Summary Plan Description
for the
SCL Health Vision Plan

SCL Health (“Plan Sponsor”) sponsors the SCL Health Vision Plan (the “Plan”) for the benefit of its eligible employees and the eligible employees of its participating employers (collectively, "Employer” or ”Employers").

Introduction

The Plan Sponsor has selected EyeMed Vision Care, LLC (“EyeMed”) as your vision care services provider. The Plan provides coverage for routine vision exams, as well as eyeglasses and contact lenses.

The formal document for the Plan consists of the SCL Health Associate Health Benefit Plan and the insurance policy or contract issued by Combined Insurance Company of America and, if applicable, any separate benefits eligibility document.

This document is the "summary plan description" or "SPD" for the Plan. The SPD provides only a summary of the Plan provisions. If there is a disagreement between the information contained in this SPD and the formal documents for the Plan, as defined above, the formal plan documents will govern. This SPD reflects the Plan as in effect on January 1, 2022.

Vision benefits are insured by Combined Insurance Company of America. Discounts are provided by EyeMed Vision Care. If you have any questions or concerns, please contact EyeMed Vision Care at eyemed.com or 1-866-800-5457.

Eligibility

Associate Eligibility

Except as specifically noted, all associates of an Employer with a payroll status of Full Time Equivalency (FTE) of 0.5 or above or, with respect to the University of Saint Mary, employees who are regularly scheduled to work 30 or more hours per week, full-time faculty while covered by an active contract, and coaches who are expected to regularly work 30 hours or more per week while fall and spring semesters are in session so long as they remain employed, are eligible to participate in the Plan. These individuals are called “Eligible Associates.” The following associates are not eligible to participate in the Plan: individuals classified as “PRN,” “Per Diem,” “Temporary,” student interns, volunteers, or any person classified as an independent contractor or a leased employee, regardless of whether such individual is subsequently determined by a court of competent jurisdiction or governmental agency or authority to have been a common law employee.

Family Member Eligibility

Eligible Associates who elect coverage under the Plan for themselves may also elect coverage for their "Eligible Dependents." Eligible Dependents are:

- The associate's lawful spouse

- The associate's "Legally Domiciled Adult" or "LDA." (LDA coverage is not offered at the University of Saint Mary or Cristo Rey.) An LDA is an individual over the age of 18 who shares the same principal residence as the associate, remains a member of the associate's household throughout the coverage period, and meets one of the following definitions:

    - **Category A LDA ("LDA A") --** (1) has lived with the associate continuously for at least 12 months, (2) has an on-going, exclusive and committed relationship with the associate similar to marriage (e.g., is not a casual roommate or tenant), (3) shares basic living expenses and is financially interdependent with the associate, and (4) is neither legally married to (or legally separated from) or in a civil union with anyone else, nor legally related to the associate by blood in any way that would prohibit marriage in the state of his or her residence; OR

    - **Category B LDA ("LDA B") --** (1) is the associate's adult child, sibling or parent by blood, adoption, or marriage (e.g., a step-child), (2) the associate claimed the individual as a dependent on his or her federal income tax return for the preceding year, and (3) has lived with the associate continuously for at least 6 months

  An associate may cover a maximum of two adults under the Plan, including himself or herself, in addition to any dependent children under age 26 or disabled. For instance, an associate who is married and covers his or her spouse cannot also cover an LDA B.

- The associate's or covered LDA A's child who is:

    - less than 26 years old.
    - 26 or more years old, unmarried, and primarily supported by the associate and incapable of self-sustaining employment by reason of mental or physical disability which has been determined to be a disability by the Social Security Administration (SSA) and which arose while the child was covered as a dependent under this Plan, or while covered as a dependent under a prior plan, with no break in coverage.

    You must provide the child's SSA Certificate of Disability from time to time, but not more frequently than once a year, and you may be required to provide proof of the continuation of such condition and dependence.

    The term "child" as used above means the associate's or covered LDA A's natural or legally adopted child. It also includes a stepchild or a child for whom the associate or LDA A is the legal guardian. A child of the associate's LDA B is not eligible to participate in the Plan.

No one may be covered as a dependent and also as an associate under the Plan. If both parents are covered as associates, children may be covered as dependents of one parent only. A child under age 26 may be covered as either an associate or as a dependent child. An individual cannot be covered as an associate while also covered as a dependent of an associate.

Note that EyeMed is not responsible for making Plan eligibility determinations.

Commencement of Coverage

Newly hired Eligible Associates become eligible for coverage under the Plan on the first day of the calendar month following the date he or she first becomes an Eligible Associate (or, with respect to resident physicians, on the date of hire as an Eligible Associate), provided he or she makes an election for coverage within 31 days of his or her date of hire.

Before the beginning of each plan year, the Eligible Associate will have the opportunity to add or drop coverage under the Plan, or change coverage options, for himself or herself and his or her Eligible Dependents. Elections made during annual open enrollment will be effective as of the first day of the following plan year (January 1).

Generally, an Eligible Associate cannot make changes to his or her coverage, such as dropping his or her coverage or adding a dependent to coverage, during the plan year. Most coverage changes may be made only during an annual open enrollment, to be effective for the following plan year. There are some circumstances, however, such as marriage or the birth of a new dependent, in which mid-year changes to coverage under the Plan may be permitted, provided you request a change within 31 days of the event. These are explained in the SCL Health Flexible Benefits Plan. You may obtain a copy of the SCL Health Flexible Benefits Plan from the SCL Health Human Resources Department or by calling (855) 412-3701.

If an Eligible Associate is required to provide vision coverage for a dependent child as a result of a divorce, legal separation, annulment, or change in legal custody, the Eligible Associate may change his or her election during a plan year to comply with the legal instrument mandating coverage. The Eligible Associate may elect to cancel any such coverage for a dependent child if the order requires his or her spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided. The Eligible Associate may obtain from the Plan Administrator a copy, free of charge, of the Plan's procedures for reviewing these orders, called "qualified medical child support orders" or QMCSOs.

Benefits

The EyeMed Network

EyeMed's network of providers includes private practitioners, as well as the nation's premier retailers, LensCrafters®, Target Optical, and most Pearle Vision locations. To locate EyeMed Vision Care providers near you, visit www.eyemed.com and choose the Access Network. You may also call EyeMed's Customer Care Center at 1-866-723-0513. EyeMed's Customer Care Center can be reached Monday through Saturday 5:30 am to 9:00 pm MST and Sunday 9:00 am to 6:00 MST.

Using In-Network Providers

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or Plan number, located on the front of your ID card. Confirm the provider is an in-network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Plan.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers

If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Vision Benefits. To receive your out-of-network reimbursement, complete and sign an out-of- network claim form and attach your itemized receipts. For your convenience, you may submit your claim form in one of the three (3) following options:

1) Online: FAA/EyeMed out-of-network claims can be completed online. To access the out-of-network form or to check the status of a claim, log in to Member Web and navigate to the Claims tab. Remember to upload an itemized paid receipt with your name included.

2) Mail: First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:

   FAA/EyeMed Vision Care
   Attn: OON Claims
   P.O. Box 8504
   Mason, OH 45040-7111

3) Email: You may also print a claim form and email it to us at oonclaims@eyemed.com or call the EyeMed Customer Care Center at **1-866-939-3633**.

Summary of Vision Care Services

	Your In-Network Cost	Your Out-of-Network Reimbursement*
Exam Dilation as necessary	$0 co-pay $0	Up to $60
Refraction	$0	
Retinal Imaging	$15 co-pay	Up to $20
Exam Options – Contact Lenses Standard Fit and Follow-Up	Up to $55	N/A
Premium Fit and Follow-Up	10% off retail price	N/A
Frames	$0 copay, plus 80% of balance over $175	Up to $90
Standard Plastic Lenses Single Vision	$10 copay	Up to $55
Bifocal	$10 copay	Up to $75
Trifocal	$10 copay	Up to $85
Standard Progressive	$75 copay	Up to $75
Premium Progressive Tiers I-III	$95 - $120 copays	Up to $75
Premium Progressive Tier IV	$75 copay,80% of balance less $120 allowance	Up to $75
Standard Lens Options UV coating	$15	N/A
Tint (solid and gradient)	$15	N/A
Standard plastic scratch coating	$0 copay	$5
Standard polycarbonate – Adults	$40 copay	N/A
Standard polycarbonate – Kids under 18	$0 copay	$5
Standard anti-reflective coating	$45	N/A
Polarized	80% of retail price	N/A
Other add-ons and services	80% of retail price	N/A
Contact Lenses** Conventional	$0 copay, $175 allowance plus 85% of balance over $175	Up to $115
Disposable	$0 copay, $175 allowance plus balance over $175	Up to $115
Medically necessary	$0 (paid in full by Plan)	Up to $200
LASIK or PRK from US Laser Network	15% off retail price or 5% off promotional price Whichever is less	N/A
Frequency - based on **calendar year** Exam	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months

* You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Additional Discounts

Under the Plan, you may receive benefits for eyeglass frames, eyeglass lenses or contact lenses as outlined on the Summary of Vision Care Services. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

Medically Necessary Contact Lenses

The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding –10D or +10D in meridian powers
- **Keratoconus** where the member's vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses
- **Vision Improvement** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

Diabetic Eye Care Benefit

Members who have Type 1 or Type 2 diabetes are eligible to receive supplemental coverage for additional services from their vision Provider. With this benefit, you can obtain a vision evaluation every six months to monitor for signs of diabetic complications. Subject to provider determination and benefit frequency limitations, you may also receive one or more of the following diagnostic testing: Fundus Photograph Examination, Extended Ophthalmoscopy, Gonioscopy and Scanning Laser. If questions, please contact EyeMed's Customer Care Center.

Availability of diagnostic equipment and services varies by location. Members are encouraged to call their provider to confirm available of services.

Retinal Imaging

Retinal imaging has been provided as an additional benefit or discount to your vision care benefit. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Please consult with your Provider to determine if you are a candidate for retinal imaging.

KidsEyes

The EyeMed KidsEyes benefit meets the unique needs of children 18 years and younger. With this benefit, qualifying dependents may receive two funded eye exams within the same benefit year. If the child's vision changes during the benefit period, they may receive one additional pair of eyeglass lenses, including funded polycarbonate lenses. A 40% discount is available to replace lost or broken glasses as often as needed.

Savings on Laser Vision Correction

EyeMed Vision Care, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers discounts to you for LASIK and PRK. You receive a discount when using a network provider in the U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call **1-877-5LASER6**.

After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at **1-877-5LASER6** to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

Hearing Discount Benefit with Amplifon Hearing Health Care

EyeMed has teamed up with Amplifon – the world's largest distributor of hearing aids and services – to add affordable hearing care to your EyeMed vision benefits package.

Participants receive a 40% discount off hearing exams and a low-price guarantee on discounted hearing aids. For additional information, call **1-877-203--0675**

International Travel Solution

No matter where work or play takes you, EyeMed is ready to help when a vision emergency sneaks up while traveling abroad. As an EyeMed member, you have access to international support and resources in 20 countries. From quick fix, temporary glasses to getting you in contact with a trusted provider, we're here to get your trip back in focus. For additional information, call 1-513-765-2870

Online Contact Lenses with ContactsDirect.com

You can now apply your in-network contact lens benefit at contactsdirect.com. Simply complete the online transaction form and the contacts will be delivered directly to your home.

Online Eyewear with Glasses.com

To make sure you get easy, convenient access to vision choices that best fit your lifestyle, we've added Glasses.com to our roster of thousands of independent providers and top optical retailers. This is great news for you because EyeMed members can now apply in-network vision benefits from anywhere, anytime. For additional information visit www.glasses.com.

Sample Savings

The following examples illustrate how your benefit would be applied to the services received at an in-network provider's office or location:

If a participant chooses to receive:	
A comprehensive vision care examination:	you pay $ **0**
A frame up to a value of $200:	you pay $**20**
One pair of lined bifocal lenses:	you pay $**10**
Ultraviolet coating:	you pay $**15**
The total cost to the participant is:	**$45**

If a participant chooses to receive:	
A comprehensive vision care examination:	you pay $ **0**
A frame up to a value of $175:	you pay $ **0**
A pair of single vision lenses:	you pay $**10**
Standard scratch coating:	you pay **$ 0**
Standard anti-reflective coating:	you pay $**45**
The total cost to the participant is:	**$55**

Plan Limitations and Exclusions

No benefits will be paid under the Plan for services or materials connected with our charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any vision examination, or any corrective eyewear required by a participant as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or require by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services or materials provided by any other group benefit plan providing vision care;
9. services rendered after the date a participant ceases to be covered under the Plan, except when vision materials ordered before coverage ended are delivered, and the services rendered to the participant are within 31 days from the date of such order; and:

10. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

Termination of Coverage

An Eligible Associate's coverage under the Plan terminates upon the earliest to occur of the following:

- the last day of the month in which he or she ceases to be an Eligible Associate;
- the last day for which the Eligible Associate has made any required contributions for coverage under the Plan;
- the effective date of the Eligible Associate's election not to participate in the Plan;
- the date the Eligible Associate's Employer ceases to be a participating employer in the Plan;
- the effective date of any Plan amendment which terminates eligibility for any class of which the Eligible Associate is a member; or
- the date the Plan is terminated.

Coverage for an Eligible Dependent will automatically terminate when the Eligible Associate's coverage under the Plan terminates or on the effective date of the Eligible Associate election to no longer cover the Eligible Dependent under the Plan. In addition, dependent coverage will terminate on the date he or she ceases to be an Eligible Dependent under the Plan (e.g., you divorce your dependent spouse or your child reaches age 26).

Coverage may continue during any approved leave of absence in accordance with the Employer's leave of absence policy. To the extent coverage is extended, the associate may be required to continue paying premiums for coverage while on such leave.

Note that associates and their family members who lose coverage under the Plan may be entitled to continue coverage under the Plan under COBRA. Please review the COBRA notice attached to this booklet for more information.

Administration

The Plan is provided for and administered through an insurance policy with the Combined Insurance Company of America. EyeMed makes all determinations regarding benefits and what constitutes covered services.

Claims and Appeal Procedures

You may request a determination as to your eligibility or enrollment under the Plan by contacting the HR Service Center and additional information will be provided to you regarding how to proceed on your request.

With respect to claims for vision benefits under the Plan, you may authorize someone else to file and pursue a claim for benefits or an appeal on your behalf. If you do so, you must notify EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to act on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

Time Frames for Processing Claims

FAA will decide benefit claims within the time permitted by applicable law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Time Frames and Procedures for Appealing Claims

If your claim is denied, in whole or in part, you may file an appeal. The appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an explanation of benefits or "EOB" within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of your vision coverage that you feel was misinterpreted or inaccurately applied.
- Additional information from the participant's eye care provider that will assist FAA in completing its review of the participant's appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA will inform you in writing of the decision on appeal within 60 days of its receipt of your request for an appeal.

As a result of the national emergency related to the COVID-19 outbreak, the time periods in which you may file a claim and file a request for an appeal of a denied claim have been extended to the extent required by law. Generally, you have up to 60 days after the announced end of the national emergency related to the COVID-19 outbreak to file a claim or request an appeal of a denied claim.

Complaint Procedure

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at ***1-844-409-3402*** to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

General Information about the Plan

Plan Name

SCL Health Vision Plan

The SCL Health Vision Plan is part of the SCL Health Associate Health Benefit Plan.

Plan Sponsor and ERISA Plan Administrator

SCL Health
500 Eldorado Blvd., Ste. 4300
Broomfield, CO 80021
(303) 813-5250
EIN: 23-7379161

As of January 1, 2022, the following employers have also adopted the Plan for the benefit of their eligible employees:

Brighton Community Hospital Association (d/b/a Platte Valley Medical Center)
Caritas Clinics, Inc.
Holy Rosary Healthcare
Marian Clinic, Inc.
Mount St. Vincent Home, Inc.
Platte Valley Medical Group, LLC
SCL Front Range Home Health, LLC
SCL Health-Front Range, Inc.
SCL Health Medical Group - Billings, LLC
SCL Health Medical Group - Butte, LLC
SCL Health Medical Group - Denver, LLC
SCL Health Medical Group - Grand Junction, LLC
SCL Health Medical Group Miles City
SCL Health - Montana
St. James Healthcare
St. Mary's Hospital and Medical Center, Inc.
Mother House of the Sisters of Charity of Leavenworth, Kansas
University of Saint Mary
Cristo Rey Kansas City, a Sisters of Charity of Leavenworth High School

Plan Number

521

Effective Date

The Vision Plan was most recently amended and restated as of January 1, 2022.

Agent for Service of Legal Process

SCL Health
c/o Senior Vice President, Chief Human Resources Officer
500 Eldorado Blvd., Ste. 4300
Broomfield, CO 80021

Service may also be made upon the Plan Administrator.

Type of Plan

Welfare benefit plan providing vision benefits

Plan Year

January 1 - December 31

Plan Funding

Premiums for coverage under the Plan are paid for solely by associates. Benefits are underwritten by the Combined Insurance Company of America under an insurance policy or contract issued to SCL Health. The address of the insurer is: 5050 Broadway, Chicago, IL 60604.

Changing or Ending the Plan

This Plan may be modified and amended at any time by the Plan Sponsor, as follows:

- The Board of Directors of the Plan Sponsor, in its sole discretion, may amend or modify the Plan, in whole or in part, at any time.

- The President/Chief Executive Officer of the Plan Sponsor, in his or her sole discretion, may amend or modify the Plan to the extent such amendment or modification would not constitute a material change in the benefits design or philosophy of the Plan Sponsor or result in a material increase in costs to the Sponsoring Employer; provided, however, that the President/Chief Executive Officer of the Sponsoring Employer shall make any Plan amendment reasonably requested by the Mother House of the Sisters of Charity of Leavenworth, the University of Saint Mary, Mount St. Vincent Home, Inc. or Cristo Rey Kansas City solely with respect to its Participants, to the extent such amendment is permitted by law, does not result in adverse tax consequences and is administratively practicable. In determining whether an amendment constitutes a material change or would result in a material cost increase for this purpose, the determination of the President/Chief Executive Officer will be binding on the Plan Sponsor and the Plan.

- The Senior Vice President, Chief Human Resources Officer, of the Plan Sponsor, or the person from time to time performing such function, may amend or modify the Plan at any time to the extent such amendment or modification is routine, required by law or where circumstances make it impracticable for action by the President/Chief Executive Officer of the Plan Sponsor.

Your Legal Rights

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan and Benefits

ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

  Send written requests to:

  HR Benefits Department
  500 Eldorado Blvd., Suite 4600
  Broomfield, CO 80021

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond

the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the plan, you should contact the plan administrator. If you have any questions about this statement or about the rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

COBRA NOTICE

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. 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 are an employee, you will 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 are the spouse of an employee, you will 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-Eligible Associate dies;
- The parent-Eligible Associate's hours of employment are reduced;
- The parent-Eligible Associate's employment ends for any reason other than his or her gross misconduct;
- The parent-Eligible Associate 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 an "Eligible Dependent."

NOTE: Although Legally Domiciled Adults and children of Legally Domiciled Adults are not eligible for COBRA coverage, the Plan makes available continuation coverage similar to COBRA to these individuals.

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

For all other qualifying events (divorce or legal separation of the associate 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 qualifying event occurs. You must provide this notice in writing to:

SCL Health
HR Service Center
500 Eldorado Blvd., Ste. 4200
Broomfield, CO 80021

Notice forms may be obtained by calling the Human Resources Department at (855) 412-3701 or online at 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.

Note: As a result of the national emergency related to the COVID-19 outbreak, the time period you have to notify the Plan Administrator of a qualifying event has been extended to the extent required by law. Generally, you have up to 60 days after the announced end of the national emergency related to the COVID-19 outbreak to provide this notification.

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:

Discovery Benefits, Inc.
P.O. Box 869
Fargo, ND 58107-0869
Phone: (866) 451-3399
Fax: (888) 408-7224
cobraforms@discoverybenefits.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 associate or former associate 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.

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 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

SCL Health
500 Eldorado Blvd., Ste. 4200
Broomfield, CO 80021

SCL Health Human Resources Department may be reached by phone at (855) 412-3701.

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