possession of the investigator before the research begins. This includes using, studying, or analyzing any of the following:
    - Identifiable private information obtained by interacting or intervening with the human subjects;
    - Identifiable private information stored in documents, records, photographs, images, video recordings, or audio recordings provided to the investigators from any source;
    - Identifiable private information stored in documents, records, photographs, images, video recordings, or audio recordings already in the possession of the investigator before the research begins;
    - Identifiable private information obtained about an individual by interviewing other people (e.g., an individual's healthcare provider or teacher);
    - Identifiable biological specimens provided to the investigators from any source; or
    - Identifiable biological specimens already in the possession of the investigator before the research begins.

A research project no longer involves human subjects once the investigators have finished obtaining data through interaction or intervention with subjects or obtaining identifiable private information about the subjects, which includes the using, studying, or analyzing identifiable private information. Once all such activities described in the IRB-approved protocol are finished, the research project no longer needs to undergo continuing review. For example, when the only remaining activity of a research project involves the analysis of aggregate data sets without individual subject identifiers, no further continuing review is necessary. At that point the IRB can formally close the IRB file for that project and advise the investigator of that action. Similarly, simply maintaining individually identifiable private information without using, studying, or analyzing such information is not human subjects research and thus does not require continuing review. See section D.1 above for additional guidance on determining when continuing review is no longer required for a particular institution involved in the conduct of a multicenter research project.

OHRP is aware that many IRBs require investigators to submit final closeout reports when a research study is completed or no longer involves human subjects. Since the HHS regulations at 45 CFR part 46 do not require submission of such reports, institutions are free to decide whether and when such reports are required and what their content should include.

L. Continuing Review is not Required for Exempt Human Subjects Research Projects

Human subjects research studies that qualify for exemption under 45 CFR 46.101(b) are exempt from all requirements of 45 CFR part 46, including the requirements related to continuing review. Investigators should follow the established institutional policies and procedures for determining

whether proposed human subjects research projects are exempt. Once the determination has been made that a project is exempt, no continuing review of the project by the IRB is required under the HHS regulations at 45 CFR part 46.

However, if an investigator decides to modify an exempt human subjects research project in such a way that it would no longer qualify for exemption, the investigator must submit the modified research protocol to the IRB for review prior to implementation of the modified research project (45 CFR 46.103(b) and 46.109(a)).

If you have specific questions about how to apply this guidance, please contact OHRP by phone at (866) 447-4777 (toll-free within the U.S.) or (240) 453-6900, or by e-mail at ohrp@hhs.gov.

Appendix
Scenarios for Determining Continuing Review Dates

A. Determining the First Continuing Review Date for Research Reviewed by the IRB at a Convened Meeting at the Time of Initial Review and Approved Without Conditions for One Year

- Scenario A: An IRB conducts initial review of a research project at a convened meeting on October 1, 2009 and approves the project for one year without requiring (a) any changes to protocol or informed consent documents, or (b) submission of any clarifications or additional documents. The effective date of the initial IRB approval would be October 1, 2009, and the expiration date of the initial approval period and the date by which the first continuing review must occur is one year after the date of the IRB meeting, that is, October 1, 2010.

B. Determining the *First* Continuing Review Date for Research Reviewed by the IRB at a Convened Meeting at the Time of Initial Review and Approved with Conditions for One Year

- Scenario B1: An IRB conducts an initial review of a research project at a convened meeting on October 1, 2009, approves the project for one year, and requires that the investigator make minor changes to the protocol as a condition of its approval. The IRB directs the IRB chairperson to review, on behalf of the IRB, the revised protocol and determine whether the changes required by the IRB have been made. On November 1, 2009, the IRB chairperson reviews the revised protocol and determines that the changes made by the investigator are satisfactory. The effective date of the initial IRB approval is November 1, 2009. When approving research for one year with conditions at the time of initial review, the IRB follows a procedure where the expiration date of the initial approval period is one year after the effective date of initial IRB approval (i.e., the date on which the IRB chairperson or any other individual(s) designated by the IRB has determined that the conditions of approval have been satisfied). Therefore, the expiration date of the initial approval period and the date by which the first continuing review must occur is November 1, 2010.
- Scenario B2: An IRB conducts an initial review of a research project at a convened meeting on October 1, 2009, approves the project for one year, and requires that the investigator make minor changes to the protocol as a condition of its approval. The IRB directs the IRB chairperson to review, on behalf of the IRB, the revised protocol and determine whether the changes required by the IRB have been made. On November 1, 2009, the IRB chairperson reviews the revised protocol and determines that the changes made by the investigator are satisfactory. The effective date of the initial IRB approval is November 1, 2009. When approving research for one year with conditions at the time of initial review, the IRB follows a procedure where the expiration date of the initial approval period is one year from the date of the IRB meeting at which the research project initially was approved with conditions. Therefore, the expiration date of the initial approval period and the date by which the first continuing review must occur is October 1, 2010.

- Scenario B3: An IRB conducts initial review of a research project at a convened meeting on October 1, 2009, and has serious concerns regarding the study design. The IRB defers taking action on the project and requires that the investigator submit a revised protocol in order to secure approval at a future IRB meeting. At a convened meeting on December 1, 2009, the IRB reviews a revised protocol, approves the research project for one year, and requires that the investigator make minor changes to the informed consent document and submit documentation of a co-investigator's hospital privileges as conditions of its approval. The IRB directs the IRB chairperson to review, on behalf of the IRB, (a) the revised informed consent document to determine whether the changes required by the IRB have been made, and (b) the documentation of the co-investigator's hospital privileges. On December 15, 2009, the IRB chairperson reviews the revised informed consent document and documentation of the co-investigator's hospital privileges, and determines that the changes made by the investigator to the informed consent document and the documentation of the co-investigator's hospital privileges are satisfactory. The effective date of the initial IRB approval is December 15, 2009. When approving research for one year with conditions at the time of initial review, the IRB follows a procedure where the expiration date of the initial approval period is one year after that effective date of initial IRB approval (i.e., the date on which the IRB chairperson or any other individual(s) designated by the IRB has determined that the conditions of approval have been satisfied). Therefore, the expiration date of the initial approval period and date by which the first continuing review must occur is December 15, 2010.

NOTE: For all of the scenarios that follow, assume that when the IRB approves research for one year with conditions at the time of initial review, the IRB follows a procedure where the expiration date of the initial approval period is one year after that effective date of initial IRB approval (i.e., the date on which the IRB chairperson or any other individual(s) designated by the IRB has determined that the conditions of approval have been satisfied).

C. Determining the Date for the *Second and all Subsequent* Continuing Reviews for Research Reviewed by the IRB at Convened Meetings and Approved for One Year Intervals, Including How to Maintain a Fixed Anniversary Date for the Expiration of Annual IRB Approvals

- Scenario C1: An IRB conducts initial review of a research project at a convened meeting and approves it without conditions on October 1, 2009 for one year. The effective date of the initial IRB approval is October 1, 2009, and that approval expires on October 1, 2010. The IRB follows a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals and conducts its first continuing review of the research project at a convened meeting on September 15, 2010 and re-approves the project without conditions for another one-year period. The expiration date of the second approval period is October 1, 2011. The second continuing review must occur by October 1, 2011.
- Scenario C2: An IRB conducts initial review of a research project at a convened meeting and approves it without conditions on October 1, 2009 for one year. The effective date of the initial IRB approval is October 1, 2009, and that approval expires on October 1, 2010. The IRB does not follow a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals and conducts its first continuing review of the research project at a convened meeting on September 15, 2010 and re-approves the project without conditions for another one-year period. The expiration date of the second approval period is September 15, 2011, and the second continuing review must occur by this date.
- Scenario C3: An IRB conducts initial review of a research project at a convened meeting and approves it without conditions on October 1, 2009 for one year. The effective date of the initial IRB approval is October 1, 2009, and that approval expires on October 1, 2010. The IRB follows a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals and conducts its first continuing review of the research project at a convened meeting on August 15, 2010 (i.e., more than 30 days before the initial IRB approval period

expires) and re-approves the project without conditions for another one-year period. Because the first continuing review did not occur within 30 days before the IRB approval period expired, the expiration date of the second approval period is August 15, 2011, and the second continuing review must occur by this date.

- Scenario C4: An IRB conducts initial review of a research project at a convened meeting and approves it without conditions on October 1, 2009 for one year. The effective date of the initial IRB approval is October 1, 2009, and that approval expires on October 1, 2010. The IRB follows a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals and conducts its first continuing review of the research project at a convened meeting on September 15, 2010 and re-approves the research for another one-year period with the condition that the investigator makes a change to the protocol. On September 22, 2010, the IRB chairperson receives from the investigator a revised protocol, and verifies that the required change has been made. The expiration date of the second approval period is October 1, 2011, and the second continuing review must occur by this date.
- Scenario C5: An IRB conducts initial review of a research project at a convened meeting and approves it without conditions on October 1, 2009 for one year. The effective date of the initial IRB approval is October 1, 2009, and that approval expires on October 1, 2010. The IRB does not follow a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals. The IRB conducts its first continuing review of the research project at a convened meeting on September 15, 2010 and re-approves the research for another one-year period with the condition that the investigator makes a change to the protocol. On September 22, 2010, the IRB chairperson receives from the investigator a revised protocol, and verifies that the required change has been made. The expiration date of the second approval period is September 15, 2011, and the second continuing review must occur by this date.
- Scenario C6: An IRB conducts initial review of a research project at a convened meeting and approves it without conditions on October 1, 2009 for one year. The effective date of the initial IRB approval is October 1, 2009, and that approval expires on October 1, 2010. The IRB follows a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals. The IRB conducts its first continuing review of the research project at a convened meeting on September 15, 2010 and re-approves the research for another one-year period with the condition that the investigator makes a change to the informed consent document within 60 days. The IRB directs the IRB chairperson to review, on behalf of the IRB, the revised informed consent document and determine whether the changes required by the IRB have been made. The IRB also specifies that no new subjects may be enrolled in the research until the IRB chairperson reviews the revised informed consent document and verifies that the required change has been made. On October 31, 2010, the IRB chairperson reviews the revised informed consent document and determines that the changes made by the investigator are satisfactory. Enrollment of new subjects may resume on October 31, 2010. The expiration date of the second approval period is October 1, 2011, and the second continuing review must occur by this date. Note that under this scenario, there is no lapse in IRB approval between October 1 and October 31, 2010, and during this time, the investigator is allowed to continue research activities involving already enrolled subjects.
- Scenario C7: An IRB conducts initial review of a research project at a convened meeting and approves it without conditions on October 1, 2009 for one year. The effective date of the initial IRB approval is October 1, 2009, and that approval expires on October 1, 2010. The IRB follows a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals. The IRB conducts its first continuing review of the research project at a convened meeting on September 15, 2010 and re-approves the research for another one-year period with the condition that within 60 days the investigator makes a change to the protocol by adding the administration of a new follow-up data collection procedure one year after the

subjects began receiving the research intervention, for all subjects who have not yet reached that point. The IRB directs the IRB chairperson to review, on behalf of the IRB, the revised protocol and determine whether the change required by the IRB has been made. On October 31, 2010, the IRB chairperson receives and reviews the revised protocol and verifies that the investigator made the requested change. The expiration date of the second approval period is October 1, 2011, and the second continuing review must occur by this date. Note that under this scenario, there is no lapse in IRB approval between October 1 and October 31, 2010, and during this time, the investigator is allowed to continue research activities involving already enrolled subjects and to enroll new subjects in the research.

- Scenario C8: An IRB conducts initial review of a research project at a convened meeting and approves it without conditions on October 1, 2009 for one year. The effective date of the initial IRB approval is October 1, 2009, and that approval expires on October 1, 2010. The investigator does not submit the necessary progress report for the first continuing review until October 31, 2010. As a result, IRB approval expired/lapsed on October 1, 2010, and all research activities involving human subjects must stop except in the limited circumstances described in section H below. The IRB conducts its first continuing review of the research project at a convened meeting on November 15, 2010 and re-approves the project without conditions for another one-year period. The expiration date of the second approval period could be as late as November 15, 2011, or the IRB could specify that the second IRB approval period expires on October 1, 2011 so as to retain the original anniversary date on which the first approval period expired. The second continuing review must occur by whichever date is specified by the IRB.

<u>D. Determining the Continuing Review Date for Research Reviewed by the IRB at a Convened Meeting and Approved for Less Than One Year</u>

- Scenario D1: An IRB conducts initial review of a research project at a convened meeting on October 1, 2009 and approves the project for 6 months without requiring (a) any changes to the protocol or informed consent document(s), or (b) submission of any clarifications or additional documents. The effective date of the initial IRB approval is October 1, 2009, and the first continuing review must occur within six months of the date of the IRB meeting, that is, by April 1, 2010. The IRB conducts its first continuing review of the research project at a convened meeting on March 15, 2010 and re-approves the project without conditions for another six-month period. The IRB stipulates that the expiration date of the second approval period is October 1, 2010, and the second continuing review must occur by this date.
- Scenario D2: An IRB conducts initial review of a research project at a convened meeting on October 1, 2009, approves the project for 6 months, and requires that the investigator make minor changes to the protocol as a condition of its approval. The IRB directs the IRB chairperson to review, on behalf of the IRB, the revised protocol and determine whether the changes required by the IRB have been made. On November 1, 2009, the IRB chairperson reviews the revised protocol and determines that the changes made by the investigator are satisfactory. The effective date of the initial IRB approval is November 1, 2009, and the first continuing review must occur within six months of that date, that is, by May 1, 2010. The IRB follows a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals, and conducts its first continuing review of the research project at a convened meeting on April 15, 2010 and re-approves the project without conditions for one year. The expiration date of the second approval period is May 1, 2011, and the second continuing review must occur by this date.
- Scenario D3: At a convened meeting on October 1, 2009, an IRB conducts initial review of a research project that is a high-risk phase I clinical trial involving healthy subjects and approves the project for 6 months or until the first three subjects have enrolled and received the study intervention – whichever is sooner – without requiring (a) any changes to the protocol or

informed consent document(s), or (b) submission of any clarifications or additional documents. The effective date of the initial IRB approval is October 1, 2009, and the first continuing review must occur within six months of the date of the IRB meeting, that is, by April 1, 2010, or after the first three subjects have enrolled and received the study intervention, whichever is sooner. The third subject is enrolled and receives the study intervention on February 1, 2010. No further subjects can be enrolled in the project until the IRB conducts continuing review at a convened meeting and re-approves the research. The IRB conducts its first continuing review of the research project at a convened meeting on February 15, 2010 and re-approves the project without conditions for another six-month period or until the next three subjects have enrolled and received the study intervention – whichever is sooner. The next continuing review must occur by August 15, 2010, or after the next three subjects have enrolled and received the study intervention, whichever is sooner.

E. Determining the Continuing Review Date for Research Reviewed by the IRB Under an Expedited Review Procedure

- Scenario E1: An IRB chairperson conducts initial review of a research project under an expedited review procedure on October 1, 2009 and approves the project for one year without requiring (a) any changes to the protocol or informed consent document, or (b) submission of any clarifications or additional documents. The effective date of the initial IRB approval is October 1, 2009, and the first continuing review must occur within one year of that date, that is, by October 1, 2010. The IRB follows a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals, and the IRB chairperson conducts the first continuing review of the research project under an expedited review procedure on September 15, 2010 and re-approves the project without conditions for one year. The expiration date of the second approval period is October 1, 2011, and the second continuing review must occur by this date.
- Scenario E2: An IRB chairperson conducts initial review of a research project under an expedited review procedure on October 1, 2009, approves the project for one year, and requires that the investigator make minor changes to the protocol as a condition of the IRB's approval. On November 1, 2009, the IRB chairperson reviews the revised protocol and determines that the changes made by the investigator are satisfactory. The date of the initial IRB approval is November 1, 2009, and the first continuing review must occur within one year of that date, that is, by November 1, 2010. The IRB does not follow a procedure for maintaining fixed anniversary dates for the expiration of annual IRB approvals, and the IRB chairperson conducts the first continuing review under an expedited review procedure on October 15, 2010, and re-approves the research for another one-year period with the condition that the investigator makes a specific word change to the informed consent document. The IRB chairperson designates the IRB administrator, who is not an IRB member, to review the revised informed consent document and confirm that the required change was made. On October 22, 2010, the IRB administrator receives from the investigator a revised informed consent document, and verifies that the required change has been made. The expiration date of the second approval period is October 15, 2011, and the second continuing review must occur by this date.

For the sake of simplification, in this sentence and many subsequent sentences, OHRP has used the singular noun "investigator" when the plural noun "investigators" may also be appropriate.

CHESTNUT HEALTH SYSTEMS

Attachment L

Expedited Review Policy and Procedures

The IRB may provide expedited review for certain kinds of research involving no more than minimal risk and if the research falls within the following categories of research as set forth in the January 26, 1987 Federal Register, 46 FR 8392, as amended from time to time:

1. Clinical studies of drugs and medical devices if there is no investigational new drug application or an investigational device exemption application is not required, or the medical device is cleared/approved for marketing and the device is used in accordance with its cleared/approved labeling;
2. Collection of blood samples by finger stick, heel stick, ear stick or venipuncture from health, nonpregnant adults who weigh at least 110 pounds, or from other adults or children, taking into consideration the age, weight, and health of the subjects and the collection procedure and amounts to be taken;
3. Prospective collection of biological specimens for research purposes by noninvasive means;
4. Collection of data through noninvasive procedures routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing;
5. Research involving materials (data, records etc.) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis);
6. Collection of data from voice, video, digital or image recordings made for research purposes; or
7. Research on individual or group characteristics or behavior (identity, language, social behavior etc.) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

An expedited review process may be used for continuing review of a research project only for minimal risk changes (or minor changes involving minimal risk) to the protocol or consent form. The periodic or annual reviews of research projects, or any project that initially required full review, must still go through the full IRB. A continuing review using an expedited review process may only be conducted on the following categories of research:

1. Continuing review of research previously approved by the convened IRB as follows:
    a. Where (1) the research is permanently closed to the enrollment of new subjects; (2) all subjects have completed all research-related interventions; and (3) the research remains active only for long-term follow-up of subjects; or
    b. Where no subjects have been enrolled and no additional risks have been identified; or
    c. Where the remaining research activities are limited to data analysis.
2. Continuing review of research (other than that described in (a), (b) or (c) above), not conducted under an investigational new drug application or investigational device exemption where categories (2) through (7) do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

Minor changes that may be considered under a continuing review on an expedited basis include the following:

1. Typographical errors; or
2. Minor changes to the protocol for clarification that will not alter the project or pose a risk to the subjects.

The Human Protections Administrator will screen the research protocol to determine if it meets the requirements for expedited review. If the research project meets one of the categories for research that may be reviewed on an expedited basis, then the research protocol and any other relevant materials shall be sent to a minimum of 2 IRB members for a final determination. A research project may be disapproved only after review in accordance with the non-expedited review procedure set forth in Section 5.2 of the IRB Policy and Procedures.

All expedited reviews of research projects will also meet the requirements found at 45 CFR 46.111 concerning criteria for IRB approval of research, as well as the requirements for informed consent found at 45 CFR 46.116 and 45 CFR 46.117. Additionally, consultants may assist the IRB in the review of issues which require expertise beyond, or in addition to, that available on the IRB. However, consultants may not carry out the actual expedited review.

The 2 IRB members may either approve, require modifications (to secure approval), or refer the research to the convened IRB for review on a non-expedited basis. The findings of the 2 IRB members regarding research proposals that have been approved under the expedited review procedures will be shared with each member of the IRB at the next regular meeting and these findings will also be entered into the meeting minutes. Any member of the IRB may request a copy of any project documents provided in connection with the expedited review.

Documentation of an initial or continuing expedited review will include the following:

1. Statement in the approval letter of the applicable permissible categories of research that qualified the project for expedited review ; and
2. Documentation of the review and action taken by the Human Protections Administrator and IRB Chairperson and any findings required under the Protection of Human Subjects regulations

Expedited review procedures will not be used for research involving prisoners. Expedited review procedures may also not be used where identification of the subjects and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.

Chestnut Health Systems
Risk Management

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Risk Management		
Policy Name and Number:	RM 10 Emergency Communication		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	MC 320 – Communication with the Media Safety Manual		
Citation(s):			

RM 10 EMERGENCY COMMUNICATION

In the event of an emergency, on duty staff shall follow the Emergency Response Plan that is specific to the affected program/business unit. The Emergency Response Plan provides practical guidance on immediate actions and management contact information. Staff should be familiar with the plan for their program/business unit. Paper versions of Emergency Response Plans are to be maintained by each program in an accessible location as determined by the program supervisor, and the Safety Coordinator will ensure electronic posting on the Intranet.

Staff should also be familiar with the telephone system paging codes. Phone paging codes by site and emergency code alerts are listed on the back of employee badges. Detailed information regarding codes and response is provided in the Safety Manual.

The staff on duty will take necessary actions to ensure the immediate well-being of individuals served and others present. Only program management is permitted to make decisions regarding immediate temporary relocation of services. As soon as practicable, staff shall notify their supervisor who shall immediately notify the Director of Quality and Compliance and the General Counsel. Only the Chief Executive Officer or their designee shall make decisions regarding long-term relocation of services. If the Chief Executive Officer is unavailable then the Chief Operating Officer shall make the decision.

Only authorized personnel are permitted to communicate with the media. No staff shall provide interviews or discuss crisis situations without express joint authorization from both the Director of Marketing and Communications and the Chief Operating Officer and General Counsel. The supervisor on duty or designee may communicate as necessary with emergency assistance personnel to assist in resolving the emergency. Additional information concerning communication with the media can be found in the Marketing and Communication policy MC 320.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Risk Management		
Policy Name and Number:	RM 15 Patient Safety Events		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RM 20 – Sentinel Events RM 60 – Incident Reporting RM 65 – Incident Review		
Citation(s):			
Related Documents:	Incident Report		

RM 15 PATIENT SAFETY EVENTS

The Joint Commission defines a patient safety event as an event, incident, or condition that could have resulted or did result in harm to an individual served. A patient safety event can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure, or human error. Patient safety events & associated responses include the following:

Sentinel Event – a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches an individual served and results in death, permanent harm or severe temporary harm. For further definition and response refer to policy on Sentinel Events (RM 20).

Adverse event – a patient safety event that resulted in harm to an individual served. An adverse event will immediately be reported to the program supervisor following the program/business unit specific Emergency Response Plan. Clinical and administrative leadership will determine and oversee the immediate response to the event. An adverse event will undergo targeted incident review as per Incident Review policy (RM 65).

No-harm event – a patient safety event that reaches the individual served but does not cause harm.

Close call (or "near miss" or "good catch") – a patient safety event that did not reach the individual.

Unsafe condition – a circumstance (other than an individual's own disease, process, or condition) that increases the probability of an adverse event.

An Incident Report must be completed for each patient safety event that occurs. Refer to RM 60.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Risk Management		
Policy Name and Number:	RM 16 Client Deaths		
Revision Date:	06/22/2022		
Applies To:	☒Employees Contractors Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CR 15 – Mandated Reporting		
Citation(s):			
Related Documents:	Incident Report		

RM 16 CLIENT DEATHS

Risk management procedures will be followed by staff when a current or former client dies. For purposes of reporting a death, "client" is defined as a person open to a program, a person who has been discharged within 6 months, a person who has been discharged longer than 6 months where there is a reasonable concern for related liability, or a person who has been deflected from crisis residential services within 24 hours.

When a staff member is notified of a client death, they must inform their supervisor, medical records and the Director of Quality and Compliance. The Director of Quality and Compliance must immediately notify the General Counsel. Additionally, staff must complete an Incident Report. Staff members may also be required to document the death in the patient's medical record and record the cause of death, if known, but only at the direction of the Director of Quality and Compliance and/or the General Counsel.

Staff are also expected to follow their program specific procedure, as applicable. See also CR 15 – Mandated Reporting.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Risk Management		
Policy Name and Number:	RM 20 Sentinel Events		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RM 30 – Root Cause Analysis RM 60 – Incident Reporting RM 65 – Incident Review CR 15 – Mandated Reporting		
Citation(s):	The Joint Commission – Sentinel Event Policy		

RM 20 SENTINEL EVENTS

A Sentinel Event is a type of patient safety event (not primarily related to the natural course of the patient's illness or underlying condition). It is an incident that reaches an individual served, a staff person or another person in a Chestnut Health Systems ("Chestnut") facility that results in death, permanent harm or severe temporary harm. Such events are considered "sentinel" because they signal a need for immediate investigation and response. Chestnut has established this Sentinel Event policy to provide necessary guidance to staff at the time of a suspected Sentinel Event and to meet these goals:

1. To have a positive impact in improving, care, treatment and services and in preventing unintended harm,
2. To focus attention on understanding the factors that contributed to the event, and on changing the culture, systems, and processes to reduce the probability of such an event in the future,
3. To increase the general knowledge about patient safety events, their contributing factors, and strategies for prevention, and
4. To maintain the confidence of internal and external stakeholders that the safety of individuals served is a priority.

The Sentinel Event policy and procedures are in addition to the requirements of the Chestnut Incident Reporting (RM 60) and Mandated Reporting (CR 15) policies and procedures.

Chestnut staff will identify and respond appropriately by immediately reporting a suspected Sentinel Event to their direct supervisor. If staff are uncertain if an incident meets the definition of a Sentinel Event, the incident should be reported.

All suspected Sentinel Events are to be reported to the appropriate Vice President of Integrated Care within one (1) hour of the occurrence. If the individual is unavailable, the report should be made to the Chief Executive Officer, or General Counsel. The corporate officer receiving the report shall be responsible to ensure further reporting of the event to the Director of Quality and Compliance, General Counsel, and the Chief Executive Officer.

Program and administrative leadership will determine and oversee the immediate response to the event.

The Director of Quality and Compliance, General Counsel and other appropriate leadership as determined by the Director of Quality and Compliance will be responsible to immediately review the event to determine if the event meets the definition of a Sentinel Event. The Joint Commission chapter on Sentinel Events shall serve as a reference regarding such determination.

If the event is determined to be a Sentinel Event, Chestnut will respond by engaging in a timely, comprehensive systemic analysis to identify causal and contributory factors according to Root Cause Analysis (RM 30). If the event is determined not to be a Sentinel Event, the Director of Quality and Compliance will determine and initiate the appropriate type/level of review as per Incident Review (RM 65).

Additionally, if the event is determined to be a Sentinel Event, the Director of Quality and Compliance, General Counsel and other appropriate leadership will make a recommendation to the Chief Executive Officer regarding a report to The Joint Commission. Chestnut is not required to report a Sentinel Event to The Joint Commission, but recognizes the benefits of self-reporting. The Chief Executive Officer has final decision-making authority regarding reports to The Joint Commission.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Risk Management		
Policy Name and Number:	RM 30 Root Cause Analysis		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RM 20 – Sentinel Events		
Citation(s):	The Joint Commission – Sentinel Event Policy		

RM 30 ROOT CAUSE ANALYSIS

As mandated by The Joint Commission, Chestnut is expected to identify and respond appropriately to all Sentinel Events. Appropriate response includes conducting a timely, thorough, and credible Root Cause Analysis ("RCA"); developing an acceptable action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements. The Joint Commission chapter on Sentinel Events shall serve as a reference regarding such response.

At the direction of the General Counsel, appropriate clinical and administrative staff will participate in the RCA process and in the development, implementation and monitoring of the resulting action plan. The applicable Vice President of Integrated Care and Corporate Compliance Officer will always be involved. The General Counsel is responsible for the oversight and completion of the RCA process; however, he/she may delegate this responsibility to the Director of Quality and Compliance. At all times throughout the RCA process, the General Counsel will be consulted regarding the protection of the confidentiality of the RCA process and related documentation.

The analysis and action plan resulting from the RCA will be completed no later than 45 business days following the occurrence or awareness of the Sentinel Event. Any report to The Joint Commission shall also occur within this same timeframe. Ongoing implementation and monitoring shall occur so long as is necessary to ensure sustained improvement and reduction of risk.

CHESTNUT
HEALTH SYSTEMS

Policy Handbook Section:	Risk Management		
Policy Name and Number:	RM 40 Liability Insurance		
Revision Date:	08/26/2020		
Applies To:	☐Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☒Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

RM 40 LIABILITY INSURANCE

Chestnut shall maintain adequate insurance coverage shall be maintained to protect its physical and financial resources. Insurance coverage for all people, buildings and equipment shall be maintained and shall include fidelity bond, cyber, automobile liability, where applicable, and broad form comprehensive general liability for property damage and bodily injury including wrongful death and incidental malpractice. If an event occurs that involves potential liability for a Chestnut program and/or employee covered by one of Chestnut's liability insurance policies, the General Counsel will immediately be notified. If advisable, the General Counsel will notify the appropriate liability carrier(s) of the possible exposure.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Risk Management		
Policy Name and Number:	RM 60 Incident Reporting		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	CR 15 – Mandated Reporting		
Citation(s):			
Related Documents:	Incident Report		

RM 60 INCIDENT REPORTING

An Incident Report is an internal control mechanism used to document and monitor unusual, unsafe or potentially harmful events as they occur to facilitate the management of a safe and therapeutic environment. Incident Report forms are available as paper forms and electronically on the Intranet.

Incident Reports are to be completed in at least the following situations (this list is not exhaustive, merely representative of the types of events that need to be reported):

- 911 Calls (police, fire or EMS)
- Allegations of Client Abuse / Neglect / Exploitation
- Building evacuations
- Death
- Door or cabinet found unlocked which would be expected to be locked
- Error by external support services (i.e. lab, pharmacy)
- Exposure to bodily fluids and/or hazardous waste
- Equipment malfunction (medical or mechanical)
- Falls
- Fire
- Injury to client or potential for injury (includes self injury)
- Injury to staff or potential for injury
- Injury to visitor or potential for injury
- Loss of power
- Medical emergencies
- Medication errors (i.e. incorrect dosage, omission, etc.)
- Missing person / Elopement
- Physical or verbal aggression
- Physical holds to client (youth residential only)
- Property missing
- Property damage
- Severe weather events causing damage to property or harm to individuals
- Sheltering in place for weather related events
- Suicide attempt
- Theft

- Threats of violence
- Use of a Chestnut emergency code (Dr. Lock, Dr. Armstrong, CPR Certified staff)
- Vehicle accident

In addition, an Incident Report should be completed whenever a mandated report is made pursuant to CR 15. Unlike other Incident Reports, an Incident Report completed in response to a mandated report should be general and simply state the client identification number and the fact that a mandated report was made to a certain agency, without divulging further details.

Privacy and confidentiality incidents, including instances of a suspected or potential breach of confidentiality, are not reported via incident reports. Such reports should be made directly to the Privacy Office.

Unsafe conditions that do not result in an incident are not reported via incident reports, but are expected to be reported as follow: Conditions that require immediate attention should be directly reported to with acknowledgement of receipt by the reporting supervisor and/or to the Regional Facilities Manager. Additionally, as appropriate, a work order marked as a safety concern should be made via the employee support portal reporting mechanism on the Chestnut intranet Conditions that are of concern but do not require immediate attention are to be reported as a work order marked as safety concern via the reporting portal with the reporting supervisor copied on the submission. The Safety Coordinator and Regional Facilities Manager are automatically copied on all work orders that are reported as a safety concern.

Incident reports shall be objective and as accurate as reasonably possible. Entries of a speculative, judgmental, or unsubstantiated nature are to be avoided. Client names should not be used in the report; instead client ID numbers should be used. The incident report is an administrative document and should not be mentioned or included in the medical record. Incident reports are not provided to clients. Clinical observations are recorded in the patient's medical record.

Incident Reports are to be completed by the staff involved and turned in to a supervisor immediately following the incident and no later than by the end of the staff's working day or shift. If staff is not able to complete the incident report, it is the responsibility of the supervisor to complete the report. The supervisor must route incident reports and completed supervisory follow-up to the Safety Coordinator within 24 hours of receipt. If the incident involves a staff injury, a copy should be routed to Human Resources upon receipt by the Safety Coordinator. If the incident involves client injury and/or law enforcement, a copy should be routed to General Counsel by the Safety Coordinator. The Safety Coordinator shall use his/her discretion regarding incidents that pose potential liability risk and send those reports on to General Counsel. Timely routing of incident and follow-up reports is intended to ensure a check and balance for a rapid, and appropriate response, as well as subsequent analysis. Additional supervisory follow-up reports should be completed and forwarded as indicated. If a supervisor is unable to route an incident report within required timeframes, the supervisor should notify the Safety Coordinator to advise of the incident and status.

Once received, incident reports are logged by the Safety Coordinator. At the discretion of the Safety Coordinator, incident reports may also be routed to the Director of Quality and Compliance, the Director of Human Resources and other managers with a need to know. The Director of Quality and Compliance shall be responsible for notifying the Chief Executive Officer and Chief Operating Officer and General Counsel of any incident that may attract the attention of third parties or the media. The Chief Executive Officer or the Chief Operating Officer and General Counsel shall involve the Director of Marketing and Communications, as appropriate.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Risk Management		
Policy Name and Number:	RM 65 Incident Review		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RM 20 – Sentinel Events RM 30 – Root Cause Analysis		
Citation(s):			

RM 65 INCIDENT REVIEW

All reported incidents will undergo clinical and/or administrative review. The type and level of review is dependent upon the nature of the incident. Levels of review include:

- **Supervisory Review** – All incidents undergo supervisory review. Within 24 hours of receipt, the program supervisor or designee will review the incident report and forward to the Safety Coordinator. He/she will advise and consult with program leadership as needed and appropriate. The program supervisor will implement immediate and necessary risk reduction strategies as indicated in the interim of other reviews, and will complete a supervisory follow-up regarding the incident, as appropriate. Current policies and procedures will be followed.

- **Routine Review by Safety Coordinator** – Following supervisory review, all incidents reports undergo review by the Safety Coordinator. The Safety Coordinator will seek additional supervisory follow-up as indicated by the incident. The Safety Coordinator will be responsible to identify and track risk management data including but not limited to no-harm events, close calls and unsafe conditions. Data will be aggregated and reported to Director of Quality and Compliance, General Counsel, and/or Safety Committees.

- **Clinical Review by Treatment Team** – The treatment team reviews clinical implications through timely individual client centered consultation and/or clinical staffings. The treatment team will make appropriate clinical recommendations that are to be documented in the medical record.

- **Routine Review by Safety Committee** - The Safety Committees will monitor program and organizational data for significant trends in the areas of quality, safety and risk When negative trends are identified, the Safety Committee is responsible to make recommendations for proposed procedural and environmental changes to the Vice President(s) of Integrated Care, as applicable.

- **Routine Review by Subject Specific Committees** – Subject specific committees such as Infection Control Committee review identified incidents during regularly scheduled meetings. When negative response or trends are identified, subject specific committees are responsible to make recommendations for proposed procedural and environmental changes to the Vice President(s) of Integrated Care, as applicable.

- **Targeted Incident Review by a Targeted Incident Review Team** – A targeted incident review team will be responsible to review patient safety events that are considered adverse events. No-harm events, close calls and unsafe conditions events, as well as incidents of non-OIG reportable allegations of client abuse, neglect, or exploitation may also be elevated to targeted incident review at the discretion of the Vice President(s) of Integrated Care, as applicable or the Learning and Safety Manager or Director of Quality and Compliance. The team will be responsible to review the incident and to develop and oversee implementation of a plan for mitigation of safety risks as appropriate to the program/facility and level of care of treatment provided at the facility. The team will make best efforts to convene no later than 3 business days of an adverse event at the direction of the Vice President(s) of Integrated Care and/or Executive Director of Chestnut Family Health Center, as applicable or Director of Quality and Compliance. The core review team will be inclusive of the Program Director, Quality Improvement Staff, and at least one Executive Leadership Council Member. The team will be supplemented with internal and external consultants with specialized knowledge appropriate to the incident (i.e. legal counsel, medical director, facilities manager, subject expert.) The team will report to the Vice President(s) of Integrated Care, as applicable or Director of Quality and Compliance.

- **Leadership Incident Review -** Patient safety events that are considered adverse events will also be reviewed by leadership. The core review team will be inclusive of the Program Director, Vice President(s) of Integrated Care, as applicable, the Learning and Safety Manager and the Director of Quality and Compliance. The team will be led by the Vice President(s) of Integrated Care, Clinical Director, as applicable and supplemented with additional staff at his/her discretion. The focus of the Leadership Incident Review will be to determine if existing rules/policies negatively contributed to the incident and to review resource allocation related to the incident.

- **Root Cause Analysis** – Root Cause Analysis is conducted for all Sentinel Events as per Sentinel Events (RM 20) and Root Cause Analysis (RM 30).

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Risk Management		
Policy Name and Number:	RM 70 Legal Hold		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

RM 70 LEGAL HOLD

Purpose and Scope

The purpose of this policy is to outline the process for preserving paper and electronic records (including health records) and related information when there is a reasonable anticipation of litigation to prevent spoliation of evidence.

This policy addresses the operational steps and communication process when litigation is anticipated and identifies the process to preserve and apply a legal hold on information and records, whether paper-based or electronic. It applies to any piece of information, record, or documentation regardless of whether it is maintained in the Management Information Systems ("MIS") department or by the administrative, clinical, or financial department that created it.

This policy applies to all Chestnut facilities, employees, records, and systems.

Policy

It is the policy of Chestnut to preserve information and records (paper and electronic) and related information that are or will potentially be utilized in litigation. It is the policy of the organization to place relevant records under a legal hold and suspend normal destruction practices to prevent against spoliation.

Procedure

Trigger Events and Application of a Legal Hold

The General Counsel and the Corporate Compliance Officer (the "Litigation Response Team"), will identify the trigger events that may indicate the potential threat of litigation. Departments/individuals are responsible for communicating to the Litigation Response Team any and all trigger events as they occur. The General Counsel must, in all circumstances, be copied on all such communications. The following are examples of trigger events:

- Notice of a lawsuit
- Charge of discrimination
- Notice of claim, including a medical malpractice claim

- Demand letter from a lawyer
- Meeting at which someone brings a lawyer
- Challenge to a corrective action (if the employee alleges a violation of state/federal law such as discrimination, harassment, whistleblower, etc.)
- Any person's credible verbal expression that he or she intends to sue the organization

Identifying, Locating and Maintaining Relevant Information

After receiving notification of a trigger event, the Litigation Response Team will review the potential issue and make a determination as to whether to apply a legal hold to relevant information. The Litigation Response Team will develop and define the process and decision making for deciding when to apply a legal hold. The following factors will be considered in deciding whether to apply a legal hold:

- The nature and specificity of the complaint or threat
- The party making the claim
- The position of the party making the claim
- The business relationship between the accused and accusing parties
- Whether the threat is direct, implied, or inferred
- Whether the party making the claim is aware of the claim
- The strength, scope, or value of a potential claim
- The likelihood that data relating to a claim will be lost or destroyed
- The significance of the data to the known or reasonably anticipated issues
- Whether Chestnut is aware of similar claims
- The experience of the industry
- Whether the relevant records are being retained for some other reason
- Media and/or industry coverage of the issue directly pertaining to the client or of complaints brought against someone similarly situated in the industry

The Litigation Response Team will document the facts relied on in deciding whether there is a duty to preserve information. If determined that a legal hold is warranted, the Litigation Response Team will engage appropriate individuals to assist in identifying, locating, and maintaining relevant information. A Legal Hold Team will be created for this purpose.

The Legal Hold Team will meet or communicate with applicable departments/data owners to determine the information available and identify the relevant information to be preserved (in all sources and formats) including information held by business associates. The following are examples of potential sources to search:

- Local area server for the office

- Personal share or personal folders on server
- Dedicated server for organization
- Laptop and/or department computer
- E-mail including archived e-mail and sent e-mail
- E-mail trash bin, desktop recycle bin
- Removable storage media (e.g., disks, CDs, DVDs, memory sticks, and thumb drives)
- Department/office files
- Personal desk files
- Files of administrative personnel in department/office
- Business files stored in a staff member's home

After the Legal Hold Team identifies relevant information to be preserved, it will communicate its findings to the General Counsel, who will provide a written notice of legal hold to the departments/data owners and identify the relevant information.

Departments/data owners will preserve the relevant information. The optimal method of preservation will be determined by the Litigation Response Team, the Legal Hold Team, and/or the Director of MIS based on the type of data and other relevant factors. Examples of preservation methods include:

- Making a mirror image of a hard drive
- Sequestering or archiving information/records
- Retaining back-up media to prevent destruction
- Taking a "snapshot" of information at a point of time and retaining on separate media
- For email and voicemail files, sequester an account and transfer files for a specific span of time
- For paper records, make photocopies. If originals requested, sequester files to protect from loss, destruction or alteration.

Monitoring Legal Holds

The Legal Hold Team may periodically query departments/data owners to ensure they are complying with the legal hold requirements. The Litigation Response Team may periodically audit for compliance with the legal hold notice and maintenance of relevant information.

Release of a Legal Hold

Once the Litigation Response Team determines that the legal hold is no longer necessary, the General Counsel will release the hold by providing written notice that the legal hold has been lifted with an instruction to resume normal retention and destruction processes. The notice will include a list of applicable records that were under legal hold and will require a sign-off by the appropriate departments/data owners. The

Litigation Response Team may perform periodic audits to ensure that information is not unnecessarily retained after the legal hold is lifted.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Risk Management		
Policy Name and Number:	RM 80 Medical Malpractice Claims Management (CFHC)		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RM 70 – Legal Hold		
Citation(s):	Federal Tort Claims Act ("FTCA") HRSA Health Center Program Compliance Manual		

RM 80 MEDICAL MALPRACTICE CLAIMS MANAGEMENT (CHESTNUT FAMILY HEALTH CENTER)

Purpose and Scope

The U.S. Department of Health and Human Services ("HHS") has deemed Chestnut Health Systems, Inc., doing business as Chestnut Family Health Center ("Health Center"), eligible for medical malpractice insurance coverage under the Federal Tort Claims Act ("FTCA"). Such coverage is extended to qualified employees and certain other individuals and independent contractors of the Health Center performing services within the Health Center's Section 330 approved scope of project and within such individual's scope of employment or contract for services.

The purpose of this policy is to outline the process for handling a medical malpractice claim or lawsuit or potential medical malpractice claim or lawsuit when it becomes known to a Chestnut or Health Center employee or contractor in order to ensure coverage under the FTCA. This policy applies to all Health Center employee and contractors, as well as all other Chestnut employees.

Procedure

Notification to applicable Vice President of Integrated Care

When an employee has knowledge of a medical malpractice claim or lawsuit against a Health Center professional (whether by receipt of notice, correspondence, or documentation related to such a claim or lawsuit, including service of process, a summons, complaint or claim form), or has knowledge of a potential medical malpractice claim or lawsuit against a Health Center professional, he or she shall immediately notify the applicable Vice President of Integrated Care He or she shall also promptly provide to the applicable Vice President of Integrated Care a copy of any of the aforementioned documents.

Preservation of Records and Documents

The Vice President of Integrated Care shall then promptly notify the General Counsel who, after consultation with the Litigation Response Team, may issue a legal hold on all existing records, documents, notes and written statements relevant to the claim or lawsuit in order to prevent spoliation of evidence, pursuant to RM 70.

Solicitation of Prompt HHS and HRSA Guidance

In consultation with the General Counsel, the Vice President of Integrated Care shall promptly seek a determination by the HHS Office of General Counsel (OGC) of whether all FTCA eligibility requirements were satisfied based on a verification of the facts, circumstances, and relevant documents related to the services at issue. The OGC will then determine whether the claim or lawsuit is covered by the Health Center's FTCA policy. The Vice President of Integrated Care shall provide a copy of the claim or complaint, along with documents related to the services in question, to the Health Center's field office FTCA coordinator, along with:

U.S. Department of Health and Human Services
Office of General Counsel, General Law Division, Claims Branch
Room 4256
300 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-2155

and

Office of Quality & Data
Health Resources and Services Administration
5600 Fishers Lane
Room 17C-05
Rockville, MD 20857
(301) 594-1202

Coordination with Federal Agencies

The Vice President of Integrated Care shall also provide to the OGC supporting documents as requested, which may include the Health Center's Notice of Grant Award, the Health Center's deeming letter, copies of employment agreements/clinical services contracts and job descriptions, credentialing and privileging documents, patient records, and documentation of compliance with other Health Resources and Services Administration ("HRSA") FTCA eligibility requirements such as ongoing quality assurance and peer review programs.

In the case of a lawsuit filed in state court, the General Counsel and/or the Vice President of Integrated Care shall consult with qualified local counsel to determine whether obtaining a stay in the proceedings is necessary (to avoid a summary/default judgment) until the U.S. Department of Justice ("DOJ") files for the case to be removed to Federal District Court and the United States is substituted as the defendant.

Further, the General Counsel and/or the Vice President of Integrated Care shall confirm with the OGC Claims Office when and under what circumstances the Health Center and/or individual providers may contact and/or respond to DOJ or U.S. Attorney inquiries and requests.

Participation in Settlement Process and Compliance with Reporting Obligations

Many claims are settled by the OGC or the DOJ. The OGC or DOJ may seek input from the Health Center, but the final settlement decision rests with HHS.

The Vice President of Integrated Care shall determine whether the claim or lawsuit has any National Practitioner Data Bank reporting implications for the Health Center and provider(s) involved and shall promptly comply with any such implications.

Other Actions Required

In managing a claim or lawsuit pursuant to this policy, the Health Center shall also take the following actions:

- Comply with federal and state medical, substance abuse, and/or mental health privacy laws and regulations.
- Follow Chestnut's marketing and communication policies (MC 310 – 340).
- Consider the possibility of whether the circumstances may involve related claims that have yet to be filed and seek guidance from HHS and the General Counsel.
- Review the terms of any gap insurance policies and the role of any insurer as they relate to DOJ.

Securing Gap Coverage, if Needed

The OGC may determine that the services that are the subject of a claim or lawsuit, or a portion of those services, are not covered under the FTCA, resulting in a coverage gap. The following may result in a coverage gap:

- Health Center provider services furnished at sites not within the approved scope of project.
- Health Center provider services furnished to non-Health Center patients.
- Employment and contracting arrangements with Health Center providers.
- Billing by individual Health Center providers.

In such an instance, the General Counsel shall consult with Chestnut's insurance carriers to determine coverage under the terms of any gap insurance policies and the interplay between such policies and FTCA coverage, if any.

Chestnut Health Systems
Safety

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CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 10 Safety Program		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 10 SAFETY PROGRAM

The safety program is built upon the concepts of Total Staff Responsibility and "See Something. Say Something". This concept calls for each staff member to be aware of their surroundings and to be responsible for safety for themselves patients, visitors and other staff members. Each staff is required to understand and participate in the safety program. All staff should be alert and report potential and observed safety concerns.

The purpose of the Chestnut Health Systems ("Chestnut") Safety Program is to:

1. Provide clear and understandable information to staff regarding their responsibilities and related processes regarding safety via a comprehensive Safety Manual;

2. Provide appropriate risk and hazard vulnerability assessments specific to the locations of services and consistent with populations served;

3. Establish and implement preventative and responsive policies concerning general safety to ensure the safety and health of all clients/patients, visitors, and staff;

4. Establish and implement organizational practices to ensure workplace safety for staff;

5. Establish and implement a bloodborne and airborne pathogens exposure control plan which:
   - establishes an information and training program to educate employees who have the potential for exposure to bloodborne pathogens and/or airborne pathogens on risk reduction while performing their job duties;
   - provides processes for appropriate engineering and work practice controls;
   - provides processes for post-exposure evaluation and follow-up for employees who become exposed to bloodborne or airborne pathogens; and
   - provides clients with education and referral, as indicated;

6. Establish and implement a plan for prevention and control of infection and disease;

7. Create the necessary infrastructure and allocation of resources to monitor the efficacy of Chestnut's safety practices;

8. Establish and implement a written plan for preventative and responsive practices concerning emergency preparedness and emergency management;

9. Establish and implement a plan for preventative and responsive practices concerning maintenance and management of the environment of care, including plans and practices that comply with any Playbook or Plan of Action established by Chestnut to respond to a workplace hazard or condition impacting Chestnut staff, patients/clients, and visitors;

10. Promote an influenza education and vaccination program to minimize the transmission of influenza virus in the workplace; and

11. Promote effective organizational communication to minimize risks and enhance safety for clients/patients, staff and visitors.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 12 Total Staff Responsibility for Safety		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 12 TOTAL STAFF RESPONSIBILITY FOR SAFETY

It is the responsibility of all staff members to be continuously aware of how their individual actions contribute to the maintenance of a safe and healthy environment. It is expected that if staff "See Something" that they "Say Something".

It is the responsibility of all staff members to promptly report any observed safety or infection control problem to their supervisor and/or the Learning and Safety Manager or Safety Coordinator. An Incident Report form should also be completed.

It is the responsibility of all staff members to be aware of the safety and infection control policies adopted as part of this safety plan. Failure of staff to respond to observed incidents of safety or infection control problems which present a hazard to clients, visitors or other staff may be grounds for suspension or termination of employment.

In the event that a safety, medication safety, or infection control problem arises and requires immediate attention, the problem should be reported to the supervisor on-call or to the backup administrative or clinical staff. To ensure the safety and well-being of those present, staff should take reasonable and necessary actions to mitigate imminent safety situations.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 15 Bloodborne and Airborne Pathogens Exposure Control Plan		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Occupational Health and Safety Administration (OSHA) Standards – Blood Borne Pathogens 1910.1030		

SI 15 BLOODBORNE AND AIRBORNE PATHOGENS EXPOSURE CONTROL PLAN

Chestnut's Bloodborne and Airborne Pathogens Exposure Control Plan is maintained in the Safety Manual. This plan is designed to demonstrate compliance with the Occupational Safety and Health Administration (OSHA) regulations governing exposure to bloodborne and airborne pathogens by employees of healthcare facilities. A copy of the Exposure Control Plan will be accessible to all staff and will be reviewed annually.

The Bloodborne and Airborne Pathogens Exposure Control Plan contains:

- Employee Blood Exposure Risk Determination;
- Hepatitis B Virus (HBV) Vaccinations;
- Engineering and Workplace Practices;
- Human Immunodeficiency Virus (HIV) and HBV Post-exposure Evaluations Procedures;
- Communication of hazards to staff;
- OSHA Recordkeeping Procedures; and
- Procedure for Evaluation of Circumstances Surrounding Exposure Incidents.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 20 Staff Responsibility for Infection/Exposure Control		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 20 STAFF RESPONSIBILTY FOR INFECTION/EXPOSURE CONTROL

All new staff shall be oriented concerning health and personal hygiene, surveillance and infection control measures, provision of a safe and healthy environment and precautions regarding exposure to bodily fluid contact (exposure).

Staff responsible for admission of residential clients will provide clients with basic information regarding infection control.

It is the responsibility of staff to report unsanitary conditions or inadequate infection/exposure control measures. Matters that require immediate attention should be directly reported to with acknowledgement of receipt by the reporting supervisor and/or to the Regional Facilities Manager. Additionally, as appropriate, a work order marked as a safety concern should be made via the employee support portal reporting mechanism on the Chestnut intranet. Conditions that are of concern but do not require immediate attention are to be reported as a work order marked as safety concern via the reporting portal with the reporting supervisor copied on the submission. The Learning and Safety Manager and Safety Coordinator and Regional Facilities Manager are automatically copied on all work orders that are reported as a safety concern.

If you are feeling ill, contact your supervisor and consider staying home to stop the spread of illness.

Staff with the following conditions shall not be permitted to administer client care:

- Temperature over 100.0 degrees Fahrenheit;
- Skin infections (open draining wounds) until drainage ceases;
- Respiratory tract infections;
- Active exanthems (widespread rash that is usually accompanied by systemic symptoms such as fever);
- Enteric (pertaining to the intestine) infection;
- Other conditions as identified by a Playbook or Plan of Action set forth by Chestnut.

Staff with the following conditions shall be limited in client contact:

- Herpes Simplex
- Poison Ivy

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 30 Blood Exposure Risk Determination Classifications		
Revision Date:	06/29/2016		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Occupational Safety and Health Administration (OSHA)		

SI 30 BLOOD EXPOSURE RISK DETERMINATION CLASSIFICATIONS

The Safety Committee in consultation with the appropriate Executive Management staff has performed an Exposure Determination to identify the potential for occupational exposure by employees based on their specific jobs and job tasks. Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties. OSHA has determined that feces, nasal secretions, saliva, sputum, sweat, tears, urine and vomit are not considered potentially infectious unless they contain blood. The risk for transmission of Hepatitis B Virus, Hepatitis C Virus, and HIV infection from these fluids is extremely low.

In addition, the committee has identified the types of activities or services rendered by employees that present potential risk of exposure. These classifications and activities shall be reviewed on an annual basis during the annual review of the Safety Manual.

Employee Risk Factor Classifications

Category I: – Routine Risk

Category I includes employees who routinely risk exposure to blood or other potentially infectious materials as a part of their daily job activities, should they fail to use personal protective equipment and procedures as instructed. The potentially high-risk activities include physical examinations, injections, drawing and handling of blood samples, care of minor wounds, dressing changes, vaginal exams, disposal of urine specimens, disposal of regulated waste, and cleaning contaminated areas or surfaces.

Category II: – Potential Risk

Category II includes employees that may occasionally risk exposure to blood or other potentially infectious materials should they fail to use personal protective equipment and procedures as instructed. The primary avenues of potential exposure are in the form of disposing of potentially infectious waste, or assisting with a sick or an injured person during an emergency situation.

Category III: Unlikely Risk

Category III includes employees that are unlikely to be exposed to blood or other potentially infectious materials.

Potential Risk Procedures and Occupational Activities

The following procedures or occupational activities are performed in this facility and could result in occupational exposure to bloodborne pathogens or other potentially infectious materials.

- Physical examinations
- Vaginal exams
- Injections
- Cleaning contaminated areas or surfaces
- Disposal of contaminated waste
- Drawing and handling of blood samples
- Disposal of urine specimens
- Care of minor wounds and dressing changes

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 35 Hepatitis B Vaccinations		
Revision Date:	06/27/2018		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RI 195 -Record Retention Schedule SI 30 - Bloodborne Pathogens		
Citation(s):			

SI 35 HEPATITIS B VACCINATIONS

All jobs are classified by risk factors for occupational exposure to Bloodborne Pathogens (see SI 30). All employees in job category I and II must either obtain the vaccine or sign a declination form that will be placed with the employee's personnel records within 10 days from the start of employment. The vaccine will be offered at no cost to the employee. The employee may request the vaccine at any later date and incur no charge for the vaccine. Employees without occupational exposure risk can request the Hepatitis B vaccine from Chestnut with supervisor approval. All documentation regarding status of the vaccine will be maintained by Chestnut as per RI 195, Record Retention Schedule.

Employees who receive the Hepatitis B Virus (HBV) vaccine or decline to have the vaccine will have documentation of the HBV vaccine status or the HBV vaccine declination form maintained in their employee records.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 40 Risk Assessment of Airborne Pathogens		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-care Facilities, 2005,		

SI 40 RISK ASSESSMENT OF AIRBORNE PATHOGENS

An annual assessment regarding risk for exposure to airborne pathogens will be conducted by the Learning and Safety Manager. The assessment will utilize most recent data from State/County Public Health Departments and will be conducted using a recognized tool such as "Protocol for conducting a TB Risk Assessment in a Health-care Facility" published by the Center for Disease Control in Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-care Facilities, 2005, Morbidity and Mortality Weekly Report (December 30, 2005, Vol. 54). Results of the Risk Assessment will be reported to the Infection Control Committee and will be included as part of the annual review of the Infection Control Plan.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 45 Tuberculosis Infection Control – Employees and Volunteers		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	Centers For Disease Control - "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005"		
Citation(s):			

SI 45 TUBERCULOSIS INFECTION CONTROL – EMPLOYEES AND VOLUNTEERS

As part of its Infection Control Plan, Chestnut screens employees and volunteers for potential Tuberculosis infection prior to beginning employment based on the "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005" published by the Center for Disease Control (CDC). Based on an assessment using CDC guidelines, Chestnut facilities are considered "low risk" which means the facilities are settings in which persons with TB disease are not expected to be encountered, and, therefore, exposure to Mycobacterium tuberculosis (TB) is unlikely.

Chestnut uses two methods of screening for Tuberculosis infection. The method used for the individual employee depends upon the employee's job description which involves direct face-to-face client contact and/or the employee's history of positive TB skin tests.

For employment/volunteer purposes, TB skin tests results will be accepted from a previous employer or medical professional (physician or mid-level practitioner). If the individual can provide evidence of a negative two-step test within three (3) months of the start date, there is no need for a TB test prior to beginning work. If the individual provides evidence of a negative two-step test within 12 months of the start date, the individual must have only the initial skin test and is not required to have the second step. These timeframes and testing requirements reflect CDC guidelines. If the individual can provide evidence of a negative blood test within 12 months of the start date, there is no need for a TB test prior to beginning work.

New Employees and Volunteers with Direct Face-to-Face Client Contact, and No History of a Positive TB Skin Test

All new employees and volunteers with job duties that primarily include direct face-to-face client contact or extended periods of time on residential units or in housing apartments (i.e. maintenance staff) that have no history of a positive TB test shall have either a interferon gamma release assay (IGRA) blood test or a two-step TB skin test, with the first test initiated prior to the first day of employment and read prior to or on the first day of employment unless medically excused or can provide documentation of a negative TB test result obtained within the past three months.

Interferon Gamma Release Assay (IGRA) blood test

TB blood tests are also called interferon-gamma release assays or IGRAs. Two TB blood tests are approved by the U.S. Food and Drug Administration (FDA) and are available in the United States: the QuantiFERON®-TB Gold Plus (QFT-Plus) and the T-SPOT®.TB test (T-Spot).

Two Step Process - Initial Skin Test

The first TB skin test is considered a "baseline test". Baseline test results serve two purposes: 1) if positive, prompt the requirement for medical and diagnostic evaluation of TB disease before employment begins; and 2) if negative, provide a basis for comparison in the event of a potential or known exposure to Mycobacterium tuberculosis occurring during the time period the employee is working at Chestnut.

If the first TB skin test result is negative, the person is classified as not contagious with Mycobacterium tuberculosis and may begin work. However, a second TB skin test is to be administered. The CDC recommends that the second skin test should be administered 1- 3 weeks after the first skin test was read. The second TB skin test is not necessary if the employee can provide documentation of a negative TB skin test obtained within the 12 months prior to the initial TB skin test. It is the employee's responsibility to comply with the second TB skin test and if it is not administered within the recommended timeframe, this may be considered an employee work performance issue and addressed with the supervisor.

If the first TB skin test result is positive, the employee may not begin work and should be promptly evaluated. The evaluation should be conducted by the local health department or a medical professional. The new employee is responsible for the cost of the evaluation. Prior to beginning work, the employee must present documentation that s/he has been medically evaluated for TB and found to be not contagious with Mycobacterium tuberculosis. The Chestnut medical staff that read the positive TB skin test will report the positive result to the local health department.

Two Step Process - Second Skin Test

The CDC states that "a positive result to the second skin test is probably caused by boosting as opposed to recent infection with Mycobacterium tuberculosis. Two-step testing will minimize the possibility that boosting will lead to an unwarranted suspicion of transmission of Mycobacterium tuberculosis with subsequent testing."

If both skin test results are negative, the person is classified as not contagious with Mycobacterium tuberculosis.

If an employee has a positive result for the second skin test, the employee will be screened for symptoms of active Mycobaterium tuberculosis.

- If positive result and no symptoms are noted, the employee should seek further evaluation from the local health department or a medical professional, however, the employee can continue to work. The employee is responsible for payment of the medical evaluation. The Chestnut medical staff that read the positive TB skin test will report the result to the local health department.

- If positive result and symptoms are noted, the employee will placed on unpaid administrative leave and not permitted to work until the employee provides written documentation that they have been found not to be contagious with Mycobacterium tuberculosis from the local health department or a medical professional. The employee is responsible for the cost of the medical evaluation. The Chestnut medical staff that read the positive TB skin test will report the result to the local health department.

New Employees and Volunteers With a History of Positive TB Skin Test, and/or
New Employees and Volunteers Without Direct Face-to-Face Client Contact

New employees and volunteers that have direct face-to-face contact but have a history of a positive TB skin test cannot be skin tested and therefore, shall be screened for symptoms of active Tuberculosis upon hire/ start of work.

All employees and volunteers that do not have regular face to face contact shall be screened for symptoms of active Airborne Tuberculosis upon hire/start of volunteer work.

If the screening results in identification of symptoms of active Tuberculosis, the employee or volunteer will not be permitted to start work until he/she was provided written documentation from the local health department or a medical professional that the individual has been found to be not contagious with Mycobacterium tuberculosis. The individual is responsible for the cost of the medical evaluation. If the symptom screening does not result in identification of symptoms of active Tuberculosis, the employee or volunteer is classified as not contagious with Mycobacterium tuberculosis.

Annual TB Screening and Testing

All employees and volunteers with job duties that primarily include direct face to face client contact or support to residential units (i.e. maintenance staff) shall be screened annually (based on anniversary of hire date) for symptoms of active TB.

If the screening results in identification of symptoms of active Tuberculosis, the employee or volunteer will be placed on unpaid administrative leave and not permitted to work until the employee is found not to be contagious. The employee should be promptly evaluated by the local health department or medical professional. Prior to returning to work, the individual must present documentation that s/he has been medically evaluated for TB and found to be not contagious with Mycobacterium tuberculosis. The individual is responsible for the cost of the medical evaluation.

Screening and Testing After Suspected Exposure to TB

Employees and volunteers shall be screened or tested upon a known or suspected occupational exposure to tuberculosis. The screening/testing process shall be conducted based on directives from the local health departments and Chestnut's Medical Director and are outlined in the Safety Manual.

Medical Clearance for TB Skin Test during Pregnancy

Any pregnant employee or volunteer must have written medical clearance from a medical professional before a TB skin test can be given. If the pregnant individual is prohibited from obtaining a TB Skin test, written documentation stating the individual is found not to be contagious with Mycobacterium tuberculosis by a medical professional is required before the employee or volunteer can begin duties.

TB Skin Test Documentation

A log is maintained by the nursing staff of every TB skin test conducted and test result. Documentation that the screening process has been completed and the employee is found to be not contagious shall be recorded in the individual's personnel file.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 46 Tuberculosis Infection Control - Clients		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Illinois Department of Public Health Control of Communicable Diseases Code: Section 690.200 Reporting Missouri Department of Mental Health – 19 CSR §20-20.020(2)		

SI 46 TUBERCULOSIS INFECTION CONTROL - CLIENTS

Staff should take immediate precautions, including the use of facemasks, and consult the Safety Manual when a client endorses or presents with symptoms consistent with active TB.

BEHAVIORAL HEALTHCARE (NON-330 PROGRAMS)

All non-residential clients that receive face-to-face clinical services are evaluated for signs and symptoms of active Airborne Tuberculosis during their initial assessment by the clinician completing the assessment. When indicated, clients should be referred to their personal physician, local health department or to Chestnut nursing staff to obtain medical clearance prior to beginning treatment.

All crisis residential, detoxification, residential substance use services clients, substance use day treatment and supervised living clients will be tested for TB upon admission, but no later than seven (7) calendar days after admission. Clients with evidence of a TB test within one year do not have to be re-tested, but should be evaluated via checklist for symptoms of active TB and past exposure. Clients that have had a positive TB skin test in the past shall be evaluated for symptoms of active TB. Clients that have no history of a positive TB skin test shall have a TB skin or blood test, if medically appropriate. Clients that are immunosuppressed may be ordered to have a blood test, chest x-ray, sputum smear and/or sputum culture/sensitivity study instead of the skin test. Any pregnant client must have written medical clearance from a medical professional before a TB skin test can be given. If the pregnant individual is prohibited from obtaining a TB Skin test, written documentation stating the individual is found not to be contagious with Mycobacterium tuberculosis by a medical professional or a negative blood test is required before the client can be admitted to the above named programs.

The results of TB testing shall be recorded in the client's medical record. Results from a skin test shall include the mm of induration, date given and date read. Clients found to have a positive reaction of 5 mm or more, positive blood test, or who have signs and symptoms of active TB shall be referred for medical evaluation. Admission may be delayed or the client may be discharged from treatment until medical clearance is gained.

The local health department shall be notified of all active TB cases in accordance with applicable State statutes.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 60 HIV/AIDS Admission and Screening		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Illinois AIDS Confidentiality Act Confidentiality of AIDS Records and Reports Missouri – Mo. Rev. Stat. §191.656		

SI 60 HIV/AIDS ADMISSION AND SCREENING

Clients with confirmed diagnoses of Acquired Immune Deficiency Syndrome (AIDS) or who test positive for the Human Immunodeficiency Virus (HIV) are eligible for Chestnut services as long as they are not exhibiting acute symptoms of the disease that interfere with their ability to effectively participate in treatment. Individuals with acute symptoms will be referred to the medical provider of choice.

HIV testing can be ordered by the appropriate provider as indicated by the client need and preference.

Those individuals at high risk for the HIV virus include (source: National Institutes for Health) those who:

- Engage in anal, vaginal, or oral sex with men who have sex with men, multiple partners, or anonymous partners without using a condom
- Inject drugs or steroids where needles/syringes are shared
- Have a sexually transmitted infection, such as syphilis, genital herpes, chlamydia, gonorrhea, bacterial vaginosis, or trichomoniasis
- Have been diagnosed with hepatitis, tuberculosis, or malaria
- Exchange sex for drugs or money
- Are exposed to the virus as a fetus or infant before or during birth or through breastfeeding from a mother infected with HIV
- Received a blood transfusion or clotting factor in the United States anytime from 1978 to 1985
- Engage in unprotected sex with someone who has any of the risk factors listed above

In the event of a positive test, the client shall be provided appropriate counseling consistent with applicable state laws. The knowledge and records of these test results shall be handled in a manner consistent with Chestnut policy and applicable state laws.

All detoxification and substance use residential clients will receive a HIV/AIDS assessment and risk reduction education during their health assessment with the nurse. All substance use program clients will receive HIV/AIDS risk reduction education during the course of their treatment. Those at high risk for HIV infection will be encouraged to seek testing.

A client that requests testing for the HIV antibody will be referred to a health care provider or the appropriate County Health Department or other available testing site for anonymous testing.

Should the client choose to share the test results with the Chestnut medical or clinical staff, those results will be held in confidence and handled in a manner consistent with Chestnut policy and applicable State statutes.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 70 Infection Prevention and Control Plan		
Revision Date:	08/25/2021		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	Safety Manual		
Citation(s):			

SI 70 INFECTION PREVENTION AND CONTROL PLAN

As per the results of ongoing vulnerability assessment, Chestnut has adopted a plan for prevention and control of infection. The Safety Manual outlines this plan and provides detailed procedures for communication, recordkeeping, and engineering/work practice controls related to infection prevention and control.

Communication of Hazards to Staff

Fluorescent orange or orange-red warning labels marked “BIOHAZARD” will be affixed to containers of all regulated waste, refrigerators and freezers containing blood or other potentially infected material and other containers used to store, transport or ship blood or other potentially infected material. Labeling of materials will be consistent with regulatory requirements and are detailed in the Safety Manual. Red bags or red containers may be substituted for labels. On residential units, the rooms of clients known to have a communicable disease should be inconspicuously marked in such a way so as to identify to staff working on the unit the need for enhanced precautions. Reference the Safety Manual.

All staff at risk for occupational exposure will receive initial and annual training regarding management of biohazard materials and other tasks where occupational exposure may take place. Additional training will be provided in the event of a modification of tasks or procedures or the institution of new tasks or procedures which affect an employee’s occupational exposure. The training program is outlined in the Safety Manual and is consistent with OSHA standards.

Recordkeeping

Accurate records will be maintained for all employees regarding infection control in accordance with State and Federal requirements. Records will be maintained for training, occupational exposure incidents and sharps injury incidents. The content and extent of each recordkeeping requirement is detailed in the Safety Manual.

Medical records related to an employee’s occupational exposure will be kept confidential and will not be disclosed or reported to any person within or outside the workplace without the employee’s express written consent except as required by law.

Such records will be maintained and made available upon request for examination and copying to employees, employee representatives and to OSHA. Chestnut will comply with all OSHA provisions related to transfer of medical records should it cease to do business.

Engineering and Work Practice Controls

Chestnut will adopt appropriate engineering and work practice control procedures. Such work practice procedures have been adopted by Chestnut as a part of its Safety program and are directed toward minimizing employee exposure to bloodborne pathogens and other potentially infectious materials. All new employees or employees reassigned to new duties are trained and instructed regarding work practice controls as required by their particular job description by their immediate supervisor. Control procedures are outlined in the Safety Manual. These procedures include, but are not limited to:

- Universal Precautions
- Urine Specimen Procedures
- Hand Washing
- Recapping and Disposal of Sharps/Needles
- Eating, Drinking, Smoking, Applying Cosmetics and Handling Contact Lenses
- Storage of Food and Drink
- Leak Proof Containers
- Minimize Splashing
- Personal Protective Equipment
- Disposal of Protective Equipment
- Housekeeping Procedures
- Regulated Wasted and Similar Materials
- Storage of Biohazard Materials
- Processing Urine Not to be Tested
- Handling Sharp Objects

Emerging Infectious Diseases

Chestnut will monitor current clinical and epidemiological information regarding new emerging infectious disease as part of its Infection Prevention and Control Plan. Accordingly, Chestnut will respond with specific playbook and action plans guided by the Centers for Disease Control and will act in accordance with these documents.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 80 Accidental Employee Needle Stick or Blood Exposure		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	29 CRF 1910.20 (OSHA)		

SI 80 ACCIDENTAL EMPLOYEE NEEDLE STICK OR BLOOD EXPOSURE

All incidents of employee accidental needle stick or blood exposure are to be immediately reported to the employee's supervisor or designee.

Should an employee accidentally pierce his/her own skin with a used needle or spill/splatter another individual's blood onto an open wound or mucous membrane (eye, mouth, etc.), the employee will follow procedures for post exposure evaluation and documentation of the incident. Staff not employed by Chestnut and working per a contract should follow the procedures of the employer.

The employee must seek post exposure evaluation within one hour of the incident. The employee should access the blood exposure packet located within the Safety page of the intranet. The packet provides needed instructions, forms and information, including guidance pertaining to the source patient. The post exposure evaluation procedure complies with OSHA standards.

The employee must document the exposure event on an incident report which is to be completed prior to the end of the employee's shift during which the event occurred.

Within 15 days of a blood exposure evaluation, the evaluating health care professional will provide to Chestnut a written opinion of the post-exposure evaluation. Chestnut will in turn provide the employee a copy of the written opinion. The healthcare professional’s written opinion for Hepatitis B vaccination will be limited to whether Hepatitis B vaccination is indicated for the employee, and if the employee has received such vaccination. Additionally, the healthcare professional’s written opinion for post-evaluation follow-up shall be limited to confirmation that the employee was informed of both the results of the evaluation and of any medical conditions resulting from the exposure which require further evaluation or treatment. All other findings or diagnoses shall remain confidential and shall not be included in the written opinion report.

A confidential record of the exposure incident will be maintained in a locked storage area and will not be released to any person inside or outside of the agency without written consent of the employee. The record will include documentation of the Hepatitis B vaccination status and the health care professional's written opinion. This record shall be maintained in accordance with Chestnut’s record retention policy.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 85 Exposure To Unknown Powdered Substances		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 85 EXPOSURE TO UNKNOWN POWDERED SUBSTANCES

While performing a task when exposure to drug powders is possible, standard precautions for dealing with suspicious substances should be implemented. The Safety Manual contains detailed procedures and should be consulted. Minimally, staff should take the following precautions related to unknown powdered substances:

- Avoid direct contact with the substance
- Wear personal protective equipment (PPE) including gloves, properly fitted respiratory protection, and safety eyewear
- Wash your hands with **soap and water** often and after handling suspicious substances or packages; do not use any sort of hand sanitizer
- Use proper decontamination and notification procedures for contaminated equipment or clothing

If an overdose is suspected, Naloxone (i.e. Narcan Nasal Spray) is safe and counteracts the effects of an opioid overdose including fentanyl and other synthetic opioids.

- **DON'T** delay. Administer naloxone, if you suspect an overdose. Administer additional doses if necessary
- Call immediately for emergency medical assistance
- If naloxone is not available, provide rescue breathing or life-saving efforts until emergency services arrive

If exposure is suspected (without overdose), the employee must seek post exposure evaluation within one hour of the incident. The employee should access the Exposure to Unknown Powdered Substance Packet-For Incidents Not Involving Overdose located within the Safety page of the Intranet. The packet provides needed instructions, forms and information. Staff not employed by Chestnut and working per a contract should follow the procedures of the employer.

The staff or supervisor must document the exposure event on an incident report which is to be completed prior to the end of the shift during which the event occurred.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 90 Safety Manual		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Illinois Department of Substance Use Recovery and Prevention Missouri Department of Mental Health		

SI 90 SAFETY MANUAL

Chestnut's Safety Manual is intended to be a convenient reference for policies and procedures in relation to safety issues and is divided into four primary sections:

- Infection & Exposure Control
- Environment of Care
- Emergency Preparedness & Response
- Client/Patient, Staff and Visitor Safety

The policies and procedures of the Manual are applicable to all Chestnut facilities.

The infection and exposure control section (plan) details how to prevent exposure and what to do in the event of exposure. It provides information to help protect employees from exposure to bloodborne pathogens, airborne pathogens and other potentially infectious materials. This section contains the exposure control plan which works in conjunction with other safety and infection control policies and procedures. It is also intended to demonstrate compliance with the Occupational and Safety Administration's (OSHA) regulations for employees of healthcare facilities regarding exposure to bloodborne pathogens.

The environment of care section provides information regarding overall environmental safety for Chestnut staff, patients, and facilities. It provides information in the functional areas of: safety, security, hazardous materials and waste, fire safety, medical equipment and utilities.

The emergency preparedness and response section provides guidance for proactive and reactive response to emergencies.

The client/patient, staff and visitor section provides guidance regarding overall safety for those working, visiting and/or receiving services at Chestnut.

All staff are responsible to become familiar with and reference the Safety Manual as appropriate. The Safety Manual is posted on the intranet and assigned via the Learning Management System for review and acknowledgement of receipt. The Learning and Safety Manager and Safety Coordinator are resources for questions regarding the content of the manual.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 92 Safety Structure and Function		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 92 SAFETY STRUCTURE AND FUNCTION

The Learning and Safety Manager is responsible for carrying out the functions of the Safety program and to:

1. Be knowledgeable about the applicable federal, state, local, and The Joint Commission safety codes, infection control policies, and emergency management procedures;
2. Take action to identify and correct potential safety or infection/exposure control problems prior to the time they represent a hazard to clients, visitors, and staff;
3. Receive, investigate, and evaluate all reported incidents related to safety, infection control, exposure to bloodborne or airborne pathogens, or risk management;
4. Function as chairperson of all safety related committees, to solicit staff members to serve on committees, and to delegate specific assignments to committee members;
5. Provide information and training to all employees who have the potential for exposure to bloodborne or airborne pathogens;
6. Maintain and/or supervise maintenance/storage of appropriate records pertaining to the operation of the Safety Program;
7. Perform an annual review of the effectiveness of the safety program, including the Environment of Care Plan;
8. Coordinate program safety and emergency preparedness activities;
9. Recommend safety rules;
10. Investigate and evaluate incident reports on safety events;
11. Annually review and update the Safety Manual;
12. Determine and assign training to staff on the safety program;

13. Formulate and supervise the implementation of an active and continuing program of risk identification and management as related to safety;

14. Develop safety checklists for the purpose of making periodic and regular safety checks on specified conditions that can adversely affect the health or safety of the occupants of the facility; and

15. Report to the Regional Quality Management Committees and Corporate Quality Management Committee on the effectiveness of the Safety Program on a regular basis through incident reports, trend analysis reports, and annual updates to the Safety Manual.

An Infection Control Committee comprised of the Learning and Safety Manager, the Safety Coordinator, Infection Control Representative, Facilities and Health Center staff from each region will meet quarterly or as needed to ensure organizational effectiveness and efficiency related to infection control activities.

The Infection Control Committee is responsible to:

1. Conduct an annual review of infection prevention and control practices at Chestnut with results published in the annual review of the Environment of Care Plans;

2. Conduct facilities inspections for purposes of infection control monitoring;

3. Monitor trends in infection prevention and control for regional area that are likely to impact the populations served;

4. Contribute to the revision of the Infection Control Plan annually or as needed;

5. Contribute to the development and coordination of infection prevention and control processes;

6. Contribute to the development of monitoring systems for infection prevention and control; and

7. Provide teaching, consultation and communication on best practices in infection prevention and control.

The Regional Safety Committees are responsible to meet with the Safety Coordinator on a routine basis regarding safety culture and safety related items specific to Region and its business units:

1. Coordinate strategies for safety program;
2. Investigate and evaluate incident reports related to safety;
3. Assess emergency preparedness activities and status;
4. Assess infection control activities and status;
5. Assess medical equipment monitoring and maintenance activities and status;
6. Assess staff development and competencies activities related to safety; and
7. Other Region and business unit specific safety items.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 94 Safety Program Records and Reports		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 94 SAFETY PROGRAM RECORDS AND REPORTS

The Safety and Learning Manager has overall responsibility for the collection of safety, infection/ exposure control and related risk management data and the preparation of reports, but may delegate specific data collection and investigative functions to appropriate staff. In conjunction with Facilities and program staff, the following reports are maintained.

1. Minutes of Safety Committee meetings. The Safety Committee minutes or data may be reported out in various Committee meetings;

2. Results of safety checks or inspections;

3. Results of routine tests and calibration of medical equipment;

4. Record of significant repairs, maintenance, and corrective action taken as a result of preventive or corrective measures;

5. Monitoring of medication administrations in residential and housing programs, including omissions and documentation omissions;

6. Monitoring of infection control data including the number of healthcare associated infections incurring in the residential and housing programs and the results of the TB skin testing of employees and clients;

7. All Incident Reports and trend analysis reports; and

8. Annual review and recommended changes to safety policies and manual.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 110 Patient Safety		
Revision Date:	06/29/2016		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RM 15 – Patient Safety Events RM 20 – Sentinel Events		
Citation(s):	The Joint Commission		

SI 110 PATIENT SAFETY

The Joint Commission defines a patient safety event as an event, incident, or condition that could have resulted or did result in harm to an individual served. All Chestnut staff will identify and respond appropriately to each patient safety event. Patient safety events and associated responses are outlined in Risk Management policies RM 15 and RM 20. Staff should reference these accordingly.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 115 National Patient Safety Goals		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	The Joint Commission		

SI 115 NATIONAL PATIENT SAFETY GOALS

The Joint Commission determines the highest priority patient safety issues and establishes National Patient Safety Goals (NPSG) to help address specific areas of concern. As part of its Quality Management program, Chestnut will focus on these NPSG.

Current NPSG focus on:

- Patient Identification
- Improved Communication
- Medication Safety
- Healthcare Associated Infections
- Risk Assessment
- Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery
- Improving Healthcare Equity for Individuals Served

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 130 General Safety		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☒Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 130 GENERAL SAFETY

1. The building and grounds will be inspected monthly by the maintenance personnel to insure that there are no safety hazards.

2. Medical device recalls and hazard notices from government agencies will be reviewed by the Learning and Safety Manager and appropriate action will be taken.

3. All accidents, injuries, and imminent safety hazards will be immediately reported to a supervisor and an incident report completed. The supervisor and the Learning and Safety Manager or designee will review reports to ensure that appropriate action is taken. Reports will then be reviewed and evaluated at Safety Committee meetings.

4. New staff will be provided with safety related information as part of new employee orientation. Staff will receive annual safety education.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 140 First Aid and Medical Emergencies		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 140 FIRST AID AND MEDICAL EMERGENCIES

General Procedures for Medical Emergencies are detailed in various manuals, including

- Safety,
- Medical Manual,
- Chestnut Family Health Center, and
- program specific.

Staff should become familiar with these manuals and procedures contained within as related to one's job responsibilities.

All staff monitoring clients are to be familiar with basic first aid procedures. Red First Aid Grab and Go bags are strategically located in each Chestnut facility. Reference the Safety Manual for contents and bag locations at each site. A first aid kit is maintained in each vehicle used to transport clients. Staff shall exercise caution in providing emergency help to individuals to avoid exposure to bodily fluids. Gloves and plastic airways are included in the first aid bags and kits. Any materials used from a first aid bag or kit are to be replaced immediately. The Safety Coordinator or purchasing staff may be contacted to request additional supplies.

Only staff certified in CPR are permitted to perform CPR in an emergency. Defibrillators are available at some Chestnut sites. 911 is to be called for all CPR emergencies. CPR should be performed consistent with training. Chestnut recognizes certifications from American Red Cross and American Heart Association as competency. If certification is from another entity, staff will be required to perform competency skill with a certified instruct ARC or AMA instructor within 90 days of start date.

All Chestnut sites, and various staff members are equipped with Naloxone for suspected opioid overdose. At Chestnut sites, Naloxone is maintained in red First Aid Grab and Go bags. During a suspected overdose event, staff should administer Naloxone, call 911, monitor the individual's response, and administer additional doses of Naloxone if no response. Detailed instructions are provided in the Grab and Go bag.

Chestnut will honor a client's expressed or written Advanced Directive within the scope of its licenses. If a known Advanced Directive has been expressed and provided by the client, a written copy of this will be provided to emergency medical personnel. In the behavioral health EMR, an alert will be created on the client facesheet when a client provides an advanced directive. In the primary care health EMR, the directive will be recorded in the designated area. For shared patients, advanced directive information will be shared upon receipt.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 170 Vehicle Safety		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	PP 1600 – Staff Transportation Of clients In Chestnut Vehicles, PP 1605 – Transportation Via, Staff's Personal Vehicles, PP 1610 – Traffic Violations		
Citation(s):	Missouri Department of Mental Health, Physical and Environment and Safety, 9 CSR §10-7.120(8).		

SI 170 VEHICLE SAFETY

All staff driving a Chestnut or personal vehicle while performing their job must possess and maintain a valid government issued driver's license and meet standards for agency auto insurance coverage, including approval by Chestnut's automobile insurance carrier. Staff must be approved prior to driving company vehicles and/or transporting patients.

While conducting Chestnut business in company or personal vehicles, including transporting patients in personal vehicles, staff must abide by all State laws and Chestnut policies. Staff should additionally refer to applicable Personnel Policies regarding use of vehicles in the course of performance of job duties.

All Chestnut staff and passengers must properly use safety belts when driving company and personal vehicles while conducting Chestnut business. Children will be secured in an age-appropriate car/booster seat in accordance with state and federal car seat laws and regulations.

There is an expectation for compliance with Chestnut rules and instructions regarding proper conduct during transportation. Staff are not expected to transport individuals who refuse to be secured and who do not comply with the requests of the driver.

Staff driving Chestnut passenger cars and vans are expected to complete training as assigned via the learning management system (LMS). Staff driving over-sized vehicles such as 15 passenger van or mobile medical unit are expected to complete LMS assigned training prior to driving an over-sized vehicle.

Staff assigned to drive the mobile medical units are expected to complete additional competency training as assigned via the learning management system (either online or in-person training documented in the learning management system) before driving the vehicle unsupervised.

Fines incurred due to driving violations are the financial responsibility of the driver, including toll violations, parking tickets and other such violations.

In the event the company vehicle is involved in an accident, the staff involved must follow the written accident procedures on vehicle's insurance card in each vehicle, including completion of an accident and incident report form.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 230 Safety Data Sheets		
Revision Date:	06/28/2023		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			
Related Documents:	Safety Data Sheets (SDS)		

SI 230 SAFETY DATA SHEETS

Safety Data Sheets (SDS) shall be maintained for all chemicals utilized by Chestnut. Purchasing staff are responsible for assuring that all SDS Sheets are obtained for new chemicals used in facilities. Staff are encouraged to become familiar with the location of the SDS sheets which are located electronically on the W: Drive SDS folder. Staff are to be oriented by their direct supervisor on to how to find an SDS sheet and information about any specific chemical typically used in their job duties as part of their orientation and training.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 240 Children Specific Areas		
Revision Date:	06/29/2016		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 240 CHILDREN SPECIFIC AREAS

Chestnut facilities include various children specific areas, including childcare areas, play therapy rooms and play areas within waiting rooms. Chestnut shall implement appropriate precautions to minimize danger to children and create a safe environment, including child-proofing and routine cleaning/sanitation of children specific areas. Items that pose a choking hazard and potential poison hazards shall be secured and kept away from young children. Chestnut maintains emergency phone numbers and first aids kits.

Chestnut shall implement safety measure to minimize access to children by unauthorized persons and to prevent elopement or escape of children.

Procedures pertaining to childcare staff are described in applicable program manuals.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 250 Service Animals and Pets		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Illinois White Cane Law Illinois Guide Dog Act Illinois Human Rights Act Missouri Human Rights Act Americans with Disabilities Act		
Related Documents:	Consent and Release Form Employee Service Animal Form Non-Employee Service Animal Form		

SI 250 SERVICE ANIMALS AND PETS

For safety reasons, pets and other animals are not allowed inside of ambulatory, outpatient or residential facilities, with the exception of service animals for persons with a disability and certified therapy animals. Service animals are permitted in facilities in accordance with the Illinois White Cane Law, Illinois Guide Dog Act, Illinois Human Rights Act, the Missouri Human Rights Act and the Americans with Disabilities Act. To determine if an animal is a service animal, staff may ask only the following two questions:
1. Is the animal a service animal required because of a disability? (Yes or No)
2. What work or task has the animal been trained to perform?

A consent and release form for service animals is required for patients with a service animal who are being treated in a residential setting. Emotional support animals are not permitted inside of ambulatory, outpatient or residential facilities. In the behavioral health EMR, an alert will be created on the client facesheet when a client has a service animal. In the primary care health EMR, the determination will be recorded in a designated area. For shared patients, service animal information will be shared upon receipt.

The Safety Manual provides further information regarding service animals at Chestnut facilities. Visitors bringing pets to the facility must be requested to leave them outside and/or to take them off Chestnut property depending upon the potential threat of the pet. Staff should take into consideration the potential therapeutic benefit to a patient who may request that a pet is brought to visit while the individual is in residential treatment.

Pets are allowed in some housing sites. See lease agreements for rules concerning pets at each site.

Therapeutic animals are allowed as per program guidelines. Programs will consult with the Learning and Safety Manager regarding therapeutic animals.

All authorized animals brought onto Chestnut premises must be:

- Immunized against rabies and tagged as such
- Under the control of the handler
- Cared for, supervised and cleaned after by the handler
- Harnessed, tethered or leashed at all times, unless doing so interferes with a service animal's functions or handler's disability. In that case, the animal must be controlled by voice or other commands
- Housebroken
- In good health and free of vermin (i.e. fleas)

Reasonable behavior is expected from animals brought onto the premises. The handlers of disruptive, aggressive animals may be asked to remove them from Chestnut property. The program supervisor must consult the Safety Coordinator if he/she seeks to exclude a service animal from a Chestnut site.

If a staff member is allergic and unable to provide care to a client, he/she should advise a supervisor. The supervisor will designate another staff member to provide care.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 260 Utility Systems		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	Safety Manual		
Citation(s):			

SI 260 UTILITY SYSTEMS

Chestnut manages risks associated with its utility systems and assures that each facility has reliable sources of electricity. Procedures for responding to utility systems disruptions are written and maintained by the Facilities Director. Inspection and maintenance activities for operating components of utility systems are documented. Response to utility systems emergencies are addressed in the Safety Manual.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 270 Facilities Maintenance		
Revision Date:	06/29/2016		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 270 FACILITIES MAINTENANCE

Chestnut manages risks associated with maintenance of its facilities and assures that each facility has available resources for proper maintenance. A help desk via the intranet is available to all staff for the purpose of making maintenance requests. All requests and subsequent responses are documented in the database. Procedures for ongoing routine cleaning and maintenance, as well as catastrophic facilities events, are written and maintained by the Facilities Director. Inspection and maintenance activities of facilities are documented.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 280 Fire Safety		
Revision Date:	08/26/2020		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):	Missouri Department of Mental Health, Physical and Environmental Safety, 9 CSR §10-7.120(7)		

SI 280 FIRE SAFETY

Chestnut manages fire risks and has a plan for reducing fire risks included in the Environment of Care Plans. Chestnut shall comply with the applicable National Fire Protection Association Life Safety (LS) chapters for applicable occupancy categories for all buildings Chestnut owns or leases. Chestnut maintains fire safety equipment and fire safety building features. Building evacuation procedures are posted in accordance with the authority having jurisdiction.

Portable space heating devices may only be used when and where approved by the Facilities Department.

Chestnut manages carbon monoxide risks and has a plan for reducing carbon monoxide risks included in the Environment of Care Plans. Chestnut shall comply with the applicable National Fire Protection Association and Life Safety (LS) chapters for applicable occupancy categories for all buildings Chestnut owns or leases.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 300 Emergency Preparedness and Management		
Revision Date:	06/22/2022		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 300 EMERGENCY PREPAREDNESS AND MANAGEMENT

The Learning and Safety Manager is responsible for the development and implementation of organizational strategies for preparedness and management of emergencies. Chestnut utilizes an Incident Command structure for emergency management. Strategies will be reviewed at least annually by the Learning and Safety Manager and updated as needed and shall include:

- A review of the Hazardous Vulnerabilities Analysis;
- A description of emergency preparedness drills to be conducted;
- An overview of how decisions are made in response to an emergency including evacuation of clients;
- A description of how clients, visitors and staff will be managed in an emergency;
- A description of communication processes during an emergency;
- Chestnut's role in a community-wide emergency situation;
- A plan for evaluating emergency preparedness and management strategies, including but not limited to a specified number of scheduled drills or activation of the incident command structure:
- Information regarding Point of Distribution.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 305 Emergency Code Alerts and Staff Response		
Revision Date:	08/21/2024		
Applies To:	☒Employees ☒Contractors ☒Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☒Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 305 EMERGENCY CODE ALERTS AND STAFF RESPONSE

Paging

Chestnut staff have the ability to notify others of an emergency situation and as appropriate request assistance by issuing an emergency code alert. These codes can be issued through the paging system, texting platform or verbally when paging is not available. Any staff member can issue the alert. When an alert is issued at a building with on duty receptionist and it safe to do so, staff initiating the page should notify reception. As available and appropriate, an email should be sent to the entire building as a follow up to the alert.

Paging codes for facilities are as follow.

Central Region	Southern Region
MLK 1: *681#	Northgate: *5250
MLK 2: *682#	64th Street: *6200
All King Drive: *684#	Maryville: *6300
720: No paging	Hillsboro: No paging
702: *889	All Housing Sites: No paging

Additionally, emergency codes are printed on the back of staff badges and contained within posted Emergency Procedure flip charts.

Available Chestnut staff are expected to respond to an emergency code, operating within the constraints of their role and training. Those that do not have proper training for specific tasks should not engage in these activities. Non-trained staff should avoid the announced area until further notice.

Emergency Code For Behavioral Incident

"Paging Dr. Armstrong to _____ (area announced)":
A behavioral incident requiring additional staff intervention is occurring in this area. Crisis Prevention Institute, CPI, staff trained on de-escalation techniques should respond.

Clinical staff will take the lead in behavioral incidents and use the team approach.

CHESTNUT HEALTH SYSTEMS

Emergency Code For Potentially Dangerous Situation

"Paging Dr. Lock to _____ (area announced)"
A dangerous situation or a possibly dangerous person is in this area of the building. Staff should assess for safety. Staff should remain in their work area, move to a more secure area, or flee the building.

Staff remaining in the building should secure the area by locking doors and remain as quiet as possible. If safe, staff should call 911.

Emergency Code For Active Shooter Situation

"Active Shooter _____ (area announced)"
A known active shooter is in this area of the building. Staff should assess for safety. Staff should remain in their work area, move to a more secure area, or flee the building.

Staff remaining in the building should secure the area by locking doors and remain as quiet as possible. If safe, staff should call 911.

Code For Medical Emergency

"All CPR Certified staff report to _____ (area announced)"
A medical emergency is occurring in this area. Staff certified in CPR should respond. Other staff should avoid this area until further notice.

Medical staff will take the lead in medical emergencies and use the team approach.

Emergency Code For Incident Command Activation

"The Incident Command Center is now operating at _____"
This alerts all staff of the location of the Incident Command center. Available staff should report to the command center.

Following the issuance of any emergency code alert, an "All Clear" announcement will be made verbally and where available via paging and email. With this announcement, staff activity may resume as usual.

Emergency Code for Missing/Abducted Child/Infant

"Code Pink _____ A child/infant has gone missing (announce information about the missing infant/child: gender, ethnicity, age, and description of clothing)."

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 310 Water Supply		
Revision Date:	06/23/2012		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):			
Citation(s):			

SI 310 WATER SUPPLY

Emergency water supplies based on the number of residents are maintained in each residential facility in the event that the public water supply becomes contaminated. In addition, local providers of bottled water will be utilized to provide water in the event of water supply difficulties.

Preferred hot water temperature should be between 110–115 degrees and never exceed 120 degrees at the outlet.

CHESTNUT HEALTH SYSTEMS

Policy Handbook Section:	Safety		
Policy Name and Number:	SI 320 Workplace Violence Prevention		
Revision Date:	06/26/2019		
Applies To:	☒Employees ☐Contractors ☐Volunteers	☐Clinical Staff Only ☐Administrative Staff Only	☐Interns ☐Board Members
Type of Policy:	☒Administrative	☐Clinical	
Policy Cross Reference(s):	RM 65 Incident Review		
Citation(s):			

SI 320 WORKPLACE VIOLENCE PREVENTION

The CDC and the National Institute for Occupational Safety and Health define workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty." The U.S. Department of Labor defines workplace violence as an action (verbal, written, or physical aggression) which is intended to control or cause, or is capable of causing, death or serious bodily injury to oneself or others, or damage to property. Workplace violence includes abusive behavior toward authority, intimidating or harassing behavior, and threats.

Chestnut is committed to providing a work environment that is safe and free of prejudice, harassment, threats, intimidation, and violence. Threats, threatening or menacing behavior, and acts of violence against employees, visitors, clients, or other individuals on Chestnut property will not be tolerated. Violations of this policy will lead to disciplinary action, which may include dismissal, arrest, or prosecution.

Any staff person who experiences or witnesses aggressive physical or verbal behavior, threatening or violent acts, conduct, or communication must immediately contact his or her supervisor or Human Resources. Employees are responsible for making this report regardless of the relationship between the individual who initiated the threat (or threatening behavior) and the person(s) who were threatened (or were the focus of threatening behavior).

Staff should complete an incident report for any perceived workplace violence incident. Incident reports will undergo review and analysis as per RM 65 Incident Review. Relevant information will be communicated to staff. All staff who apply for or obtain a protective or restraining order which lists a Chestnut location as being a protected area should provide to Human Resources a copy of the petition or declaration used to seek the order and a copy of any restraining order which is granted.

Chestnut prohibits the use or possession of firearms (or any other weapon or device intended to be used as a tool of violence) by staff, clients and visitors on Chestnut premises or while carrying out Chestnut business.