Legal Notices:
Health & Welfare Benefits

10/102022

Table of Contents

These legally required notices apply to the legacy SCL Health, now Intermountain Healthcare - Peaks Region benefit plans and have no impact on your employment or coverage status. If you have questions about the notices or your Intermountain Healthcare - Peaks Region benefits, please visit the benefits website at www.sclhealthbenefits.org, or contact the HR Service Center by logging a ticket in The Hub or by calling 303-813-5250 or 855-412-3701.

ERISA Plan Documents

ERISA covers retirement, health and other welfare benefits plans (e.g., life, disability). ERISA requires benefit plan administrators to distribute certain notices and plan information to participants.

One important document you are entitled to receive when becoming a participant of an ERISA-covered retirement, health or welfare benefit plan (or a beneficiary receiving benefits under such a plan) is a summary of the plan, called the **summary plan description**, or **SPD**. The SPD describes what the plan provides and how it operates. It explains when you can begin participating in the plan, how service and benefits are calculated, when benefits become vested, when and in what form benefits are paid, and how to file a claim for benefits. If a plan is changed, participants normally must be informed, either through a revised summary plan description, or in a separate document, called a **summary of material modifications**.

In addition to the summary plan description, the plan administrator must give participants each year a copy of the plan's **summary annual report**. This is a summary of the annual financial report that most plans must file with the Department of Labor. These reports are filed on government forms called the Form 5500.

You can obtain copies of these documents free of charge from the benefits website at www.sclhealthbenefits.org/plan-documents, AskHR at 855-412-3701, or by mailed request to the Benefits Department, Intermountain Healthcare - Peaks Region, 500 Eldorado Blvd., Suite 4200, Broomfield, CO 80021.

Summary of Benefits and Coverage and Uniform Glossary

Choosing a medical plan is an important decision. To help you make an informed choice, regulations under the Affordable Care Act require health insurers and group health plans to provide clear, consistent and comparable information about the health plan benefits and coverage offered to you. Specifically, consumers must have access to two forms that will help them understand and evaluate their health coverage choices. These forms are the:

- **Summary of Benefits and Coverage (SBC)**, and
- **Uniform Glossary** of terms commonly used in health insurance coverage

You can obtain copies of these documents and additional information about the Plans from the benefits website www.sclhealthbenefits.org AskHR at 855-412-3701, or by mailed request to the Benefits Department, Intermountain Healthcare - Peaks Region, 500 Eldorado Blvd., Suite 4200, Broomfield, CO 80021.

HIPAA Privacy Notice

Effective February 15, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The SCL Health Associate Health Benefit Plan and the SCL Health Associate Flexible Benefit Plan ("Plans") are dedicated to maintaining the privacy of your health information. This Notice explains the Plans' legal responsibility under the Health Insurance Portability and Accountability Act of 1996 (commonly known as "HIPAA") to protect your health information and your rights to access your health information. This Notice applies to the self-insured medical and dental programs under the Health Benefit Plan and the health care spending account program under the Flexible Benefit Plan. It does not apply to any programs under the Health Benefit Plan which are fully insured, such as the vision program and the insured medical programs offered to Mother House, Cristo Rey, University of Saint Mary and Mount Saint Vincent employees, or to the employee assistance program under the Health Benefit Plan. The insurers or provider, in those cases, will provide their own notices of privacy practices.

The Plans are required by law to maintain the privacy of your health information, provide you with notice of their legal duties and privacy practices, and notify you if there has been a breach of your unsecured health information that may compromise the privacy or security of your information. The Plans are also required to inform you about:

- Their uses and disclosures of health information;
- Your privacy rights with respect to your health information;
- Their duties with respect to your health information;
- Your right to file a complaint with the Plan or the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plans' privacy practices.

The Plans are required to comply with the terms of this Notice. However, the Plans reserve the right to change their privacy practices and to apply the changes to all health information received or maintained by the Plans, including health information received or maintained prior to the revision. If this Notice is materially changed, a revised version of the Notice will be posted on the Plans' website at www.sclhealthbenefits.org no later than the effective date of the change, and the Plans will provide the revised Notice in the next annual mailing to participants.

Please note that, for purposes of the privacy rules, the SCL Health Associate Health Benefit Plan and the SCL Health Associate Flexible Benefit Plan are considered an "organized health care arrangement." This means that these Plans may coordinate their operations. To do so, the Plans may need to share your health information with each other in order to manage their operations. However, the Plans will only share your health information with each other as is necessary for treatment, payment or health care operations of the Plans and their common operation.

Uses and Disclosures of Health Information

Under HIPAA, the Plans are permitted to make certain types of uses and disclosures of your health information without your authorization. The following is a summary of the circumstances under which, and the purpose for which, your health information may be used and disclosed without your authorization:

To the Plan Sponsor

The Plans may provide summary health information to the plan sponsor, SCL Health, so that the plan sponsor may solicit premiums bids from insurers or modify, amend or terminate the Plans. The plan sponsor is prohibited, however, from using or disclosing health information that is genetic information for underwriting purposes on behalf of the Plans.

The Plans may also disclose your health information to the plan sponsor to allow it to perform administrative functions on behalf of the Plans. The Plans have been amended to require that the plan sponsor use and disclose health information for administrative purposes only as permitted by federal law. The plan sponsor will not use any health information for employment-related purposes.

To Business Associates

The Plans contract with business associates, such as CIGNA and Kaiser Permanente, for certain services related to the Plans. Health information about you may be disclosed to these business associates so that they can perform contracted services for the Plans. To protect your health information, each business associates is required to appropriately safeguard the health information it creates or maintains. Nearly all of the Plans' records containing your health information are held by the Plans' business associates.

For Treatment Purposes
The Plans may use or disclose your health information to one or more of your health care providers to provide, coordinate or manage health care and its related services. For instance, the Plans may disclose to a treating cardiologist the name of your treating physician so that the cardiologist may ask for your lab results from the treating physician.

To Make or Obtain Payment
The Plans may use or disclose your health information to determine responsibility for coverage and benefits, for instance, when the Plans confer with other health plans to resolve a coordination of benefits, for other payment-related purposes, such as to assist in making plan eligibility and coverage determinations, for utilization review activities, and to help employees resolve covered expense and claim payment issues.

To Conduct Health Care Operations
The Plans may use or disclose health information to facilitate the administration of the Plans and as necessary to provide coverage and services to the Plans' participants. Your information may be used, for example, to assist in the evaluation of one or more vendors who support the Plans, or the Plans may contact you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the Plans that may be of interest to you.

To Family Members and Others Involved in Your Care
Disclosure of health information to your family members and your close personal friends is allowed if:

- The information is directly relevant to the family member's or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to the disclosure of your health information, the Plans will take action that in their judgment is in your best interests regarding such disclosure and will disclose only the information that is directly relevant to the recipient's involvement with your health care.

Other Purposes
In addition, the Plans are permitted to use or disclose your health information without your authorization for various purposes, provided all legal requirements are satisfied. These purposes include:

- Public health and safety activities. For instance, the Plans can disclose your health information for purposes of preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, or preventing or reducing a serious threat to health or safety.
- Health research purposes.
- Compliance with the law. The Plans may disclose your health information if state or federal laws require it, including if the Department of Health and Human Services wants to confirm that the Plans are complying with HIPAA.
- For organ, eye or tissue donation programs, or with a medical examiner or funeral director. The Plans may share health information with an organ procurement organization or with a coroner, medical examiner or funeral director after your death.
- Workers' compensation, law enforcement and other government requests. The Plans can share your health information for workers' compensation claims or for law enforcement purposes, with health oversight agencies or for special government functions, such as military, national security and presidential protective services.
- Respond to lawsuits and legal actions. The Plans can share your health information in response to a court or administrative order, or in response to a subpoena.

Authorization to Use or Disclose Health Information
Except as outlined above, the Plans cannot use or disclose your health information without your written authorization. Your authorization is always required for: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures of your health information for marketing purposes; (3) disclosures that constitute a sale of your health information, and (4) any other uses and disclosures not described in this notice. Note, however, that the Plans will never market or sell your health information.
Generally, you may revoke your authorization in writing at any time. After you revoke your authorization, the Plans will no longer use or disclose your health information for the reasons described in the authorization, unless the Plans have taken action in reliance on your authorization before they received your written revocation.

Individual Rights

Right to Request a Restriction
You have the right to request that the Plans not use or disclose certain health information for treatment, payment or health care operations purposes. However, the Plans are not required to agree to your request.

Right to Request Confidential Communications
The Plans will accommodate reasonable requests to receive communications of health information by alternative means or at alternative locations, if necessary for your safety. For instance, you can ask the Plans to contact you in a specific way (for example, home or office phone) or to send mail to a different address. The Plans will consider all reasonable requests and must agree to your request if you tell them you would be in danger if they do not.

Right to Inspect and Copy Health Information
You have a right to inspect and obtain a copy of your health information (other than psychotherapy notes). The Plans will provide a copy or a summary of your health and claims records, usually within 30 days of your request. In addition, to the extent your health information is maintained in an electronic record, you have the right to request access in electronic format (if the information is readily accessible in such format) or to have the Plans transmit this information to a person or entity you designate. The Plans may charge a reasonable, cost-based fee. If your request for access is denied, you will receive notice of the reason for the denial and any rights you may have to appeal the denial.

Right to Amend Health Information
You have the right to request that the Plans correct your health information if you think it is wrong or incomplete. The Plans may deny your request but will explain the reason for the denial in writing within 60 days of your request.

Right to Receive an Accounting of Health Information Disclosures
Within 60 days of your request, the Plans will provide you with a list (or accounting) of the times the Plans have shared your health information during the six years prior to the date you ask, who the Plans have shared it with, and why. The list will include all disclosures except those that were made for treatment, payment or health care operations purposes, or those made to you or at your request.

Right to Receive a Paper Copy of This Notice upon Request
You can request a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. An electronic copy of this Notice is available on the Plans' website at www.sclhealthbenefits.org/plan-documents.

Choose Someone to Act for You
You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your health information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as your conservator or guardian;
- an individual who is the parent of a minor child; or
- a designation on an approved form.

The Plans retain discretion to deny access to your health information to a personal representative if the Plans reasonably believe that you have been or may be subject to abuse or neglect by such individual or treating the individual as your personal representative could endanger you.

File a Complaint
You have the right to express a complaint to the Plans if you believe your privacy rights have been violated. Any complaints to the Plans should be made in writing to Plan Privacy Officer at Associate Benefits, legacy SCL Health Human Resources, 500 Eldorado Boulevard, Suite 4200, Broomfield, CO 80021 or at 855-412-3701.
You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, emailing OCRComplaint@hhs.gov, calling 800-36-1019, or visiting the OCR Complaint Portal, https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

The Plan will not retaliate against you for filing a complaint.

For Additional Information
If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan Privacy Officer at Associate Benefits, legacy SCL Health Human Resources, 500 Eldorado Boulevard, Suite 4200, Broomfield, CO 80021 or at 855-412-3701. You may also obtain more information regarding HIPAA at www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

HIPAA Model Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, or 60 days in the case of birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact AskHR at 303-813-5250 or 855-412-3701.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program	Health First Colorado Website: www.healthfirstcolorado.com

Website: www.myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: www.myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)	Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
A HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: www.in.gov/medicaid/ Phone: 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: https://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: www.kancare.ks.gov Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS - Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON-Medicaid**

Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Women's Health and Cancer Rights Act of 1998

Under Federal law, Group Health Plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and physical complications of mastectomy, including lymphedemas.

These services must be provided in a manner determined in consultation between the attending Physician and the patient. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits under the Intermountain Healthcare – Peaks Region medical plans. You can obtain information about the deductibles and coinsurance applicable under a particular plan by reviewing the summary plan description for that plan.

For questions, please call AskHR at 303-813-5250 or 855-412-3701.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (NMHPA) is a Federal law that includes important protections for mothers and their newborn children with regard to the length of the hospital stay following childbirth. In general, the NMHPA requires that group health plans and health insurance issuers may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicare Part D Certificate of Creditable Coverage

Important Notice from SCL Health About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage offered under the CIGNA and Kaiser Permanente medical plans sponsored by SCL Health and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard

level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. SCL Health has determined that the prescription drug coverage offered by the CIGNA Medical Plans and the Kaiser Permanente Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is, therefore, considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current SCL Health coverage will not be affected.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your SCL Health medical and prescription drug coverage, be aware that you and your dependents may only re-enroll in SCL Health medical and prescription drug coverage during open enrollment each year, or if you have a change in status that would permit a mid-year enrollment. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

If you and/or your covered dependents enroll in the Medicare prescription drug coverage, there will be no negative impact to your current prescription coverage with the SCL Health medical plans.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with SCL Health and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the HR Service Center for further information at 855-412-3701. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage though SCL Health changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the"Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join, to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	10/01/2022
Name of Entity:	SCL Health
Contact Name and Position/Office:	Human Resources/Total Rewards Department
Address:	500 Eldorado Blvd. Suite 4200, Broomfield, CO 80021
Phone Number:	855-412-3701

Notice Regarding Wellness Program

The 2023 Intermountain Healthcare – Peaks Region Wellness Program "wellness program" is a voluntary program available to all benefits-eligible caregivers as well as spouses/Type A Legally Domiciled Adults (LDA) enrolled in an Intermountain Healthcare – Peaks Region medical plan, over the age of 18. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve caregiver health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary Health Check Survey that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for Total Cholesterol, HDL, LDL, TC/HDL risk ratio, Triglycerides, Glucose Measurement and Hemoglobin A1c. You are not required to complete the health check survey or to participate in the biometric screening or other medical examinations.

However, eligible caregivers and spouses/LDAs who choose to participate in the wellness program will receive an incentive of $100 into a health reimbursement account "HRA" for completing the health check survey and an incentive of $100 into a HRA for completing the biometric screening. Caregivers not enrolled

in an Intermountain Healthcare – Peaks Region medical plan will receive earned incentives through gift cards rather than as contributions into a HRA.

Additional incentives of up to $400 in gift cards may be available for eligible caregivers and $200 for spouses/ LDAs who participate in certain health-related activities such as online Virgin Pulse Journeys, device syncing or activity tracking.

In addition, a tobacco surcharge of $50 per month will be applied to your medical premiums if one adult covered on the SCL Health medical plan currently uses or has used tobacco products within the last six months; or $100 per month if two or more adults are covered on the SCL Health medical plan who currently use or have used tobacco products within the last six months. You will be required to provide your Tobacco-Use status upon enrollment in the SCL Health medical plan.

The surcharge will be waived if each adult tobacco-user covered under your medical plan completes the Intermountain Healthcare – Peaks Region QuitLine tobacco cessation program or any other Intermountain Healthcare – Peaks Region tobacco cessation program that may be offered at your local care site within the six-month period ending on the date you submit the Tobacco-Use status.

If you and/or your eligible dependents are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, or are tobacco-user(s) on your Intermountain Healthcare – Peaks Region medical plan and have been advised not to attempt to cease tobacco use, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Virgin Pulse at 844-724-5612.

The information from your health check survey and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to direct you to additional services or resources available through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

In addition to the programs outlined above, medical plan enrollees can participate in certain criteria based wellness programs described in the following table:

Program Name	Eligibility	Medical Criteria	HRA Incentive Earnings	Additional Information
Spine Strong	Caregivers and Spouses/LDAs on the Cigna Medical plans (Colorado Front Range only)	Moderate to severe low back pain	• $700 for completing unique treatment plan • $100 for attending 3-month follow-up visit • $100 for attending 6-month follow-up visit • $100 for attending 12-month follow-up visit	www.my.cigna.com
Healthy Pregnancies, Healthy Babies	Caregivers and Spouses/LDAs on the Cigna Medical plans	Confirmed pregnancy	• $200 when registering in the first trimester; • $100 when registering in the second trimester	www.my.cigna.com
Personal Health Team Coaching	Caregivers and Spouses/LDAs on the Cigna Medical plans	Must have 3 or more chronic medical conditions such as diabetes, asthma, heart disease	Up to $400 for completing unique goals as agreed upon between the coach and participant	www.my.cigna.com

Omada	Caregivers and Spouses/LDAs 18 years or older on the Cigna medical plans or Kaiser EPO medical plan	BMI greater or equal to 25 and pre-diabetic or pre-hypertensive or elevated cholesterol levels	$100 for 5% weight loss	www.omadahealth.com/sclhealth

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Intermountain Healthcare – Peaks Region may use aggregate information it collects to design a program based on identified health risks in the workplace; Virgin Pulse, a third party vendor who administers the Intermountain Healthcare – Peaks Region wellness program, will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) health coaches through Virgin Pulse and medical professionals accessing your electronic medical records for healthcare services requested by you in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact AskHR at 855-412-3701 or mail requests to Total Rewards, Intermountain Healthcare – Peaks Region Human Resources, 500 Eldorado Blvd., Suite 4200, Broomfield, CO 80021.

General Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you recently gained coverage under the SCL Health Associate Health Benefit Plan and/or SCL Health Associate Flexible Benefit Plan (collectively, the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. COBRA and the description of COBRA continuation coverage set forth in this notice applies only to the group health plan benefits offered under the Plan (medical, dental, vision, and/or health FSA benefits) and does not apply to any other benefits offered under the Plan. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

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

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

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

NOTE: Legally Domiciled Adults and children of Legally Domiciled Adults are not eligible for COBRA coverage.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;

- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the later of the date the qualifying event occurs. You must provide this notice in writing to:

Intermountain Healthcare – Peaks Region
AskHR
500 Eldorado Blvd., Ste. 4200
Broomfield, CO 80021

Online instructions or forms may be obtained by contacting the Human Resources Department at (855) 412-3701 or so-hrsupport@sclhealth.org. If you do not provide notice within the time period above or if you do not provide any additional documentation or information (if requested) in a timely manner, your notice will be rejected and COBRA coverage will not be offered.

IMPORTANT INFORMATION: Extensions for COVID-19 outbreak
On March 13, 2020, President Trump declared that a national emergency exists nationwide beginning March 1, 2020, as the result of the COVID-19 outbreak (the National Emergency). In accordance with guidance issued by the Department of Labor and the Department of Treasury, the Plan is required to disregard the "Outbreak Period". The Outbreak Period generally is the period beginning on the date of an event triggering a notice or election time period (but not earlier than March 1, 2020) and ending on the earlier of (1) one year from the date of such event (or March 1, 2020, if later) or (2) 60 days after the announced end of the National Emergency. This means that, in some cases, your 60-day period to provide notice of a qualifying event or notice of a disability determination (explained below), may be extended. *While these periods may have been extended, note that your COBRA coverage will not be in effect unless and until you elect and pay for COBRA.*

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

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

WEX, Inc.
P.O. Box 869
Fargo, ND 58107-0869
Phone: (866) 451-3399
Fax: (888) 408-7224
Ask a question: cobraadmin@wexhealth.com
Submit a form: cobraforms@wexhealth.com

If the above notification is not timely made, or if you do not provide the additional documentation or information (if requested) in a timely manner, your notification will be rejected and any additional COBRA/continuation coverage beyond the original 18-month period will not be offered.

The affected individual must also notify the Discovery Benefits, Inc. within 30 days of any final determination by the Social Security Administration that the individual is no longer disabled.

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

Special rule for Health FSAs

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage that have under-spent accounts and such coverage will only be offered through the end of the Plan year in which the qualifying event occurs. A qualified beneficiary has an under-spent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Health FSA COBRA coverage that will be charged for the remainder of the Plan year. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan year, and the COBRA coverage for the Health FSA plan will terminate at the end of the Plan year.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Intermountain Healthcare – Peaks Region
Total Rewards
500 Eldorado Blvd., Ste. 4200
Broomfield, CO 80021

AskHR may be reached by phone at (855) 412-3701.

Health Insurance Marketplace Coverage Options and Your Intermountain Healthcare – Peaks Region Benefits Coverage

General Information
When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment¬-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November each year for coverage starting as early as the immediately following January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about SCL Health coverage, please visit the benefits website www.sclhealthbenefits.org, or contact AskHR at 855-412-3701 or by mailed request to Caregiver Benefits, Intermountain Healthcare – Peaks Region, 500 Eldorado Blvd., Suite 4200, Broomfield, CO 80021.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Information about Health Coverage Offered by legacy SCL Health
This section contains information about any health coverage offered by SCL Health. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
SCL Health	**23-7379161**
5. Employer address	6. Employer phone number
500 Eldorado Blvd, Ste. 4200	**855-412-3701**

7. City	8. State	9. ZIP code
Broomfield	**CO**	**80021**

10. Who can we contact about employee health coverage at this job?	
Human Resources (HR) Service Center	
11. Phone number (if different from above)	12. Email address
	so-hrsupport@sclhealth.org

Legacy SCL Health offers health plan coverage to:

- Regular full-time and part-time caregivers of legacy SCL Health scheduled to work 20 or more hours per week.
- Note: An individual classified as temporary, a “leased employee” or an independent contractor is not a regular caregivers and is not eligible for legacy SCL Health plan coverage regardless of the individual’s work schedule or number of hours worked.

With respect to dependents, legacy SCL Health offers health plan coverage to the following eligible dependents, as long as the eligible caregiver also elects coverage:

- Spouse
- Certain domestic partners and family members who are federal tax dependents of the eligible caregiver
- Dependent child under age 26
- Fully handicapped dependent child age 26 or older

The coverage offered by SCL Health meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on caregiver wages.

> ** Even if legacy SCL Health intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

If you require assistance completing the Marketplace Employer Coverage Tool, please visit the benefits website www.sclhealthbenefits.org, or contact AskHR at 855-412-3701 or by mailed request to Caregiver Benefits, Intermountain Healthcare – Peaks Region, 500 Eldorado Blvd., Suite 4200, Broomfield, CO 80021.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Summary Annual Report

Below are the SCL Health benefit plans’ Summary Annual Reports for the 2021 plan year. You are receiving this information because our records indicate you were a participant in at least one of these plans during the 2021 Plan Year. This report is provided for your information only. There is no action required on your part. Remember, you can always find information about your plans in your latest Benefits Guide. You can access the Benefits Guide—as well as benefit updates, network provider directories and other valuable information—on www.sclhealthbenefits.org, SCL Health’s benefits website. Be sure to take advantage of all of the plans, programs and services offered by SCL Health to help you live a healthier life!

FOR ASSOCIATES OF SCL HEALTH
Sister of Charity of Leavenworth Health Systems (“SCL Health”) sponsors a variety of benefit plans to provide financial protection and security for you and your family. The following report contains summary financial information for the SCL Health benefit plans. Your receipt of this report does not indicate that you were covered by any or every plan described in this report. If you have any questions regarding these plans, please contact a representative at the HR Service Center at 1-855-412-3701.
This is a summary annual report for the following plans:

SCL Health Associate Health Benefit Plan
SCL Health Associate Welfare Benefit Plan

SCL HEALTH ASSOCIATE HEALTH BENEFIT PLAN
This is a summary of the annual report of the SCL Health Associate Health Benefit Plan, Employer Identification Number 23-7379161, Plan Number 521, for the plan year January 1, 2021 through December 31, 2021. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).
Sister of Charity of Leavenworth Health Systems ("SCL Health") has committed itself to pay certain health, dental, and EAP claims incurred under the terms of the plan.

Insurance Information
The plan has insurance contracts with EyeMed Vision Care and Kaiser Foundation Health Plan of Colorado to pay certain vision, health and HMO contract claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2021 were $2,035,671.

Your Rights to Additional Information
You have the right to receive a copy of the full annual report, or any part thereof, on request. Insurance information, including sales commissions paid by insurance carriers, is included in that report.
To obtain a copy of the full annual report, or any part thereof, write to SCL Health - Associate Benefit Plans, at 500 Eldorado Blvd. Suite 4300, Broomfield, CO 80021 or call 303-813-5000. The charge to cover copying costs will be $2.75 for the full annual report, or $0.25 per page for any part thereof.
You also have the legally protected right to examine the annual report at the main office of the plan: SCL Health, 500 Eldorado Blvd. Suite 4300, Broomfield, CO 80021, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

SCL HEALTH ASSOCIATE WELFARE BENEFIT PLAN
This is a summary of the annual report of the SCL Health Associate Welfare Benefit Plan, Employer Identification Number 23-7379161, Plan Number 522, for the plan year January 1, 2021 through December 31, 2021. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).
Sister of Charity of Leavenworth Health Systems ("SCL Health") has committed itself to pay certain short-term disability claims incurred under the terms of the plan.

Insurance Information
The plan has insurance contracts with MetLife Legal Plans, Life Insurance Company of North America and Lincoln National Life Insurance Company to pay certain pre-paid legal, accidental death & dismemberment, life insurance, accidental death & disability, long-term disability and temporary disability claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2021 were $7,951,165.

Your Rights to Additional Information
You have the right to receive a copy of the full annual report, or any part thereof, on request. Insurance information, including sales commissions paid by insurance carriers, is included in that report.
To obtain a copy of the full annual report, or any part thereof, write to SCL Health - Associate Benefit Plans, at 500 Eldorado Blvd. Suite 4300, Broomfield, CO 80021 or call 303-813-5000. The charge to cover copying costs will be $5.75 for the full annual report, or $0.25 per page for any part thereof.
You also have the legally protected right to examine the annual report at the main office of the plan: SCL Health, 500 Eldorado Blvd. Suite 4300, Broomfield, CO 80021, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee

Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Your Rights and Protections against Surprise Medical Bills

Effective 1/1/2022

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected by federal law from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Labor or your medical vendor.

Visit the Department of Labor's website (www.dol.gov/ebsa)or call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1–866–444–EBSA (3272) for more information about your rights under federal law.