# SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT

# OF THE

# SCL HEALTH
# ASSOCIATE FLEXIBLE BENEFIT PLAN

**Restated Effective January 1, 2021,**
**Except as Otherwise Provided Herein**

# TABLE OF CONTENTS

ARTICLE I BENEFITS AVAILABLE AND CONTRIBUTIONS .......... 2
1.1 How the Plan Saves You Money -- Some Tax Consequences of Your Plan Contributions. .......... 2
1.2 Benefits Available. .......... 3
1.3 How this Plan works with the Premium Plan. .......... 3

ARTICLE II PARTICIPATION .......... 3
2.1 Who is Eligible to Participate. .......... 3
2.2 When Participation Terminates. .......... 4
2.3 Rehired Employees. .......... 4

ARTICLE III YOUR ACCOUNTS AND ELECTIONS .......... 5
3.1 Your Accounts. .......... 5
3.2 Annual Enrollment Period. .......... 5
3.3 Initial Enrollment Period for New Employees. .......... 6
3.4 Failure to Elect. .......... 6
3.5 Irrevocability of Election During a Calendar Year. .......... 7
3.6 Election Changes Under Health Savings Account. .......... 11
3.7 Automatic Termination of Election. .......... 11
3.8 Nondiscrimination Rules. .......... 12
3.9 Participation During or Upon Return From Leave of Absence. .......... 12

ARTICLE IV HEALTH CARE SPENDING ACCOUNT PROGRAM .......... 13
4.1 Eligibility. .......... 13
4.2 Definitions. .......... 14
4.3 The Maximum Amount of Coverage. .......... 14
4.4 Your Health Care Spending Account. .......... 15
4.5 When Claims Must be Filed/Forfeiture of Your Account. .......... 15
4.6 Debit Card. .......... 16
4.7 Coordination with Health Reimbursement Arrangement. .......... 16
4.8 Termination of Benefits; Special Rules for Former Employees. .......... 16
4.9 Continuation of Health Care Spending Account Benefits. .......... 17
4.10 Qualified Reservist Distributions. .......... 17
4.11 Compliance with HIPAA. .......... 18
4.12 Determinations of Qualified Medical Child Support Orders. .......... 18
4.13 Participants' Rights. .......... 18

ARTICLE V DEPENDENT CARE SPENDING ACCOUNT PROGRAM .......... 18
5.1 Eligibility. .......... 18
5.2 Definitions. .......... 18
5.3 Covered Expense. .......... 19
5.4 Further Limitations. .......... 19
5.5 Prohibition of Certain Payments. .......... 20
5.6 Your Dependent Care Spending Account. .......... 20
5.7 When Claims Must be Filed/Forfeiture of Your Account. .......... 20
5.8 Debit Card. .......... 20
5.9 Termination of Benefits; Special Rules for Former Employees. .......... 21
5.10 Important Reporting Requirements. .......... 21
5.11 Alternative Tax Credit. .......... 21

ARTICLE VI CLAIM PROVISIONS ..... 21
6.1 Filing a Claim. ..... 21
6.2 Payment of Claims. ..... 22
6.3 Appealing a Claim. ..... 23

ARTICLE VII ADMINISTRATION OF PLAN ..... 24
7.1 Plan Administrator ..... 24
7.2 Named Fiduciary. ..... 24
7.3 Reliance on Tables, etc. ..... 25
7.4 Actions. ..... 25
7.5 Expenses. ..... 25

ARTICLE VIII GENERAL PROVISIONS ..... 25
8.1 Modification and Amendment of Plan. ..... 25
8.2 Plan Termination. ..... 26
8.3 Election to Withdraw by an Employer. ..... 26
8.4 Governing Law. ..... 26
8.5 Construction of Plan Document. ..... 26
8.6 Severability Clause. ..... 27
8.7 No Guarantee of Employment. ..... 27
8.8 Non-Gender Clause. ..... 27
8.9 Alienation. ..... 27
8.10 General Information. ..... 27

ARTICLE IX DEFINITIONS ..... 27
9.1 “Administrator” ..... 27
9.2 “Claims and Appeals Committee” ..... 27
9.3 “COBRA” ..... 27
9.4 “Code” ..... 28
9.5 “Compensation” ..... 28
9.6 “Eligible Employee” ..... 28
9.7 “Employer” ..... 28
9.8 "ERISA ..... 28
9.9 “FMLA Leave” ..... 28
9.10 "HIPAA ..... 28
9.11 “Military Leave” ..... 28
9.12 “Plan” ..... 28
9.13 “Plan Administrator” ..... 28
9.14 “Premium Plan” ..... 28
9.15 “Sponsoring Employer” ..... 29
9.16 “You” ..... 29

ARTICLE X PLAN INFORMATION ..... 29

# INTRODUCTION

The Sisters of Charity of Leavenworth Health System ("Sponsoring Employer") sponsors this SCL Health Associate Flexible Benefit Plan ("Plan") for the benefit of its eligible employees. Employers affiliated with the Sponsoring Employer may also elect to participate in the Plan. The affiliated Employers listed in Appendix D have adopted this Plan on behalf of their eligible employees.

The Plan is intended to be a "cafeteria plan" under Section 125 of the Internal Revenue Code. By structuring the Plan in this manner, your contributions to purchase the benefits available under the Plan (see Article I) will generally not be subject to federal or state income or federal social security taxes.

It is important that you carefully review this Plan to understand the benefits which are available to you, as well as your responsibilities to ensure that you receive all the benefits to which you are eligible. This document has been written so that it is not just a summary of the Plan, but also the legal Plan document written so that it can be used by you, your Employer, and the Administrator in understanding and administering the Plan.

If you have any questions regarding the Plan, please contact the SCL Health Human Resources Department at (303) 813-5250 or (855) 412-3701.

# ARTICLE I
## BENEFITS AVAILABLE AND CONTRIBUTIONS

### 1.1 How the Plan Saves You Money -- Some Tax Consequences of Your Plan Contributions.

The Plan is intended to be a "cafeteria plan" under Code Section 125. By structuring the Plan in this manner, you should realize substantial tax savings on the amounts you contribute to purchase the benefits described in Section 1.2. In general, your Plan contributions will not be subject to federal or state income taxes or federal social security taxes.

The intended tax savings under this Plan are just one piece of your Employer's benefit package. For example, in addition to making the benefits described in Section 1.2 available to you, your Employer may pay, directly or indirectly, a portion of the costs of such benefits. This Plan allows you to purchase, in a tax-effective manner, benefits or coverage tailored for you and your family's individual situation.

The following example illustrates how the Plan may benefit you.

*Example:*

Assume John's annual compensation is $30,000, and he becomes eligible to purchase benefits on January 1, 2021. John elects to purchase family medical, dental, and vision insurance ($200 per month) and $1,500 of health care spending account benefits for 2021 ($125 per month). John is married and files a joint tax return.

Although John's tax situation will depend upon his individual circumstances (i.e., cost of Optional Benefits elected, number of exemptions, other taxable income, and claimed deductions), in general, participating in the Plan will result in the following savings to John:

| | WITHOUT PLAN | WITH PLAN |
|---|---|---|
| Gross Earnings per Month ($30,000/12) | 2,500 | 2,500 |
| Pre-Tax Monthly Contribution to Plan | 0 | ( 325) |
| Taxable Monthly Compensation | 2,500 | 2,175 |
| Federal and State Income Tax (assumes effective rate of 15% for federal and 6% for state) | ( 525) | ( 457) |
| FICA (7.65%) | ( 191) | ( 166) |
| After-Tax Compensation | 1,784 | 1,552 |
| After-Tax Payments for Health Premiums and Medical Expenses | ( 325) | 0 |
| Net Take-Home Pay | $1,459 | $ 1,552 |

In our example, the Plan has saved John $93 per month in taxes.

*Because your Plan contributions will generally be excluded from your taxable income, the amount of your social security benefits may be affected to a small degree. This is because the amount of your social security benefits partially depends upon your taxable income. For more details, you should contact your nearest Social Security office.*

### 1.2 Benefits Available.

In general, you may elect to have a portion of your Compensation (which you would otherwise be entitled to receive in cash as part of your paycheck) applied toward your cost of one or more of the following benefits (the "Optional Benefits"):

(a) medical, dental, and vision coverage available to you under the Premium Plan;

(b) the Health Care Spending Account Program described in Article IV;

(c) the Dependent Care Spending Account Program described in Article V; and

(d) if you are employed by the University of Saint Mary or Cristo Rey Kansas City, a Health Savings Account (see Section 1.4 below).

### 1.3 How this Plan works with the Premium Plan.

Although the election to purchase one or more of the Optional Benefits is made under this Plan, only the Health Care Spending Account Program and the Dependent Care Spending Account Program are described in, and governed by, this document. Benefits under the Premium Plan, including eligibility for medical, dental and vision coverage, are determined in accordance with the terms of the Premium Plan, and any insurance contracts relating to such benefits. Summaries of benefits available to you under the Premium Plan are available from the SCL Health Human Resources Department. To obtain a copy of these documents, call (855) 412-3701 or visit www.sclhealthbenefits.org.

### 1.4 How this Plan Works with your Health Savings Account.

As with the Premium Plan, the election to make pre-tax contributions to a Health Savings Account is made under this Plan, but the terms of your Health Savings Account are determined entirely by your agreement with the trustee/custodian, which is not a part of this Plan.

Your participation in a Health Savings Account, to the extent available to you, is entirely voluntary. Your Health Savings Account is not an employer-sponsored benefit plan. Neither the Sponsoring Employer nor any other Employer has any authority or control over the funds deposited in your Health Savings Account. By allowing you to make pre-tax contributions to your Health Savings Account through this Plan, neither the Sponsoring Employer nor any other Employer is endorsing your Account, nor does your Health Savings Account constitute an employer-sponsored plan for purposes of ERISA. Only participants employed by the University of Saint Mary or Cristo Rey Kansas City may make pre-tax contributions to a Health Savings Account under this Plan.

## ARTICLE II
## PARTICIPATION

### 2.1 Who is Eligible to Participate.

Each Eligible Employee, as defined in Section 9.6, is eligible to participate in the Plan. You become eligible to participate in the Plan (i.e., to make pre-tax contributions for the Optional Benefits in Section 1.2) when you become eligible for coverage under one or more of the Optional Benefits. Because different eligibility and waiting periods may apply under the Optional Benefits, you may be able to purchase one or more, but not all, of the Optional Benefits. Similarly, you may be able to purchase all of the Optional Benefits, but at different

commencement dates. For purposes of this Plan, you are treated as an Eligible Employee only with respect to the Optional Benefits for which you are eligible, and only at the times you become eligible for such coverage under the terms of such Optional Benefits.

In addition, a former Eligible Employee who is receiving separation pay from the Employer under the Sisters of Charity of Leavenworth Health System Separation Benefit Plan is also considered an Eligible Employee during his or her separation pay period with respect to any Optional Benefits for which he or she remains eligible.

Participants employed by the University of Saint Mary or Cristo Rey Kansas City may make pre-tax contributions to a Health Savings Account under this Plan. Additional special eligibility requirements apply to participation in a Health Savings Account. You are responsible for determining whether you are eligible to participate in a Health Savings Account. By allowing you to make pre-tax contributions to your Health Savings Account through this Plan, neither the Sponsoring Employer nor any other Employer is assuming any responsibility to make an independent determination as to your eligibility to contribute to a Health Savings Account.

### 2.2 When Participation Terminates.

Your eligibility to make contributions under the plan with respect to Compensation earned terminates on the earliest of:

(a) The date you cease to be an Eligible Employee for any reason (or, with respect to Optional Benefits which are health benefits, the end of the month in which your separation pay period ends if you are eligible to receive separation pay from the Employer under the Sisters of Charity of Leavenworth Health System Separation Benefit Plan);

(b) With respect to any Optional Benefit, the date you cease to be eligible to purchase such Optional Benefit;

(c) The effective date of your election not to participate in the Plan;

(d) The date your Employer ceases to be a participating employer in the Plan;

(e) The effective date of any Plan amendment which terminates eligibility for any class of which you are a member; or

(f) The date the Plan is terminated.

### 2.3 Rehired Employees.

If you cease to be an Eligible Employee due to a termination of employment or other change in employment status and again become an Eligible Employee, you will be treated as a new Eligible Employee for purposes of all Optional Benefits and will become eligible to participate at the times described in Section 2.1. See Section 3.9 for special rules if you take FMLA Leave or Military Leave.

## ARTICLE III
## YOUR ACCOUNTS AND ELECTIONS

### 3.1 Your Accounts.

If you elect to participate in the Health Care Spending Account Program or the Dependent Care Spending Account Program, you may have up to two bookkeeping accounts established to keep track of the "benefit dollars" available to you for the reimbursement or payment of covered expenses. The term "benefit dollars" refers to that portion of your Compensation that you elect to contribute to purchase Optional Benefits.

(a) Your "Health Care Spending Account" keeps track of the benefit dollars available for the reimbursement of medical, dental and vision expenses under the Plan's Health Care Spending Account Program described in Article IV.

(b) Your "Dependent Care Spending Account" keeps track of the benefit dollars available for the reimbursement of dependent care expenses covered under the Plan's Dependent Care Spending Account Program described in Article V.

Benefit dollars you elect to contribute toward coverage under the Premium Plan or, with respect to participants employed by the University of Saint Mary or Cristo Rey Kansas City, to your Health Savings Account, will be paid to the Premium Plan or the trustee/custodian of your Health Savings Account, as applicable.

### 3.2 Annual Enrollment Period.

Prior to each calendar year, you will be provided an opportunity to elect Optional Benefits for that year. If you wish to purchase for the following year one or more of the Optional Benefits for which you are otherwise eligible, you must so specify and agree to a reduction in your Compensation in an amount sufficient to pay your costs of the Optional Benefits you elect. The amount you elect to contribute to your accounts will be taken from your pay on a pre-tax basis in equal installments throughout the following calendar year. (Note that the cost of Optional Benefits you elect for any Legally Domiciled Adult or his or her children who are not your tax dependents for federal income tax purposes must be paid on an after-tax basis outside of this Plan.)

Your election must be made in the form required by the Administrator and returned to your Human Resources Department on or before the date specified by the Administrator. If your election is made electronically, it must be done so in accordance with the procedures established by the Administrator for such electronic elections. *Section 3.4 below describes what happens if you fail to timely make an election during an annual enrollment period*.

As part of your election you will be required to specify the amount, if any, to be contributed to each of your accounts. The maximum amount you may contribute during a calendar year to your accounts is as follows:

(a) Premium Payment Account: Your cost for the medical, dental, and vision coverage you elect under the Premium Plan. The amount you elect to contribute to your Premium Payment Account will be adjusted automatically in the event of a change in your cost for the options you elected under the Premium Plan.

(b) Health Care Spending Account: The maximum amount under Code Section 125(i) (provided, however, that in the event any indexed amount is not

announced prior to September 1 preceding an applicable Plan Year, the amount in effect for the preceding Plan Year shall remain in effect for such Plan Year).

(c) Dependent Care Spending Account: $5,000 ($2,500 if you are married and will file a separate federal tax return). See Article V for further limitations.

(d) Health Savings Account: The maximum amount you may contribute to your Health Savings Account under Code Section 223. The maximum amount is pro-rated if you do not participate in the Health Savings Account for the entire year. Other special rules may also apply. Please note that it is your responsibility to make sure that you do not exceed the maximum set by law. By allowing you to make pre-tax contributions to your Health Savings Account under this Plan, neither the Sponsoring Employer nor any other Employer is assuming any responsibility for ensuring you do not exceed the maximum.

### 3.3 Initial Enrollment Period for New Employees.

As soon as practicable after your date of hire, you will be provided the opportunity to make the election described in Section 3.2. Your election with respect to any Optional Benefit will be effective on the date you become eligible for such Optional Benefit and will remain in effect through the end of the calendar year. If you desire to purchase an Optional Benefit, you must so specify and agree to a reduction in your Compensation as provided in Section 3.2. The election must be made in the form required by the Administrator and returned to your Human Resources Department within 31 days of your date of hire. If your election is made electronically, it must be done so in accordance with the procedures established by the Administrator for such electronic elections. *Section 3.4 below describes what happens if you fail to timely make an election during your initial enrollment period with respect to any Optional Benefit*.

### 3.4 Failure to Elect.

(a) Initial Election Period.

If you fail to timely make or return an election during your initial enrollment period under Section 3.3, you will be treated as having elected to receive for such calendar year (or balance thereof) the full amount of your Compensation, i.e., you will be treated as having elected not to purchase any Optional Benefits for the balance of the year.

(b) Annual Enrollment Period.

(1) Premium Plan. If you fail to timely make or return an election during an annual enrollment period under Section 3.2, in accordance with your Employer's policy, you will be treated as having elected to continue the Premium Plan elections you had in effect at the end of the preceding calendar year (or, in the event any Premium Plan ceased to be available, the default Premium Plan designated by the Administrator). You also will be treated as having agreed to a corresponding reduction in Compensation for the following calendar year equal to your share of the adjusted cost of such coverage. Notwithstanding the preceding, if there is a change in coverage offered or the Administrator imposes a mandatory enrollment, you may be required to make a new election.

(2) Health Care and Dependent Care Spending Accounts. A special rule applies to elections to purchase benefits under the Health Care Spending Account Program or the Dependent Care Spending Account Program. Elections to purchase such benefits never automatically renew from one calendar year to the next year. *It is thus important for you to always make a new election during the annual enrollment period if you wish to purchase health care or dependent care spending account benefits for the following year.*

(3) Health Savings Account. With respect to your Health Savings Account, you may increase, decrease or revoke your contribution election prospectively at any time, to be effective no later than the first day of the next calendar month following the date that the election change was filed, or as soon thereafter as is administratively practicable.

### 3.5 Irrevocability of Election During a Calendar Year.

Federal tax laws generally require that an election made under the Plan (or deemed made under Section 3.4) (other than Health Savings Account elections) remain in effect without modification for the entire calendar year for which the election is made. (Any elections made on an after-tax basis outside the Plan may be changed during a calendar year in accordance with your Employer's policy and any insurance policy limitations.)

You may, however, revoke an election for the balance of a calendar year and file a new election if the revocation and new election are on account of, and consistent with, a "Change in Status" or in certain other special circumstances outlined below. To become effective, a new election under this Section 3.5 must be made in the form required by the Administrator and returned to your Human Resources Department within 31 days (or 60 days in the case of an event described in Section 3.5(i) or the birth or adoption of a child) of the date the Change in Status or other event permitting such election. If your election is made electronically, it must be done in accordance with procedures established for such elections. The new election generally will be prospectively effective the first day of the month following the date of the event, unless otherwise provided in the Premium Plan. The only exception is for the addition of coverage due to the birth or adoption of a child. In that event, coverage will be effective as of the date of the birth or adoption if your election is made within 60 days of such event (except as otherwise provided in Section 3.5(f). (Note that any periods of retroactive coverage, other than related to the birth or adoption of a child, must be paid with after-tax dollars.)

With respect to the Health Care Spending Account Program, if you are permitted to change your election during the year, you may elect to increase or decrease the amount contributed to your Account, but you may not decrease your annual contribution below the greater of the amount you have already contributed during the calendar year or the amount you have already been reimbursed during the calendar year.

Because the IRS restricts the ability to make mid-year election changes, in all cases this Section 3.5 will be administered and interpreted with IRS guidelines or interpretations.

(a) Altering Benefit Elections Due to Changes in Status.

(1) You are entitled to change a previous benefit election, in the event that you, your spouse or dependent experience a "Change in Status" that affects such individual's eligibility for coverage under an Optional Benefit sponsored by your Employer or similar benefit under another employer's

plan and your new election is on account of and corresponds with the "Change in Status." For instance, with respect to health, dental or vision coverage, an election is consistent with a Change of Status if the Change in Status results in you, your spouse, or your dependent gaining or losing eligibility for coverage under the Optional Benefits or similar benefits of those of your spouse's or dependent's employer, *and* the election change corresponds with that gain or loss of coverage. For example, you may not cancel health, dental or vision coverage for an individual who has become eligible for coverage under another plan unless the individual actually becomes covered under the other plan. [Note: Termination of employment is not a Change in Status for a former Employee who is receiving separation pay from the Employer under the Sisters of Charity of Leavenworth Health System Separation Benefit Plan.]

(2) For this purpose, a "Change in Status" includes the following:

(A) events that change the number of your dependents (e.g. birth, death, adoption, placement for adoption);

(B) your marriage, divorce, legal separation, annulment or the death of your spouse;

(C) a change in your employment status or that of your spouse or a dependent (e.g., commencement or termination of employment, reduction or increase in work hours, change from salary to hourly status, strike or lock-out, commencement of or return from an approved unpaid leave of absence, new worksite, etc.);

(D) a change in the residency of you, your spouse or a dependent; or

(E) a change in the status of one of your dependents under a Premium Plan's eligibility criteria (e.g. attainment of a specified maximum age, enrollment or graduation in school, and any similar circumstance).

(b) <u>Altering Benefit Elections Due to Changes in Cost of Coverage.</u>

(1) If the cost of a Premium Plan increases (or decreases) during a calendar year and, under the terms of that Premium Plan, participants are required to make a corresponding change in payments, your contributions under the Plan for the costs of such coverage will automatically be adjusted.

(2) If the cost charged to you for an Optional Benefit option significantly changes during a calendar year, you will be permitted to file a new election under this Plan in circumstances permitted by IRS guidelines. For this purpose, a significant cost change refers to an increase or decrease in the amount of your salary contributions under this Plan, whether that increase or decrease results from an action taken by you (such as switching between full-time and part-time status), from an action taken by your Employer (such as reducing the amount of Employer contributions for a class of Employees), or the costs charged by the Optional Benefit or insurer providing these benefits.

(3) In the case of an election under the Dependent Care Spending Account Program, your prior election may be altered during the calendar year only

if the cost change is imposed by a dependent care provider who is not your relative.

(4) This Section 3.5(b) does not apply to the Health Care Spending Account Program.

(c) Altering Elections for Significant Coverage Changes.

(1) If you or your spouse or dependent have a significant reduction in benefits under an Optional Benefit during a calendar year (e.g., there is a significant increase in the deductible, the required co-payments, or the out-of-pocket cost sharing limit), the Plan will allow you to revoke such coverage and, to the extent available, elect to receive coverage under another benefit option providing similar coverage.

(2) If you or your spouse or dependent have a significant "loss of coverage" under an Optional Benefit during a calendar year, you may revoke such coverage and, instead, elect to receive coverage under another benefit option made available under the Plan that provides similar coverage. If no similar benefit option is available, then you will be permitted to drop such coverage. For these purposes, a "loss of coverage" means a complete loss of coverage, such as an HMO ceasing to be available, a substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO), or any other similar fundamental loss of coverage as determined by the Administrator.

(3) If, during a calendar year, an Optional Benefit adds a new benefit option or other coverage option, or if coverage under an existing benefit option or other coverage option is significantly improved during the calendar year, otherwise eligible employees (regardless of whether they have previously made an election under this Plan for that particular calendar year or have previously elected the benefit option in question) may revoke their election under this Plan and, instead, make an election for coverage under the new or improved benefit option.

(4) This Section 3.5(c) does not apply to the Health Care Spending Account Program.

(d) Altering Elections Due to Changes in Coverage Under Another Employer Plan.

You may make an election change that is on account of and corresponds with a change made under another employer plan if the other employer's cafeteria plan annual enrollment period is different than this Plan's or if the other employer's cafeteria plan permits a mid-year change for reasons set forth in Section 3.5(a), (b), (c), or (f), as applicable to the other employer's cafeteria plan or benefits. This Section 3.5(d) does not apply to the Health Care Spending Account Program.

(e) Loss of Other Group Health Plan Coverage.

You may make an election to add coverage for you or your spouse or dependent if you, your spouse or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including:

(1) a state children's health insurance program (SCHIP);

(2) a medical care program of an Indian tribal government, the Indian Health Service, or a tribal organization;

(3) a state health benefits risk pool; or

(4) a foreign government group health plan.

This Section 3.5(e) does not apply to the Health Care Spending Account Program.

(f) Altering Elections for HIPAA Special Enrollments.

You may revoke an election for health, dental or vision benefits under the Premium Plan and file a new election if a "special enrollment period" is available to you under HIPAA. Under HIPAA, you are generally afforded the opportunity to elect health coverage for you, your spouse and/or your dependents where coverage was previously declined either because (1) you, your spouse and/or your dependents had COBRA coverage and such COBRA coverage has since been exhausted (nonpayment of premiums is not sufficient for this purpose); or (2) you, your spouse and/or your dependents had non-COBRA health coverage and the other coverage has been terminated due to loss of eligibility for coverage (*e.g.* loss of student-only coverage available through a college due to the individual ceasing to be a student) or other employer contributions towards the other coverage have terminated. HIPAA also provides a special enrollment period where you previously declined coverage either for yourself, your spouse and/or your dependents and you subsequently acquire a new dependent by marriage, birth, adoption or placement for adoption.

**Note**: As a result of the national emergency related to the COVID-19 outbreak, the time period in which you may make a mid-year election change on account of a "special enrollment" event has been extended. Generally, the Administrator must disregard the period beginning March 1, 2020 and ending 60 days after the announced end of the national emergency related to the COVID-19 outbreak (called the "Outbreak Period"), when applying your 30-day notice period. Thus, you generally may change your election on account of a special enrollment event through the end of the Outbreak Period.

(g) Altering Elections Upon Medicare or Medicaid Entitlement.

If you, your spouse, or a dependent becomes enrolled for general benefits under Medicare or Medicaid, you may cancel health, dental, vision or health care spending account benefits for such individual. Alternatively, if you, your spouse, or dependent loses coverage under Medicare or Medicaid, you may make an election to begin or increase such coverage.

(h) Altering Elections for Court Ordered Coverage.

If you are required to provide health, dental, or vision coverage, or coverage under the Plan's Health Care Spending Account Program for a dependent child as a result of a divorce, legal separation, annulment, or change in legal custody, the Plan may change your election during a calendar year to comply with the legal instrument mandating coverage. You may elect to cancel any such coverage for a dependent child if the order requires your spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

(i) Altering Elections for CHIPRA Special Enrollments.

If you, your spouse or a dependent: (1) were covered under a state Medicaid or SCHIP plan and such coverage terminated due to a loss of eligibility; or (2) become eligible for assistance with premium payments under this Plan, you may make an election to add health coverage for you, your spouse or dependent.

**Note**: As described in subsection (f) above, the Administrator must disregard the Outbreak Period when applying your 60-day notice period. Thus, you generally may change your election on account of a CHIPRA special enrollment event through the end of the Outbreak Period.

(j) Special ACA Rules.

You may revoke your election for health coverage if you have been in an employment status under which you are reasonably expected to average at least 30 hours per week and there is a change in your employment status so that you will reasonably be expected to average less than 30 hours per week (regardless of whether such reduction results in a loss of coverage under the medical Premium Plan) and the revocation corresponds to your enrollment (and that of your affected dependents) in another plan that provides minimum essential coverage, with the new coverage date no later than the first day of the second month following the month of the revocation. In addition, you may revoke your election for health coverage if you are eligible for a special enrollment period to enroll in a qualified health plan through a Marketplace, or you enroll in a qualified health plan through the Marketplace during its annual open enrollment period, as long as you enroll in such qualified health plan for coverage that is effective beginning no later than the day immediately following the last day of the coverage under the medical Premium Plan. This Section 3.5(j) shall be applied in accordance with IRS Notice 2014-55.

### 3.6 Election Changes under Health Savings Account.

Elections to contribute to a Health Savings Account generally can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed, or as soon thereafter as administratively practicable. For more information regarding changes in election under your Health Savings Account, refer to your agreement with the trustee/custodian.

### 3.7 Automatic Termination of Election.

Elections made under this Plan (or deemed made under Section 3.4) automatically terminate when you become ineligible to participate or, if earlier, the first day you properly elect to discontinue your Plan elections (if such discontinuance is authorized under the Plan). Your contributions to this Plan will cease with your final paycheck as an Eligible Employee, except as otherwise provided in the Sisters of Charity of Leavenworth Health System Separation Benefit Plan. Coverage under an Optional Benefit under the Premium Plan continues only to the extent provided under such plan. Health Care Spending Account Program benefits continue as provided in Article IV and Dependent Care Spending Account Program benefits continue as provided in Article V. Your participation in your Health Savings Account may continue as provided in your agreement with the trustee/custodian.

### 3.8 Nondiscrimination Rules.

If the Administrator determines, before or during any calendar year, that the Plan or any Optional Benefit fails to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to key employees, the Administrator may take such action as it deems appropriate, under rules uniformly applicable to similarly situated Employees, to assure compliance with any such requirement or limitation. Such action may include, without limitation, a modification of an election by a highly compensated employee or a key employee, with or without the consent of such individual.

### 3.9 Participation During or Upon Return Leave of Absence.

Special rules apply if you take FMLA Leave or Military Leave. These rules are very complex and, in part, depend upon whether your leave is paid or unpaid and the terms of your Employer's leave policy. Your rights during or upon return from FMLA Leave or Military Leave under this Plan will be determined in accordance with your Employer's leave policy, to the extent consistent with the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act, as may be amended.

In general, however, if you are on a paid FMLA Leave or paid Military Leave, your elections under this Plan will automatically continue, so long as you remain eligible for the Optional Benefits during such leave in accordance with your Employer's leave policy. To the extent provided in your Employer's leave policy, your Employer's contributions towards the cost of such Optional Benefits will continue as if you remained actively employed with your Employer. If you are on a paid FMLA Leave or a paid Military Leave during annual enrollment period, you may change your elections during the annual enrollment period as if you were not on a paid leave.

Different rules apply if your FMLA Leave or Military Leave is unpaid. With respect to an unpaid FMLA Leave, you will have the opportunity to discontinue your contributions towards the Optional Benefits. If you do so, your coverage under such benefits may terminate while you are on leave. While on unpaid FMLA Leave you have the right to continue your coverage under your Employer's health benefits, including medical, dental, vision, and the Health Care Spending Account Program described in Article IV. Your Employer's contributions towards such health benefits will continue, if you elect to continue such coverage, on the same basis as if you were actively employed with your Employer. Your Employer's leave policy may also allow you to continue your coverage of non-health benefits. Employer contributions towards the cost of non-health benefits while you are on unpaid FMLA Leave will be determined in accordance with your Employer's leave policy.

If you elect to continue coverage while on unpaid FMLA Leave, your Employer's leave policy may allow you to continue contributions on an after-tax "pay as you go basis," which generally means that to continue such coverage you will be required to make payments to your Employer at the times payments would otherwise be withheld from your pay. Alternatively, your Employer's leave policy may permit you to make special pay arrangements, including the payment by your Employer of your premiums for the period while you are on FMLA Leave, with the understanding that you will repay such premiums at the conclusion of your leave. It might also allow you at your request to pay the amounts that become due during your leave out of your paychecks preceding the leave.

If you are on an unpaid Military Leave, your rights are very similar to those described above. However, in these circumstances your Employer's obligation to make contributions towards your health benefits generally ceases if your Military Leave exceeds 31 days. In that event, however, you may still continue your health benefits, including the Health Care Spending Account Program described in Article IV, by paying the full cost of such coverage in accordance with the methods described above.

Upon your timely return to active employment from FMLA Leave or Military Leave, you will have the opportunity to be reinstated in any Optional Benefits (to the extent available to other employees) which you had previously elected, without evidence of insurability or the new imposition of a waiting period. Your Employer's leave policy may also allow you to make "catch-up" contributions for any Optional Benefits during your unpaid leave. Unless you continued coverage during your leave or your Employer allows you to make "catch-up" contributions, the coverage to which you are reinstated will not be given retroactive effect. As a result, if you discontinue coverage in the Health Care Spending Account Program while on leave, and subsequently elect to be reinstated upon return from such leave, your coverage for the remainder of the calendar year (assuming you return to employment in the same calendar year) is equal to your initial election for the calendar year, prorated for the period during the FMLA or Military Leave for which no contributions were paid, reduced by prior reimbursements.

With respect to other leaves of absence, 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 making contributions for coverage while on such leave.

# ARTICLE IV
## HEALTH CARE SPENDING ACCOUNT PROGRAM

### 4.1 Eligibility.

All Eligible Employees are eligible to participate in the Health Care Spending Account Program described in this Article IV. You become eligible to purchase this benefit on the first day of the calendar month following the date you become an Eligible Employee or, if you are a resident physician, the date you become an Eligible Employee, provided you make an election under Section 3.3 within 31 days of your date of hire. In addition, if you are a participant in the Health Care Spending Account Program on the date your termination of employment occurs and you are eligible to receive severance pay under the Sisters of Charity of Leavenworth Health System Separation Benefit Plan, you shall continue your coverage during your severance pay period. Note that if you elect to participate in the Health Care Spending Account Program for a calendar year, you may not make contributions to a Health Savings Account during that calendar year (or through the end of the month in which the Grace Period related to that calendar year ends, unless your Health Care Spending Account balance at the end of the calendar year is $0 (determined on a cash basis)).

If you timely elect to purchase benefits under the Health Care Spending Account Program, you may submit claims for the reimbursement of your Covered Medical Expenses in accordance with this Article IV.

### 4.2 Definitions.

For purposes of this Article, the following special definitions apply:

(a) "**Dependent**" means: (1) your spouse (unless legally separated); (2) any person who is your dependent as defined in Code Section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof); (3) your child (as defined in Code Section 152(f)(1)) through the end of the month in which the child attains age 26; and (4) your child to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year).

(b) **"Grace Period"** means the period that begins immediately following the close of a calendar year and ends on the date that is two months and 15 days following the close of that calendar year.

(c) The term "**Medical Expenses**" means medical, vision and dental expenses incurred by you or your dependents of the type deductible under Code Section 213(d), excluding, however, voluntary abortions or sterilizations. Effective January 1, 2020, "Medical Expenses" shall also include over-the-counter medications and expenses provided in Code Section 106(f). Medical Expenses for this purpose may include, for example, deductibles and co-payments under a Premium Plan, physicals, and well care. Expenses that are not covered include premium payments for medical, dental or vision coverage and expenses reimbursed through any other program or plan, or for cosmetic surgery. IRS Publication 502, Medical and Dental Expenses, contains a good explanation of the types of expenses generally reimbursable by the Plan.

(d) The term "**Covered Medical Expenses**" means Medical Expenses incurred during the calendar year (or, if you are a new hire, the portion of the calendar year for which you are eligible) for which you have an effective election to purchase Health Care Spending Account Program benefits or during the Grace Period immediately following such calendar year. For this purpose, an expense is "incurred" when you or your dependent are furnished the medical care or services giving rise to the claimed expense. Covered Medical Expenses do not include expenses incurred for the payment of premiums under a health insurance plan, expenses which are reimbursable through insurance or otherwise (other than this Plan), expenses for cosmetic surgery or for which you are not obligated to pay.

### 4.3 The Maximum Amount of Coverage.

The amount of Health Care Spending Account Program benefits during any calendar year may not exceed the maximum amount under Code Section 125(i) (provided, however, that in the event any indexed amount is not announced prior to September 1 preceding an applicable Plan Year, the amount in effect for the preceding Plan Year shall remain in effect for such Plan Year).

### 4.4 Your Health Care Spending Account.

An amount equal to the reduction (if any) in your Compensation in accordance with your election under Article III will be credited to your Health Care Spending Account. Your Health Care Spending Account for each calendar year will be debited from time to time in the amount of any Plan reimbursement for Covered Medical Expenses. At any time during a calendar year (or during the Grace Period immediately following such calendar year), the Plan will reimburse you for Covered Medical Expenses up to the amount you have elected to contribute for the calendar year, less prior reimbursements for that calendar year.

### 4.5 When Claims Must be Filed/Forfeiture of Your Account.

The amount credited to your Health Care Spending Account for any calendar year may be used only to reimburse you for Covered Medical Expenses incurred during such year or during the Grace Period immediately following such year. In order to receive reimbursement, you must file a claim for such Covered Medical Expenses in accordance with Article VI by April 30 following the close of the calendar year to which the expense is attributable. *If any balance remains in your account for any calendar year after all permissible reimbursements, such balance may not be used to reimburse you for Covered Medical Expenses incurred during a subsequent period or be made available to you in any other form or manner. You will forfeit all rights with respect to such balance.* Forfeitures will be used to defray the administrative costs of this Program and, if any amounts remain, will be used as determined by the Administrator.

Claims filed for Covered Medical Expenses incurred during the Grace Period after each calendar year will first be automatically applied to any balance remaining in your Health Care Spending Account from the prior year and, once those funds are exhausted, subsequent claims will be applied to the balance in your Health Care Spending Account for the current year, based on the order in which the claims are processed. The only exception to this is that if a debit card is available, Covered Medical Expenses incurred during the Grace Period may need to be submitted manually in order to for them to be reimbursed from your Health Care Spending Account for the prior year if the card is unavailable for such reimbursement. Once a claim has been paid from a Health Care Spending Account, the claim is closed and cannot be reassigned or reallocated to a Health Care Spending Account established in a different calendar year.

*Example:* If you have $500 left in your 2021 Health Care Spending Account at the end of 2021, those funds may be used to reimburse you for Covered Medical Expenses you incur during the period January 1, 2022 - March 15, 2022. You have until April 30, 2022 to submit claims for reimbursement from funds left over in your 2021 Health Care Spending Account. As claims are submitted, they will be applied to your remaining 2021 Health Care Spending Account, if any. Once any funds remaining in your 2021 Health Care Spending Account are exhausted, you will be reimbursed for these Covered Medical Expenses from amounts you elect to contribute to your Health Care Spending Account for 2022, if any, and you will have until April 30, 2023 to submit those claims.

***To ensure proper reimbursement, you should always submit claims incurred during the calendar year to which your election applies first - before you submit claims incurred after the end of the calendar year (and before March 15).*** For example, assume you have $500 in your Health Care Spending Account at the end of 2021, and you elected to contribute $1,000 to your Health Care Spending Account for 2022. In February 2022, you submit a claim for $500 for a claim incurred in January 2022. The Administrator will apply this claim to the funds remaining in your 2021 Health Care Spending Account. If

you later submit a $500 claim for expenses incurred in December 2021, that claim will be denied because you have no funds remaining in your 2021 Health Care Spending Account. If you had submitted the second claim first, it would have been paid from your 2021 Health Care Spending Account, and the first claim would have been paid from your 2022 Health Care Spending Account. Thus, you should always submit claims promptly and in the order in which they are incurred.

### 4.6 Debit Card.

The annual amount elected to defer to your Health Care Spending Account will be loaded onto a debit card. You may pay Covered Medical Expenses directly with the debit card or pay cash and submit a reimbursement form. In order to be eligible to use the debit card, you must agree to abide by the terms and conditions of the card, including any fees, limitations as to card usage, and the Plan's right to withhold and offset for ineligible claims. A Cardholder Agreement will be provided to you.

You may be required to submit documentation that shows the expenses are Covered Medical Expense if you use the card for items other than office visits and certain prescription copays, which are normally validated at the time the expense in incurred. A provider's bill, explanation of benefit (EOB) or cash register receipt for over-the-counter medications (purchases must be listed) are acceptable.

Your debit card privileges will be revoked if you fail to substantiate your card use or use your card to purchase anything other than Covered Medical Expenses, and you will be required to repay the account for any non-qualified purchases. In this event, future eligible expenses from your Health Care Spending Account will require you to provide paper documentation and submit a claim form.

Note that your debit card will also be terminated upon your termination of employment and you will have to submit any outstanding claims manually. You may not use the card during any applicable COBRA continuation coverage period.

### 4.7 Coordination with Health Reimbursement Arrangement.

Covered Medical Expenses which are also eligible for reimbursement under a Health Reimbursement Arrangement provided under the medical Premium Plan may be submitted for reimbursement to either the Health Care Spending Account Program or the Health Reimbursement Arrangement, but not both. When deciding whether to submit the expenses to the Health Care Spending Account Program or the Health Reimbursement Arrangement, keep in mind that unused Health Reimbursement Arrangement funds earned through wellness incentives will roll over to the next plan year if you remain on a plan sponsored by SCL Health. Unused Health Care Spending Account Program funds are forfeited at the end of the Grace Period for the year.

### 4.8 Termination of Benefits; Special Rules for Former Employees.

Your coverage will automatically terminate as of the last day of the month in which you cease to be an Eligible Employee, unless you are eligible for severance pay under the Sisters of Charity of Leavenworth Health System Separation Benefit Plan as provided in Section 4.1 or you continue coverage under Section 4.8. You may continue to file claims for Covered Medical Expenses incurred through the date your coverage ceased (or, if your termination occurs on December 31, through the end of the applicable Grace Period). Claims must be filed by April 30

following the close of the calendar year in which you ceased to be an Eligible Employee. As noted above, your debit card will be terminated upon your termination of employment. If you wish to submit claims incurred prior to the date your coverage ceased, you must do so manually on a paper form.

### 4.9 Continuation of Health Care Spending Account Benefits.

You and your spouse or dependents may be entitled to continue participation in the Health Care Spending Account Program after the date your participation would otherwise end. Your rights under COBRA are described in Appendix A. (For information regarding your COBRA rights under the Premium Plan, you should review each Plan's Summary Plan Description. You cannot continue your Dependent Care Spending Account Program participation through COBRA.)

### 4.10 Qualified Reservist Distributions.

Notwithstanding anything herein to the contrary, if you meet each of the following requirements, you may elect to receive a distribution of certain funds from your health care spending account for a calendar year (a "Qualified Reservist Distribution"):

(a) Your contributions to your Health Care Spending Account for the calendar year as of the date of your request for a Qualified Reservist Distribution exceed the reimbursements you have received from your account for the calendar year as of that date.

(b) You are ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

(c) You have provided the Administrator (or its designee) with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.

(d) During the period beginning on the date of the order or call to active duty and ending on the last day of the calendar year during which the order or call occurred (or the end of the applicable grace period), you deliver a written election to the Administrator (or its designee) in such form as the Administrator may prescribe, requesting a Qualified Reservist Distribution.

The Administrator will review all requests for Qualified Reservist Distributions on a uniform and consistent basis. Requests for such distributions that are approved by the Administrator will be paid within a reasonable time, but not more than 60 days, after the date of the Participant's request.

The amount of any Qualified Reservist Distribution made under this provision will be equal to your contributions to your health care spending account for the calendar year as of the date of the request for distribution, minus reimbursements you have received from the Account for the calendar year as of that date. Any portion of the distribution that is not a reimbursement for substantiated medical care expenses will be included in your gross income and wages.

If you request a Qualified Reservist Distribution, you will forfeit the right to receive additional reimbursements for Covered Medical Expenses incurred during the calendar year and on or after the date of the distribution request. However, you may claim reimbursement for Covered Medical Expenses incurred during the calendar year and before the date of your distribution request, even if those claims are submitted after the date of your distribution, so long as the dollar amount of the claim does not exceed the amount of your election under the Health Care Spending Account for the calendar year, less the sum of your Qualified Reservist Distribution under this provision and the reimbursements you have received from your Account for the calendar year.

### 4.11 Compliance with HIPAA.

HIPAA imposes certain requirements and limitations on the use and disclosure of health information held by the Health Care Spending Account Program. For more information, see Appendix B.

### 4.12 Determinations of Qualified Medical Child Support Orders.

A qualified medical child support order is a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires you to provide coverage for your child under the Health Care Spending Account Program. The Health Care Spending Account Program's procedures for handling qualified medical child support orders are available without charge upon request to the Administrator.

### 4.13 Participants' Rights.

As a participant in the Health Care Spending Account Program, you are entitled to certain rights and protections under ERISA. A summary of your ERISA rights is attached as Appendix C.

## ARTICLE V
## DEPENDENT CARE SPENDING ACCOUNT PROGRAM

### 5.1 Eligibility.

All Eligible Employees are eligible to participate in the Plan's Dependent Care Spending Account Program described in this Article V, other than an Eligible Employee who is a highly compensated employee for the calendar year within the meaning of Code Section 414(q). You become eligible to purchase these benefits on the first day of the calendar month following the date you become an Eligible Employee or, if you are a resident physician, the date you become an Eligible Employee, provided you make an election under Section 3.3 within 31 days of your date of hire.

If you timely elect to purchase benefits under the Dependent Care Spending Account Program, you may submit claims for the reimbursement of your Covered Dependent Care Expenses in accordance with this Article V.

### 5.2 Definitions.

For purposes of this Article, the following special definitions apply:

(a) "**Dependent**" means (1) your tax dependent under the age of 13 who is your qualifying child as defined in Code Section 152(a)(1); (2) your tax dependent as defined in Code Section 152, but determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof, who is physically or mentally incapable of caring for himself or herself and has the same principal place of residence for more than half of the year; and (3) your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of residence for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Dependent who is a child shall, as provided in Code Section 21(d)(5), be treated as a Dependent of the custodial parent (within the meaning of Code Section 152(e) and shall not be treated as the Dependent with respect to the noncustodial parent.

(b) "**Dependent Care Expense**" means amounts paid or incurred by you for "household services" or for the care of a Dependent, either inside or outside of your home, subject to the limitations in Section 5.5, in order to enable you to be gainfully employed for any period for which you have one or more Dependents. In the case of dependent care provided outside of your home, where the person or facility providing the care cares for more than six individuals, expenses will be considered Dependent Care Expenses only if the person or facility complies with all applicable state and local laws and the benefits are provided (1) for the care of your Dependent child under the age of 13 or (2) any other Dependent who regularly spends at least eight hours each day in your household.

(c) "**Household Services**" means expenses paid for the performance of ordinary and usual services necessary to the maintenance of your household. Such expenses must also be attributable to the care of a Dependent, as defined above. For example, amounts paid for the services of a cook may only be reimbursed if the services are provided to a Dependent and enable you to be gainfully employed.

**5.3 Covered Expense.**

The Plan will reimburse only Dependent Care Expenses incurred while you have an effective election to purchase dependent care benefits for a calendar year (or, if you are a new hire, the portion of the calendar year for which you are eligible). Dependent Care Expenses will be considered incurred when the dependent care is provided and not when you are formally billed, charged for or pay the Dependent Care Expenses.

**5.4 Further Limitations.**

Your dependent care benefits during any taxable year may not exceed the least of:

(a) $5,000 ($2,500 if you are married and file a separate return);

(b) your earned income for the year (after all reductions in pay to provide dependent care benefits under this Plan); or

(c) the actual or deemed earned income of your spouse for the year.

For purposes of Section 5.4(c), if your spouse is a full-time student at an educational institution or physically or mentally incapable of caring for himself or herself, your spouse is deemed to have earned income of $200 per month if you have only one Dependent, and $400

per month if you have two or more Dependents. When completing your elections under Article III, you should be careful not to exceed the permissible amount described in this Section.

### 5.5 Prohibition of Certain Payments.

No reimbursements will be paid to you during any taxable year for Dependent Care Expenses paid to an individual:

(a) with respect to whom, for such taxable year, you or your spouse is entitled to a personal tax exemption as a Dependent; or

(b) who is your child under age 19 or your spouse.

### 5.6 Your Dependent Care Spending Account.

An amount equal to the reduction (if any) in your Compensation in accordance with your election under Article III will be credited to your Dependent Care Spending Account. Your Dependent Care Spending Account for each calendar year will be debited from time to time in the amount of any Plan reimbursement for Covered Dependent Care Expenses. *Reimbursement from your Dependent Care Spending Account for Covered Dependent Care Expenses may never exceed the amount then remaining in your Account.*

### 5.7 When Claims Must be Filed/Forfeiture of Your Account.

The amount credited to your Dependent Care Spending Account for any calendar year may be used only to reimburse you for Dependent Care Expenses incurred during such year. In addition, you must file a claim for reimbursement in accordance with Article VII on or before April 30 following the close of the calendar year in which the claimed expense is incurred. *If any balance remains in your Account for any calendar year after all permissible reimbursements, such balance may not be used to reimburse you for Dependent Care Expenses incurred during a subsequent calendar year, and will not be available to you in any other form or manner. You will forfeit all rights with respect to such balance.* Forfeitures will first be used to defray the administrative costs of the Plan and, if any amounts remain, will then be retained by the Sponsoring Employer.

### 5.8 Debit Card.

The annual amount elected to defer to your Dependent Care Spending Account will be loaded onto a debit card. You may pay Dependent Care Expenses directly with the debit card or pay cash and submit a reimbursement form. You may be required to submit documentation that shows the expenses are Dependent Care Expenses.

Your debit card privileges will be revoked if you fail to substantiate your card use or use your card to purchase anything other than Dependent Care Expenses, and you will be required to repay the account for any non-qualified purchases. In this event, future eligible expenses from your Dependent Care Spending Account will require you to provide paper documentation and submit a claim form.

Note that your debit card will also be terminated upon your termination of employment and you will have to submit any outstanding claims manually.

### 5.9 Termination of Benefits; Special Rules for Former Employees.

Your coverage will automatically terminate as of the last day of the month in which you cease to be an Eligible Employee. You may continue to file claims for Dependent Care Expenses incurred through the date your coverage ceased. Claims must be filed on or before the April 30 following the close of the calendar year in which you ceased to be an Eligible Employee.

### 5.10 Important Reporting Requirements.

Federal law requires that in order for you to exclude such expenses from your federal taxable income, you must include certain information on your federal tax returns. In particular, you will have to report the correct name, address, and taxpayer identification number of the dependent care provider. If the dependent care provider is an individual, the taxpayer identification number is the individual's social security number. Special reporting rules apply if the provider is tax exempt for federal tax purposes. You should consult your personal tax adviser for more information concerning the reporting requirements.

### 5.11 Alternative Tax Credit.

In some circumstances it may be to your advantage not to contribute to your dependent care spending account. This is because federal law includes a dependent care "tax credit" which is an alternative to the dependent care benefits under this Plan. A comparison of the dependent care "tax credit" and the dependent care benefits provided by this Plan is available from your Human Resources Department.

## ARTICLE VI
## CLAIM PROVISIONS

**NOTE: As a result of the national emergency related to the COVID-19 outbreak, the time periods in which you may file a claim under the Health Care Spending Account Program and file a request for an appeal of a denied claim under the Health Care Spending Account Program, 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. This extension does not apply to claims and appeals under the Dependent Care Spending Account Program.**

### 6.1 Filing a Claim.

**The claims and appeal procedures described below do not apply to claims for Optional Benefits provided under the Premium Plan or the Health Savings Account. If you have a claim for benefits under the Premium Plan or the Health Savings Account, you will need to follow the claims procedures described in booklets summarizing the Premium Plan and the Health Savings Account.**

When you wish to be reimbursed for medical or dependent care expenses, you may file a claim in accordance with procedures established by the Administrator from time to time. You may also use your debit card in certain circumstances.

Your claim form generally must be accompanied by a receipt or bill indicating the type of expense incurred and the amount of that expense. In the case of a medical expense, you may be required to provide a statement indicating that you have not been reimbursed for the expense from any health plan and that the expense is not reimbursable to you from any health

plan. In the case of a dependent care expense, you must also provide the name, address and social security number (or taxpayer identification number in the case of a corporation or other organization) of the person providing the care for your dependent.

If you use your debit card to pay a medical expense, some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is conditional and you will still have to submit supporting documents. You will be required to comply with substantiation procedures established by the Administrator in accordance with IRS Rev. Rul. 2003-43, IRS Notice 2006-69, IRS Notice 2007-2, Prop. Treas. Regs. Sec. 1.125-6 and other IRS guidance. In addition, expenses incurred during a Grace Period (as defined in Article IV) may need to be submitted manually in order to be reimbursed from unused amounts in your Health Care Spending Account from the preceding calendar year if the card is unavailable for such reimbursement.

If you wish to file a claim pertaining to any other Plan matter, you should file a claim with your Human Resources Department. These claims will also be reviewed in accordance with the procedures described in this Article.

### 6.2 Payment of Claims.

The Claims and Appeals Committee or its designee will decide each claim as soon as possible after the claim is received.

You will be notified of all payments and will receive an explanation of how the payments were calculated. If a claim is wholly or partially denied, you will be furnished a written notice setting forth:

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

(b) a specific reference to pertinent Plan provisions on which the determination was based;

(c) a description of any additional material or information necessary to process your claim and an explanation of why such material or information is necessary;

(d) a description of the Plan’s review procedures and the time limits applicable to such procedures, including, if applicable, a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review; and

(e) with respect to the Health Care Spending Account Program, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

The notice will be furnished to you within 30 days after receipt of the claim by the Claims and Appeals Committee, unless special circumstances require an extension of time for processing the claim. No extension will be for more than 15 days after the end of the initial 30-day period. If an extension of time for processing is required, written notice of the extension shall be furnished to you before the end of the initial 30-day period. The extension notice will indicate

the special circumstances requiring an extension of time and the date by which a final decision is expected to be made. If an extension is necessary due to your failure to submit the information necessary to decide the claim the extension notice will specifically describe the required information and you will be afforded 45 days from your receipt of the notice within which to provide the specified information.

### 6.3 Appealing a Claim.

If a claim is denied in whole or in part, you may appeal the adverse benefit determination by filing a written appeal with the Claims and Appeals Committee. The Claims and Appeals Committee will not afford deference to the initial adverse benefit determination. The decision of the Claims and Appeals Committee is final and binding on all parties. You may review documents pertinent to the appeal and submit issues and comments in writing as part of your appeal. No appeal will be considered unless it is received by the Claims and Appeals Committee within 180 days after you receive written notification of the adverse benefit determination with respect to your claim. The Claims and Appeals Committee will decide the appeal within 60 days after it is received. The Claims and Appeals Committee will notify you in writing of the benefit determination on review. If the claim is wholly or partially denied, the notice will set forth

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

(b) a specific reference to pertinent Plan provisions on which the determination was based;

(c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

(d) if applicable, a statement of your right to bring a civil action under section 502(a) of ERISA; and

(e) with respect to the Health Care Spending Account Program, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

You may not bring any action at law or in equity regarding a claim for benefits under the Plan, unless and until you exhaust your rights to review under this Article VI in accordance with the time-frames set forth herein. No action at law or in equity shall be brought to recover benefits under the Plan later than one (1) year from the date you believed you were denied a benefit or right or the date you should have known that such benefit or right was not provided, if you did not file a claim during that period, or one (1) year from the date of the final adverse benefit determination of your appeal of the denial of your claim for benefits. Notwithstanding the foregoing, if the applicable, analogous Colorado statute of limitations has run or will run before the referenced one (1)-year period, the Colorado statute of limitations is controlling.

For purposes of this Article VI, claims will be processed in the manner allowed or required by the Affordable Care Act and guidance thereunder.

# ARTICLE VII
## ADMINISTRATION OF PLAN

### 7.1 Plan Administrator

The Sponsoring Employer is the administrator of the Plan, as defined in Section 3(16)(A) of ERISA, and shall be responsible for the performance of all reporting and disclosure obligations under ERISA, and all other obligations required to be performed by the plan administrator under ERISA or the Code, except such obligations and responsibilities delegated herein to the Administrator or such other person or entity. The Sponsoring Employer shall be the designated agent for service of legal process with respect to the Plan.

### 7.2 Named Fiduciary.

The administration of the Plan is under the supervision of the Administrator. It is the principal duty of the Administrator to see that the Plan is carried out in accordance with its terms and for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them. The Administrator has full power to administer the Plan in all of its details, subject to applicable requirements of law. The Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, supply omissions, and determine the benefits available under the Plan. All decisions and interpretations of the Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious. For this purpose, the Administrator's powers include, but are not limited to, the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(b) The discretion and authority to interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) The discretion and authority to decide all questions concerning the Plan, the eligibility of any person to participate in the Plan, and the amount of any benefits to which a Participant may be entitled;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan;

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan; and

(f) To enter into any and all contracts and agreements for carrying out the terms of this Plan and for the administration of the Plan and to do all acts as it, in its discretion, may deem necessary or advisable. Such contracts and agreements shall be binding and conclusive on the parties hereto and anyone claiming benefits hereunder.

Notwithstanding the foregoing, any claim which arises under a Premium Plan is not subject to review under this Plan, and the Administrator's authority does not extend to any matter as to which any other person or entity is empowered to make determinations under the policy(ies) or documents evidencing such arrangement.

### 7.3 Reliance on Tables, etc.

In administering the Plan, the Administrator is entitled to the extent permitted by law, to rely on all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Administrator.

### 7.4 Actions.

Any act which the Plan authorizes or requires the Administrator to do may be done by a majority of the members thereof then in office, which concurrence may be had without a formal meeting. The Administrator shall select a Secretary, who may or may not be an Employee or a member of the Administrator, and such other officers it deems necessary. The Administrator shall adopt rules governing its procedures not inconsistent with this Plan. The Administrator may authorize one or more of its members to sign on its behalf any instructions, instruments, or other documents. No member serving as Administrator shall be entitled to vote on any matter pertaining solely to herself. The Administrator shall keep a permanent record of its meetings and actions.

### 7.5 Expenses.

The proper expenses of the Administrator will be paid by the Sponsoring Employer to the extent not payable with forfeitures arising under the Plan or assessed against accounts of Eligible Employees.

## ARTICLE VIII
## GENERAL PROVISIONS

### 8.1 Modification and Amendment of Plan.

The Sponsoring Employer reserves the right at any time and from time to time to modify or amend, in whole or in part, any or all of the provisions of the Plan, as follows:

(a) The Board of Directors of the Sponsoring Employer, in its sole discretion, may amend or modify the Plan, in whole or in part, at any time. The Board of Directors of the Sponsoring Employer shall have exclusive authority to amend the Plan to the extent such amendment constitutes a material change in the benefits design or philosophy of the Sponsoring Employer or results in a material increase in costs to the Sponsoring Employer.

(b) The President/Chief Executive Officer of the Sponsoring Employer, 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 Sponsoring Employer or result in a material increase in costs to the Sponsoring Employer; provided, however, that the President/Chief Executive Office 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 or Mount St. Vincent Home, Inc. 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 purposes of this subsection (b), the determination of the President/Chief Executive Officer will be binding on the Sponsoring Employer and the Plan.

(c) The Senior Vice President, Chief Human Resources Officer, of the Sponsoring Employer, 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 Sponsoring Employer. In addition, the Senior Vice President, Chief Human Resources Officer, of the Sponsoring Employer, or the person from time to time performing such function, may waive or otherwise modify the eligibility provisions, or similar provisions, of any Welfare Program in connection with an acquisition or similar corporate transaction, to the extent such waiver or modification is consistent with the terms of the acquisition agreement and would not result in a material increase in costs to the Sponsoring Employer. Such waiver or modification shall be reflected in Appendix E attached hereto.

### 8.2 Plan Termination.

The Plan may be terminated at any time by the Board of Directors of the Sponsoring Employer upon the date of its due authorization. If the Plan is terminated, the Plan will make payments from your accounts for covered expenses incurred through the effective date of Plan termination.

### 8.3 Election to Withdraw by an Employer.

An Employer who wishes to withdraw from this Plan must deliver written notice of such withdrawal to the Senior Vice President, Chief Human Resources Officer, of the Sponsoring Employer, at least 31 days prior to the date the withdrawal is to be effective, unless such notice period is waived in writing by the Senior Vice President, Chief Human Resources Officer. A withdrawal may take place only with the approval of the Senior Vice President, Chief Human Resources Officer, of the Sponsoring Employer, and may only be effective as of the last day of a calendar year, unless otherwise agreed to by the Senior Vice President, Chief Human Resources Officer. Additionally, the Senior Vice President, Chief Human Resources Office, of the Sponsoring Employer may withdraw consent to the participation of any Employer at any time on reasonable notice to such Employer. In the event such a withdrawal occurs, benefits will be paid in accordance with the terms of the Plan for claims incurred prior to the date of withdrawal from this Plan. To the extent authorized by the Sponsoring Employer, that portion of any surplus assets of the accounts attributable to the withdrawing Employer or its Employees may be transferred to a successor plan established by the withdrawing Employer for its Employees providing benefits of the type provided by this Plan.

### 8.4 Governing Law.

This Plan shall be construed and enforced according to the laws of the State of Colorado, other than its laws respecting choice of law, to the extent not preempted by federal law.

### 8.5 Construction of Plan Document.

Any headings or subheadings in this Plan are inserted for convenience of reference only and in the event of any conflict, the text of this document, rather than such headings or subheadings, shall control.

### 8.6 Severability Clause.

In the case any provision of this Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of this Plan and this Plan shall be construed and enforced as if such illegal or invalid provisions had never been inserted herein.

### 8.7 No Guarantee of Employment.

This Plan shall not be deemed to constitute a contract between you and your Employer, or to be a consideration or an inducement for your employment. Nothing contained in this Plan shall be deemed to give you the right to be retained in the service of your Employer or to interfere with the right of the Employer to discharge any individual at any time.

### 8.8 Non-Gender Clause.

Except when the context indicates to the contrary, when used herein, masculine terms shall be deemed to include the feminine and feminine terms shall be deemed to include the masculine, and terms in the singular shall be deemed to include the plural, and the plural the singular.

### 8.9 Alienation.

No benefits under this Plan may be assigned, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for your debts or obligations. If a person who is entitled to receive a payment under the Plan is, in the Administrator's opinion, incapable of giving a valid receipt for the payment and if no guardian has been appointed for that person, payment may be made to the person or persons who in the Administrator’s opinion have assumed the obligations of caring for the person on whose behalf the payment is made.

### 8.10 General Information.

The Plan is funded through Compensation reductions made by Eligible Employees. Amounts contributed to purchase coverage under the Premium Plan are held by your Employer as part of its general assets until paid to the Premium Plan or its insurers as premiums become due. Amounts contributed to purchase Health Care Spending Account or Dependent Care Spending Account benefits are held by your Employer as part of its general assets until requests for payment of covered expenses are approved.

## ARTICLE IX
## DEFINITIONS

**9.1 "Administrator**" means the Senior Vice President, Chief Human Resources Officer, of the Sponsoring Employer, or the person from time to time performing such function.

**9.2 "Claims and Appeals Committee**” means the Claims and Appeals Committee under the Plan, the member of which are appointed from time to time by the Administrator.

**9.3 “COBRA”** means the federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985. This law provides employees and their spouses and dependents who participate in certain plans providing medical benefits the right to continue such benefits at their own cost following certain events.

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

**9.5 "Compensation"** means the salary or wages paid to you by your Employer, including amounts you contribute to the Plan pursuant to a compensation reduction election. In addition, Compensation includes severance pay paid to any former Employee under the Sisters of Charity of Leavenworth Health System Separation Benefit Plan.

**9.6 "Eligible Employee"** means an employee 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. "Eligible Employee" does not include individuals classified by the Employer 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. Additionally, "Eligible Employee," for purposes of this Plan, including the Health Care Spending Account Program and the Dependent Care Spending Account Program, does not include any employee who participates in the SCL Health Pay in Lieu of Benefits Program.

**9.7 "Employer"** means the Sponsoring Employer and any employer affiliated with the Sponsoring Employer whose participation in the Plan has been approved by the Senior Vice President, Chief Human Resources Officer, of the Sponsoring Employer. The participating employers are listed on Appendix D, which may change from time to time to reflect new participating employers or withdrawing participating employers.

**9.8 "ERISA"** the Employee Retirement Income Security Act of 1974, as amended, and including all regulations promulgated thereto.

**9.9 "FMLA Leave"** means a leave of absence that the Employer is required to extend, and which is taken by you, in accordance with the Family and Medical Leave Act, as may be amended, and your Employer's FMLA Leave Policy.

**9.10 "HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, as amended, and including all regulations promulgated thereto.

**9.11 "Military Leave"** means a leave of absence to perform service in the uniformed services of the United States of America that is taken in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as may be amended.

**9.12 "Plan"** means the SCL Health Associate Flexible Benefit Plan, as herein set forth and as amended from time to time.

**9.13 "Plan Administrator"** means the Sponsoring Employer.

**9.14 "Premium Plan"** means the SCL Health Associate Health Benefit Plan.

**9.15 "Sponsoring Employer"** means the Sisters of Charity of Leavenworth Health System, its successors and assignees.

**9.16 "You"** refers to any person who is participating in the Plan as an Eligible Employee.

## ARTICLE X
## PLAN INFORMATION

**Name of Plan:** SCL Health Associate Flexible Benefit Plan

**Name, Address and Telephone Number of Sponsoring Employer and ERISA Plan Administrator:**

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

**Employer Identification Number (EIN):** 23-7379161

**IRS Plan Number:** 523

**Effective Date of Plan:** The Plan was originally effective on January 1, 1989. The Plan has been most recently amended and restated effective January 1, 2021

**Type of Plan:** The Plan is a cafeteria plan under Code Section 125. The Health Care Spending Account Program is a self-insured medical plan under Code Section 105(h). The Dependent Care Spending Account Program is provided under Code Section 129. Although contained in this document, the Health Care Spending Account Program and the Dependent Care Spending Account Program are separate plans for purposes of administration and reporting and nondiscrimination requirements imposed under the Code.

**Name, Business address, and Business Telephone Number of the Administrator:**

Senior Vice President, Chief Human Resources Officer
SCL Health
500 Eldorado Blvd., Ste. 4300
Broomfield, CO 80021
(303) 813-5250

**Third-Party Administrator/Custodian:** The company or companies which provide certain administrative services for the Plan. The Third-Party Administrator for the Health Care Spending Account Program and the Dependent Care Spending Account Program, and the custodian for the Health Savings Account, are:

**Health Care Spending Account Program/Dependent Care Spending Account Program**

Discovery Benefits
PO Box 2926
Fargo, ND 58108
866-451-3245
customerservice@discoverybenefits.com

**Health Savings Account**

Select Account
P.O. Box 64193
St. Paul, MN 55164-0193

**Person designated as 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 of process may also be made upon the Plan Administrator.

**Plan Year:** Calendar year

Executed this ______ day of __________________ 2021, but effective as of January 1, 2021 (except as otherwise expressly stated herein).

**SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM**

By:________________________________________
Tamara Saunaitis,
Senior Vice President, CHRO

# APPENDIX A

## COBRA COVERAGE CONTINUATION
## HEALTH CARE SPENDING ACCOUNT PROGRAM

**This notice explains COBRA continuation coverage with respect to the Health Care Spending Account Program, 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 coverage under the Health Care Spending Account Program 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-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 an eligible dependent.

**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 under the Health Care Spending Account Program that generally lasts only through the end of the calendar year in which the qualifying event occurs.

**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](http://www.healthcare.gov).

**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.

## APPENDIX B

## HIPAA PRIVACY AND SECURITY

***This Appendix B applies solely to the Health Care Spending Account Program.***

### Section 1. HIPAA Privacy Compliance.

(a) Notice of Privacy Rights.

A federal law, known as "HIPAA," restricts the Plan's uses and disclosures of your medical information. HIPAA requires that the Plan provide a notice to certain covered individuals of how the Plan may use and disclose your medical information and how you can get access to this information. You may request a copy of the Plan's notice from the Sponsoring Employer.

(b) Disclosures to Sponsoring Employer.

In accordance with HIPAA, the Plan may disclose summary health information to the Sponsoring Employer as requested by the Sponsoring Employer to allow it to modify, amend or terminate the Plan or to obtain premium bids from insurers to provide health insurance coverage with respect to the Plan. The Plan may disclose to the Sponsoring Employer information on whether an individual is participating or enrolled in the Plan. In addition, the Plan may disclose protected health information to the Sponsoring Employer as necessary to allow the Sponsoring Employer to perform plan administration functions, as defined in HIPAA privacy regulations, including the following functions on behalf of the Plan:

(1) Collection of Participant premiums or contributions;

(2) Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives, and related functions;

(3) Reviewing health plan performance;

(4) Activities relating to obtaining or renewing health insurance or determining premium pricing for such benefits, or placing a contract for reinsurance of risk relating to such claims;

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

(6) Business planning and development of the Plan, such as conducting cost-management and planning-related analyses, including formulary development and administration, development or improvement of methods of payment or coverage policies;

(7) Business management and general administrative activities of the Plan;

(8) Determination of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of benefit claims;

(9) Billing, claims management, collection activities, obtaining payment under a stop-loss contract, and related health care data processing;

(10) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;

(11) Utilization review activities; and

(12) Disclosure to consumer reporting agencies of any of the following "protected health information" relating to collection of premiums or reimbursement:

(A) Name and address;
(B) Date of birth;
(C) Social security number;
(D) Payment history;
(E) Account number; and
(F) Name and address of the health care provider and/or health plan.

(c) Access to Medical Information.

The following employees or individuals under the control of the Sponsoring Employer shall have access to the Plan's protected health information to be used solely for the purposes described above:

(1) SCL Health Human Resources employees;

(2) Administrator;

(3) Members of the Claims and Appeals Committee; and

(4) Legal, finance and information system personnel to the extent they perform functions with respect to the Plan.

(d) Sponsoring Employer Agreement to Restrictions.

The Plan will not disclose "protected health information" to the Sponsoring Employer until the Sponsoring Employer has certified to the Plan that it agrees to:

(1) Not use or disclose protected health information other than as permitted or required by law or as specified above;

(2) Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan;

(3) Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which Sponsoring Employer becomes aware;

(4) Make protected health information accessible to the subject individual in accordance with 45 CFR § 164.524;

(5) Allow the subject individuals to amend or correct their protected health information in accordance with 45 CFR § 164.526;

(6) Make available the information to provide an accounting of its disclosures of protected health information in accordance with 45 CFR § 164.528;

(7) Make its internal practices, books and records available to the Secretary of Health and Human Services for determining compliance;

(8) Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or if not feasible, restrict access and uses as required by 45 CFR § 164.504(f)(2)(ii)(I);

(9) Ensure that any agents, including a subcontractor, of the Sponsoring Employer to whom the Sponsoring Employer provides protected health information shall also agree to these same restrictions;

(10) Restrict access to protected health information to those classes of employees or individuals identified above; and

(11) Restrict the use of protected health information by those employees identified above for plan administration functions within the meaning at 45 CFR § 164.504(a).

(e) Noncompliance Resolution.

In the event of noncompliance with the above restrictions by a designated employee receiving protected health information on behalf of the Sponsoring Employer, the employee or other individual shall be subject to discipline in accordance with the Sponsoring Employer's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Official.

(f) Privacy Officer.

The Privacy Officer shall be appointed and removed from time to time in the sole discretion of the Administrator.

**Section 2. HIPAA Security Compliance.**

(a) The Sponsoring Employer shall do the following:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and

availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that the adequate separation required by Section 164.504(f)(2)(iii) of the HIPAA privacy regulations is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

(4) Report to the Plan any security incident of which it becomes aware.

(b) The provisions of (a) apply to all disclosures of electronic protected health information by the Plan to the Sponsoring Employer except:

(1) Disclosures of summary health information to the Sponsoring Employer as reasonably requested by the Sponsoring Employer to allow it to modify, amend or terminate the Plan, or to obtain premium bids from insurers to provide health insurance coverage under the Plan;

(2) Disclosures of information on whether an individual is participating or enrolled in the Plan; and

(3) Disclosures of information authorized by an individual in accordance with 45 CFR Section 164.508.

(c) Any term used in this Section shall have the meaning set forth in the HIPAA security regulations at 45 CFR Parts 160, 162 and 164.

(f) The Security Officer shall be appointed and removed from time to time in the sole discretion of the Administrator.

## APPENDIX C

## STATEMENT OF ERISA RIGHTS

As a participant in Health Care Spending Account Program, you are entitled to certain rights and protections under 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. For more information regarding your rights to continue your coverage, see Appendix A.

### *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.

## APPENDIX D

## PARTICIPATING EMPLOYERS

### As of January 1, 2021

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 (Only for the KICF Pooled Employee Health Insurance Program, Dental and Vision coverage under the Premium Plan, the Health Care Spending Account Program, and the Dependent Care Spending Account Program)
University of Saint Mary (Only for the KICF Pooled Employee Health Insurance Program, Dental and Vision coverage under the Premium Plan, the Health Care Spending Account Program, the Dependent Care Spending Account Program, and Health Savings Account Contributions)
Cristo Rey Kansas City, a Sisters of Charity of Leavenworth High School (Only for the KICF Pooled Employee Health Insurance Program, Dental and Vision coverage under the Premium Plan and Health Savings Account Contributions)

# APPENDIX E

## SPECIAL PROVISIONS

## As of January 1, 2021