SUPPLEMENTAL INFORMATION
REGARDING THE LIFE INSURANCE PLAN

This Attachment supersedes and replaces the Summary Plan Description pages of the Certificate of Coverage, except the Claims and Appeal Procedures.

1. **Name of Plan:** SCL Health Life Insurance Plan

   The Plan is part of the SCL Health Associate Welfare Benefit Plan

   The SCL Associate Welfare Benefit Plan and the Policy together are the formal plan document for the Plan. The Certificate of Coverage and this attachment are the summary plan description for the Plan.

2. **Name and address of Plan Sponsor and Plan Administrator:**

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

   As of January 1, 2021, the following employers have also adopted the Plan for the benefit of their eligible employees:

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

3. **Employer Identification No. (EIN) of the Plan Sponsor:** 23-7379161

4. **Type of Plan:** Welfare benefit plan providing life insurance benefits

5. **Plan No.:** 522

6. **Type of Administration:** Insurer Administration

7. **The name and address of the person designated as agent for service of legal process and address at which process may be served.**

   SCL Health
   Attn: Senior Vice President, Chief Human Resources Officer
   500 Eldorado Blvd., Suite 4300
   Broomfield, CO 80021

8. **Sources of Contributions:** Premiums for basic life and AD&D coverage for the associate under the Plan are paid for by the Employer. Associates may purchase additional optional life coverage as well as dependent coverage. Benefits are underwritten by the Lincoln Life Assurance Company of Boston under an insurance policy or contract issued to SCL Health, Group Life Policy No. SA3-860-061065-01. The address of the insurer is: 100 Liberty Way, Suite 100, Dover, New Hampshire 03820-4695.

9. **Plan Year:** January 1 – December 31

10. **Amendment of the Plan:** The Plan Sponsor 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 or to terminate the Plan, at any time, as follows:

    (a) The Board of Directors of the Plan Sponsor, in its sole discretion, may amend or modify the Plan, in whole or in part, at any time. The Board of Directors of the Plan Sponsor 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 Plan Sponsor or results in a material increase in costs to the Plan Sponsor.

    (b) The President/Chief Executive Officer of the Plan Sponsor, in his or her sole discretion, may amend or modify the Plan to the extent such amendment or modification would not constitute a material change in the benefits design or philosophy of the Plan Sponsor or result in a material increase in costs to the Sponsoring Employer; provided, however, that the President/Chief Executive Officer of the Sponsoring Employer shall make any Plan amendment reasonably requested by the Mother House of the Sisters of Charity of Leavenworth, the University of Saint Mary, 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 this purpose, the determination of the President/Chief Executive Officer will be binding on the Plan Sponsor and the Plan.

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

11. **Eligibility**: Notwithstanding anything in the Policy or Certificate of Coverage to the contrary, except as specifically noted, all employees of SCL Health or any participating employer (collectively “Employer” or “Employers”) with a payroll status of Full Time Equivalency (FTE) of 0.5 or above, or, with respect to the University of Saint Mary, employees who are regularly scheduled to work 30 or more hours per week, full-time faculty while covered by an active contract, and coaches who are expected to regularly work 30 hours or more per week while fall and spring semesters are in session so long as they remain employed, are eligible to participate in the Plan. The following associates are not eligible to participate in the Plan: individuals

classified as "PRN," "Per Diem," "Temporary," student interns, volunteers, or any person classified as an independent contractor or a leased employee, regardless of whether such individual is subsequently determined by a court of competent jurisdiction or governmental agency or authority to have been a common law employee.

This Certificate of Coverage applies to the following class of eligible associates: Class 1, Class 2, and Class 6

Additionally, eligible associates may purchase coverage under the Plan for the following dependents:

- The associate's lawful spouse
- The associate's "Legally Domiciled Adult" or "LDA." (LDA coverage is not offered at the University of Saint Mary.) An LDA is an individual over the age of 18 who shares the same principal residence as the associate, remains a member of the associate's household throughout the coverage period, and meets the following requirements: (1) has lived with the associate continuously for at least 12 months, (2) has an on-going, exclusive and committed relationship with the associate similar to marriage (e.g., is not a casual roommate or tenant), (3) shares basic living expenses and is financially interdependent with the associate, and (4) is neither legally married to (or legally separated from) or in a civil union with anyone else, nor legally related to the associate by blood in any way that would prohibit marriage in the state of his or her residence. *(References in the Policy and/or Certificate to "Domestic Partner" include LDAs.)*

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

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

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

  The term "child" means the associate's or LDA's natural or legally adopted child. It also includes a stepchild or a child for whom the associate is the legal guardian. An individual will be considered a "child" for this purposes if he or she meets the above requirements, regardless of whether he or she is a member of the armed forces.

  (References in the Policy and/or Certificate to "child" or "Dependent" include children of LDAs as defined above.)

12. **Family Status Change**: Notwithstanding anything in the Policy or Certificate of Coverage to the contrary, an event shall be considered a "Family Status Change" only if it affects the individual's eligibility for coverage under the Plan.

13. **Leaves of Absence**: Notwithstanding anything in the Policy or Certificate of Coverage to the contrary, coverage may continue during any approved leave of absence in accordance with the Employer's leave of absence policy. To the extent coverage is extended, the associate may be required to continue paying premiums for coverage while on such leave.

14. **Termination Provisions**: Notwithstanding anything in the Policy to the contrary, Section 6, item 6, regarding termination of coverage while an associate is not actively at work due to a labor dispute, including any strike, work slowdown, or lockout, is not applicable to the Plan.

15. **Claims and Appeal Provisions:**

Applicable to All Claims, except Waiver of Premium Claims:

What is the Time Frame For Claim Decisions?

If your claim is denied, Lincoln will notify you of the adverse decision within a reasonable period of time, but not later than 90 days after receiving the claim, unless Lincoln determines that special circumstances require an extension. In such case, a written extension shall be furnished before the end of the initial 90-day period. The extension cannot exceed 90 days. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the decision. The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

What If Your Claim Is Denied?

Lincoln's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those specific Plan provisions on which the denial is based;

2. A description of any additional material or information necessary to complete the claim and an explanation of why that material or information is necessary; and

3. A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring a civil action under ERISA following an adverse decision on appeal.

What Do You Do To Appeal A Claim Denial?

You or your authorized representative may appeal a denied claim within 60 days after you receive Lincoln's notice of denial. You have the right to:

1. Submit, for review, written comments, documents, records and other information relating to the claim to Lincoln;

2. Request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and

3. A review on appeal that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision.

Lincoln will make a full and fair review of your appeal and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be

made within a reasonable period of time, but not later than 60 days following receipt of the written request for review, unless Lincoln determines that special circumstances require an extension. In such case, a written extension notice will be sent to you before the end of the initial 60 day period. The extension notice must indicate the special circumstances and the date by which Lincoln expects to render the appeal decision. The extension cannot exceed a period of 60 days.

The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

Lincoln's notice of denial on appeal shall include:

1. The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

2. 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; and

3. A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

Applicable to Waiver of Premium Claims:

What is the Time Frame For Claim Decisions?

If your claim is denied, Lincoln will notify you of the adverse decision within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if Lincoln: (1) determines the extension is necessary because of matters beyond the Plan’s control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date. If, before the end of the first 30-day extension, Lincoln determines, due to matters beyond the Plan’s control, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days, provided Lincoln notifies you, before the end of the first 30-day extension period, why the extension is needed and the expected decision date.

The notice of extension shall explain: (1) the standards on which benefit entitlement is based, (2) the unresolved issues that prevent a claim decision, and (3) the additional information needed. You have at least 45 days to provide the information.

The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date Lincoln sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

What If Your Claim Is Denied?

Lincoln's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those specific Plan provisions on which the denial is based;

2. A description of any additional material or information necessary to perfect the claim and an explanation of why that material or information is necessary;

3. A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring a civil action under ERISA following an adverse decision on appeal;

4. If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; and

5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

What Do You Do To Appeal A Claim Denial?

You, or your authorized representative, may appeal a denied claim within 180 days after you receive Lincoln's notice of denial. You have the right to:

1. Submit to Lincoln, for review, written comments, documents, records, and other information relating to the claim;

2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;

3. A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision;

4. A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person's subordinate;

5. If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual; and

6. The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision.

Lincoln will make a full and fair review of your appeal and may require additional documents as it deems necessary in making such a review. A final decision on the review will be made within a reasonable period of time but not later than 45 days following receipt of the written request for review unless Lincoln determines that special circumstances require an extension. In such case, a written notice will be sent to you before the end of the initial 45-day period. The extension notice shall indicate the special circumstances and the date by which Lincoln expects to render the appeal decision. The extension cannot exceed a period of 45 days from the end of the initial period.

The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

Lincoln's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

2. 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;

3. A statement describing any voluntary appeal procedures offered by Lincoln and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;

4. If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; and

5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

RIGHTS AND PROTECTIONS UNDER ERISA

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

Receive Information About Your Plan and Benefits

ERISA provides that all Plan participants will be entitled to:

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

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

  Send written requests to:

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

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

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.