SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT

FOR THE

SCL HEALTH
SHORT-TERM DISABILITY PLAN

January 1, 2021

Summary Plan Description/Plan Document
for the
SCL Health Short-Term Disability Plan

SCL Health ("Plan Sponsor") sponsors the SCL Health Short-Term Disability Plan (the "Plan") for the benefit of its eligible employees and the eligible employees of its participating employers (collectively, "Employer" or "Employers").

The Plan Sponsor has selected Lincoln Life Assurance Company of Boston ("Lincoln" or "Claims Administrator") to administer claims under the Plan. Lincoln does not insure any benefit under the Plan. All benefits are paid from the general assets of the Employers.

This document has been written so that it is not just a summary of Plan benefits, but also the legal plan document written so that it can be used by you or the Plan Sponsor in understanding and administering the benefits provided under the Plan. This document is effective as of January 1, 2021 and replaces all prior versions. This document and the SCL Health Associate Welfare Benefit Plan constitute the formal plan document for the Plan.

Note that capitalized terms used in this booklet are defined the first time they are used or are defined in Section 2 - Definitions of this booklet.

SECTION 1 - PLAN SPECIFICATIONS

Who is Eligible for Short Term Disability Benefits?

Except as specifically noted, all associates of an Employer with a payroll status of Full Time Equivalency (FTE) of 0.5 or above are eligible to participate in the Plan. The following associates are not eligible to participate in the Plan: associates classified as Level A or Level B executives, 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.

What is the Eligibility Waiting Period?

If you are employed by the Employer on the Plan effective date - First of the month following the date of hire or, with respect to associates who are resident physicians, the date of hire

Are Employee Contributions Required?

No

What is the Elimination Period?

The period for which a benefit is payable will commence following the Elimination Period. For this purpose, the Elimination Period is 7 calendar days. (Beginning March 11, 2020 and until otherwise determined by the Employer, the Elimination Period is waived in the event of a positive COVID-19 test.)

Note: Benefits will begin on the first day following the completion of the Elimination Period.

What is the Amount of Benefits?

70.00% of Basic Weekly Earnings less Other Income Benefits and Other Income Earnings for associates who are physicians and hospitalists.

60.00% of Basic Weekly Earnings less Other Income Benefits and Other Income Earnings for all other associates.

What is the Maximum Benefit Period?

The period for which a benefit is payable, following completion of the Elimination Period, for any one Disability will end on the earliest of:

a. the end of the Disability; or

b. the end of the 173rd day of Disability for which a benefit is payable.

SECTION 2 - DEFINITIONS

This section defines some basic terms needed to understand this Plan. The male pronoun whenever used in this Plan includes the female.

"**Active Employment**" means you must be actively at work for the Employer:

1. on a full-time or part-time basis and paid regular earnings;

2. for at least the minimum number of hours shown in the Plan Specifications; and either perform such work:

    a. at the Employer's usual place of business; or
    b. at a location to which the Employer's business requires you to travel.

You will be considered actively at work if you were actually at work on the day immediately preceding:

1. a weekend (except where one or both of these days are scheduled work days);
2. holidays (except when the holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. an excused leave of absence pursuant to your Employer's leave policy (except medical leave for your own disabling condition and lay-off); and
6. an emergency leave of absence (except emergency medical leave for your own disabling condition).

"**Appropriate Available Treatment**" means care or services which are:

1. generally acknowledged by Physicians to cure, correct, limit, treat or manage the disabling condition;
2. accessible within your geographical region;
3. provided by a Physician who is licensed and qualified in a discipline suitable to treat the disabling Injury or Sickness;
4. in accordance with generally accepted medical standards of practice.

"**Basic Weekly Earnings**" means the employee's biweekly rate of earnings from the Employer in effect immediately prior to the date disability or partial disability begins. However, such earnings will not include bonuses, commissions, overtime pay, and extra compensation. Benefits are issued according to the Employee's normal, biweekly pay cycle.

"**Disability**" or "**Disabled**" means you, as a result of Injury or Sickness, are unable to perform the Material and Substantial Duties of your Own Job.

"**Eligibility Date**" means the date you become eligible to participate in this plan. Eligibility Requirements are shown in the Plan Specifications.

"**Eligibility Waiting Period**" means the continuous length of time you must be in Active Employment in an eligible class to reach your Eligibility Date.

"**Elimination Period**" means a period of consecutive days of Disability for which no benefit is payable. The Elimination Period is shown in the Plan Specifications and begins on the first day of Disability.

"**Employee**" means a person in Active Employment with the Employer who is participating in this Plan.

"**Family and Medical Leave**" means a leave of absence for the birth, adoption or foster care of a child, or for the care of your child, spouse or parent or for your own serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 (FMLA) and any amendments, or by applicable state law.

"**Gross Weekly Benefit**" means your Weekly Benefit before any reduction for Other Income Benefits and Other Income Earnings.

"**Hospital**" or "**Institution**" means a facility licensed to provide Treatment for the condition causing your Disability.

"**Injury**" means bodily impairment resulting directly from an accident and independently of all other causes. For the purpose of determining benefits under this Plan:

1. any Disability which begins more than 60 days after an Injury will be considered a Sickness; and

2. any Injury which occurs before you are a participant under this Plan, but which accounts for a medical condition that arises while you are participating in this Plan will be treated as a Sickness.

"**Material and Substantial Duties**" means responsibilities that are normally required to perform your Own Job and cannot be reasonably eliminated or modified.

"**Own Job**" means your job that you were performing when your Disability or Partial Disability began.

"**Partial Disability**" or "**Partially Disabled**" means you, as a result of Injury or Sickness, are able to:

1. perform one or more, but not all, of the Material and Substantial Duties of your Own Job or another job on an Active Employment or a part-time basis; or

2. perform all of the Material and Substantial Duties of your Own Job or another job on a part-time basis; and

3. earn between 20.00% and 80.00% of your Basic Weekly Earnings.

"**Physician**" means a person who:

1. is licensed to practice medicine and is practicing within the terms of his license; or

2. is a licensed practitioner of the healing arts in a category specifically favored under the health coverage laws of the state where the Treatment is received and is practicing within the terms of his license.

It does not include you, any family member or domestic partner.

"**Plan Specifications**" means the section of this plan which shows, among other things, the Eligibility Requirements, Eligibility Waiting Period, Elimination Period, Amount of Benefits, Minimum Benefit, and Maximum Benefit Period.

"**Proof**" means the evidence in support of a claim for benefits and includes, but is not limited to, the following:

1. a claim form completed and signed (or otherwise formally submitted) by you claiming benefits;

2. an attending Physician's statement completed and signed (or otherwise formally submitted) by your attending Physician; and

3. the provision by the attending Physician of standard diagnosis, chart notes, lab findings, test results, x-rays and/or other forms of objective medical evidence in support of a claim for benefits.

Proof must be submitted in a satisfactory form or format.

"**Regular Attendance**" means your personal visits to a Physician which are medically necessary according to generally accepted medical standards to effectively manage and treat your Disability or Partial Disability.

"**Sickness**" means illness, disease, pregnancy or complications of pregnancy.

"**Treatment**" means consulting, receiving care or services provided by or under the direction of a Physician including diagnostic measures, being prescribed drugs and/or medicines, whether you choose to take them or not, and taking drugs and/or medicines.

"**Weekly Benefit**" means the weekly amount payable by the Plan to you if you are Disabled or Partially Disabled.

SECTION 3 - ELIGIBILITY

Who is Eligible for Benefits?

The eligibility requirements for participation are shown in the Plan Specifications.

What is Your Eligibility Date for Benefits?

If you are in an eligible class you will be eligible for coverage on the day after you complete the Eligibility Waiting Period shown in the Plan Specifications.

What Happens to Your Benefits During a Family and Medical Leave?

Your participation may be continued under this Plan for an approved family or medical leave of absence for up to 12 weeks following the date participation would have terminated, subject to the following:

1. the authorized leave is in writing;

2. the required contribution is made;

3. your benefit level, or the amount of earnings upon which your benefit may be based, will be that in effect on the date before said leave begins; and

4. continuation of participation will cease immediately if any one of the following events should occur:

    a. you return to work;
    b. this group benefit Plan terminates;
    c. you are no longer in an eligible class;
    d. fails to make the required contribution when due to the Employer;
    e. your employment terminates.

SECTION 4 - DISABILITY INCOME BENEFITS

Disability Benefit

When is Your Disability Benefit Payable?

When the Plan receives satisfactory Proof that you are Disabled due to Injury or Sickness and require the Regular Attendance of a Physician, you may be eligible to receive a Weekly Benefit after the end of the Elimination Period, subject to any other provisions of this Plan. The benefit will be paid for the period of Disability if you give to the Plan satisfactory Proof of continued:

1. Disability;

2. Regular Attendance of a Physician; and

3. Appropriate Available Treatment.

The Proof must be given upon the Plan's request and at your expense. In determining whether you are Disabled, the Plan will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, paycuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining Disability, the Injury must occur and Disability must begin while you are a participant of this Plan.

The Weekly Benefit will not:

1. exceed your Amount of Benefits; or

2. be paid for longer than the Maximum Benefit Period.

The Amount of Benefits and the Maximum Benefit Period are shown in the Plan Specifications.

How is the Amount of Your Disability Weekly Benefit Figured?

To figure the amount of Weekly Benefit:

1. Take the lesser of:

   a. your Basic Weekly Earnings multiplied by the benefit percentage shown in the Plan Specifications; or

   b. the Maximum Weekly Benefit shown in the Plan Specifications; and then

2. Deduct Other Income Benefits and Other Income Earnings, (shown in the Other Income Benefits and Other Income Earnings provision of this Plan), from this amount.

Partial Disability

When is Your Partial Disability Benefit Payable?

When the Plan receives satisfactory Proof that you are Partially Disabled and have experienced a loss of earnings due to Injury or Sickness and require the Regular Attendance of a Physician, you may be eligible

to receive a loss of earnings Weekly Benefit, subject to any other provisions of this Plan. To be eligible to receive Partial Disability benefits, you may be employed in your Own Job or another job, must satisfy the Elimination Period, and must be earning between 20.00% and 80.00% of your Basic Weekly Earnings. A Weekly Benefit will be paid for the period of Partial Disability if you give to the Plan satisfactory Proof of continued:

1. Partial Disability;

2. Regular Attendance of a Physician; and

3. Appropriate Available Treatment.

The Proof must be given upon the Plan's request and at your expense. In determining whether you are Partially Disabled, the Plan will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, paycuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining Partial Disability, the Injury must occur and Partial Disability must begin while you are a participant of this Plan.

How is Your Loss of Earnings Partial Disability Benefit Figured using the Work Incentive Calculation?

The work incentive benefit will be an amount equal to your Basic Weekly Earnings multiplied by the benefit percentage shown in the Plan Specifications, without any reductions from earnings, unless you are receiving Other Income Earnings.

The work incentive benefit will be reduced, if the Weekly Benefit payable plus any earnings exceed 100% of your Basic Weekly Earnings. If the combined total is more, the Weekly Benefit will be reduced by the excess amount so that the Weekly Benefit plus your earnings does not exceed 100% of your Basic Weekly Earnings.

The Weekly Benefit payable will not be more than the Disability benefit otherwise payable under this Plan.

Other Income Benefits and Other Income Earnings

What are Your Other Income Benefits and Other Income Earnings?

Other Income Benefits means:

1. The amount for which you are eligible under:

   a. any work loss provision in mandatory “No-Fault” auto coverage; or

   b. any governmental program or coverage required or provided by statute (including any amount attributable to your family).

2. any amount you receive from any unemployment benefits; or

3. any amount of Disability and/or Retirement Benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar Plan or act, which:

a. you receive or are eligible to receive; and

b. your spouse, child or children receives or are eligible to receive because of your Disability; or

c. your spouse, child or children receives or are eligible to receive because of your eligibility for Retirement Benefits.

Other Income Earnings means:

1. any amount you receive from any formal or informal sick leave or salary continuation Plan(s); and

2. the amount of earnings you earn or receive from any form of employment.

Other Income Benefits, except Retirement Benefits, must be payable as a result of the same Disability for which the Employer pays a benefit. The sum of Other Income Benefits and Other Income Earnings will be deducted in accordance with the provisions of this Plan.

Estimation of Benefits

How will Your Benefits be Estimated?

Your Disability or Partial Disability benefits will be reduced by the amount of Other Income Benefits that the Plan estimates is payable to you and your dependents.

Your Disability benefit will not be reduced by the estimated amount of Other Income Benefits if you:

1. provide satisfactory proof of application for Other Income Benefits;

2. sign a reimbursement agreement under which, in part, you agree to repay the Plan for any overpayment resulting from the award or receipt of Other Income Benefits;

3. if applicable, provide satisfactory proof that all appeals for Other Income Benefits have been made on a timely basis to the highest administrative level unless the Plan determines that further appeals are not likely to succeed; and

4. if applicable, submit satisfactory proof that Other Income Benefits have been denied at the highest administrative level unless the Plan determines that further appeals are not likely to succeed.

In the event that the Plan overestimates the amount payable to you from any Plans referred to in the Other Income Benefits and Other Income Earnings provision of this Plan, the Plan will reimburse you for such amount upon receipt of written proof of the amount of Other Income Benefits awarded (whether by compromise, settlement, award or judgement) or denied (after appeal through the highest administrative level).

What Happens if You Receive a Lump Sum Payment?

Other Income Benefits from a compromise, settlement, award or judgement which are paid to you in a lump sum and meant to compensate you for any one or more of the following:

1. loss of past or future wages;

2. impaired earnings capacity;
3. lessened ability to compete in the open labor market;
4. any degree of permanent impairment; and
5. any degree of loss of bodily function or capacity;

will be prorated on a weekly basis as follows:

1. over the period of time such benefits would have been paid if not in a lump sum; or

2. if such period of time cannot be determined, over a period of 260 weeks.

What Happens when Your Benefit Period is Less than a Week?

For any period for which a Short Term Disability benefit is payable that does not extend through a full week, the benefit will be paid on a prorated basis. The rate will be $1/7^{th}$ for each day for such period of Disability.

When will Your Short Term Disability Benefit be Discontinued?

The Weekly Benefit will cease on the earliest of:

1. the date you fail to provide Proof of continued Disability or Partial Disability and Regular Attendance of a Physician;

2. the date you fail to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

3. the date you refuse to be examined or evaluated at reasonable intervals;

4. the date you refuse to receive Appropriate Available Treatment;

5. the date you refuse a job with the Employer where workplace modifications or accommodations were made to allow you to perform the Material and Substantial Duties of the job;

6. the date you are able to work in your Own Job on a part-time basis, but choose not to;

7. the date your current Partial Disability earnings exceed 80.00% of your Basic Weekly Earnings;

   Because your current earnings may fluctuate, earnings will be averaged over three consecutive weeks rather than immediately terminating your benefit once 80.00% of Basic Weekly Earnings has been exceeded.

8. the date you are no longer Disabled according to this Plan;

9. the end of the Maximum Benefit Period; or

10. the date you die.

Successive Periods of Disability

What Happens if You Return to Work and Become Disabled Again?

With respect to this Plan, "Successive Periods of Disability" means a Disability which is related or due to the same cause(s) as a prior Disability for which a Weekly Benefit was payable.

A Successive Period of Disability will be treated as part of the prior Disability if, after receiving Disability benefits under this Plan, you:

1. return to your Own Job on an Active Employment basis for less than seven continuous days; and

2. perform all the Material and Substantial duties of your Own Job.

To qualify for the Successive Periods of Disability benefit, you must experience more than a 20% loss of Basic Weekly Earnings.

Benefit payments will be subject to the terms of this Plan for the prior Disability.

If you return to your Own Job on an Active Employment basis for seven continuous days or more, the Successive Period of Disability will be treated as a new period of Disability. You must complete another Elimination Period.

If you become eligible for benefits under any other group short term disability Plan, this Successive Periods of Disability provision will cease to apply to you.

SECTION 5 - EXCLUSIONS

GENERAL EXCLUSIONS

What Disabilities are Not Covered?

This Plan will not provide benefits for any Disability due to:

1. war, declared or undeclared, or any act of war;
2. intentionally self-inflicted injuries, while sane or insane;
3. active Participation in a Riot;
4. the committing of or attempting to commit an indictable offense; or
5. cosmetic surgery unless such surgery is in connection with an Injury or Sickness sustained while the individual is an Employee.

No benefit will be payable during any period of incarceration.

With respect to this provision, **Participation** shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of you, if such actions of defense are not taken against persons seeking to maintain or restore law and order including, but not limited to police officers and fire fighters.

With respect to this provision, **Riot** shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

Disability Benefit Exclusions

What Disabilities are Not Covered?

A Weekly Benefit will not be payable if you become Disabled due to:

1. Injury that arises out of or in the course of employment; or
2. Sickness when a benefit is payable under a Workers' Compensation Law, or any other act or law of like intent.

SECTION 6 - TERMINATION

When will Your Coverage End?

You will cease to be covered on the earliest of the following dates:

1. the date this Plan terminates;

2. the date you are no longer in an eligible class;

3. the date your class is no longer included for benefits;

4. the date employment terminates. Cessation of Active Employment will be deemed termination of employment, except the insurance will be continued for an Employee absent due to Disability during the Elimination Period; or

5. the date benefits end for failure to comply with the terms and conditions of the Plan.

SECTION 7 - CLAIMS AND APPEAL PROCEDURES

How Do I File a Claim for Benefits under the Plan?

Notice of your claim must be given to the Plan within 30 days of the date your purported disability begins, or as soon as it is reasonably possible to do so. Your notice of claim must be provided to the Claims Administrator by either:

- Logging in to MyLincolnPortal.com (Note: First time users will need to register using company code SCLHEALTH.); or
- Using the Interactive Voice Response (IVR) system by calling 1-800-213-7646 and answering questions using your phone's keypad or by voice response; or
- You may also contact the Claims Administrator at 1-888-408-7300.

When notice of your claim is received by the Plan, you will be provided with claim forms. If you do not receive the forms within 15 days after written notice of your claim is sent, you can send written Proof of your claim to the address above without waiting for the forms.

Satisfactory Proof of your loss must be given to the Plan no later than 30 days after the end of the Elimination Period. If you are unable, through no fault of your own, to submit a claim within this time period, you must submit a claim as soon as possible, but no later than one year after the end of the Elimination Period (unless you are legally incapacitated). No benefits will be paid for any claim not submitted within the appropriate time period.

What are the Claims Administrator's Rights?

The Claims Administrator has the right to:

- require continued proof of Disability or Partial Disability, at your expense, during the pendency of a claim and periodically (as required by the Claims Administrator) while you are receiving benefits;
- request that you be examined or evaluated at reasonable intervals to confirm your continued Disability or Partial Disability. This right may be used as often as reasonably required;
- require written authorization for medical records and other information necessary to properly document your file;
- require information with respect to your age, address, marital status, dependents, employment record and medical history;
- require any other information reasonably relevant to a determination of whether you are (or continue to be) eligible to receive Plan benefits;
- personally contact and interview you, your Physician or any other persons who can provide relevant information regarding your Disability or Partial Disability;
- require you to apply for all other benefits to which you may be eligible, including Social Security Disability Income, and appeal any initial denial of such benefits; and

- recover any overpayment of Plan benefits either directly from you or by deduction from your future monthly income benefit payments.

Your failure to cooperate with the Plan in a reasonable investigation or processing of a claim may result in benefits being denied, suspended or terminated.

What Happens After I Submit a Claim?

After the Claims Administrator has reviewed the notice of claim and other information, the Claims Administrator will notify you of its approval or denial of your claim.

If the claim is denied in whole or in part, the Claims Administrator will provide you with a notice of its adverse benefit determination within a reasonable time period, but no later than 45 days, after the claim is received. The Claims Administrator may extend this period twice for up to 30 days if circumstances beyond the control of the Claims Administrator require an extension of time for processing the claim. If an extension is required, written or electronic notice will be furnished to you within the initial 45-day or 30-day period, as applicable, which notice shall state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. In the event that an extension is necessary due to your failure to submit information necessary to decide the claim, you will be given at least 45 days in which to provide the additional information and the Claims Administrator's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to you until the date you respond to the request for additional information.

The Claims Administrator's notice of adverse benefit determination will set forth:

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for you to perfect the 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 a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

(e) A discussion of the decision, including an explanation of the basis for disagreeing with the views of the health care professionals treating you, medical or vocational experts retained by the Plan, and any Social Security disability determination;

(f) 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;

(g) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(h) A statement that you are is 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.

How Do I Appeal a Claim Denial?

If your claim for benefits is denied in whole or in part by the Claims Administrator, you or your duly authorized representative may appeal the adverse benefit determination by submitting to the Claims Administrator a written request for review of the adverse benefit determination within 180 days after receiving notification of such adverse benefit determination from the Claims Administrator.

Upon receipt of a request for review, the Claims Administrator shall, within a reasonable time period but no later than 45 days after receiving the request, provide you with written notification of its decision, stating the specific reasons and referencing specific Plan provisions on which its decision is based. The Claims Administrator may extend this period for up to one additional 45-day period if special circumstances require an extension for processing the claim and you are notified of the extension within the original 45-day period.

In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by you, the following:

(a) The specific reason or reasons for the adverse benefit determination;

(b) Reference to the specific Plan provisions on which the adverse benefit determination is 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;

(d) 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 Section 502(a);

(e) A discussion of the decision, including an explanation of the basis for disagreeing with the views of the health care professionals treating you, medical or vocational experts retained by the Plan, and any Social Security disability determination;

(f) 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 rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and

(g) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Do I have to appeal a claim denial or can I sue the Plan?

No legal action for benefits under the Plan shall be brought unless and until you have exhausted the procedures in this Section 3 and your claim remains partly or wholly denied or deemed denied. Any such legal action must be filed within one year after the date the procedures in this Section 3 are fully exhausted.

Also, note that the usual time periods for filing a claim under the Plan or for appealing a claim denial, as set out in Section 3 of the Plan, are extended through the date that is 60 days after the announced end of the national emergency related to the COVID-19 outbreak.

SECTION 8 - GENERAL PROVISIONS

Is Assignment Allowed?

No assignment of any present or future right or benefit under this Plan will be allowed.

What are the Examination Rights?

The Plan may have the right and opportunity to have you, whose Injury or Sickness is the basis of a claim, examined or evaluated at reasonable intervals deemed necessary by the Plan. This right may be used as often as reasonably required.

When Must Lincoln be Notified of a Claim?

a. Notice of claim must be given to the Plan within 30 days of the date of the loss on which the claim is based. If that is not possible, Lincoln, on behalf of the Employer, must be notified as soon as it is reasonably possible to do so. Such notice of claim must be received in a form or format satisfactory to the Plan.

b. When written notice of claim is applicable and has been received by the Plan you will be sent claim forms. If the forms are not received within 15 days after written notice of claim is sent, you can send to the Plan written Proof of claim without waiting for the forms.

When Must Lincoln Receive Proof of Claim?

a. Satisfactory Proof of loss must be given to the Plan, no later than 30 days after the end of the Elimination Period.

b. Failure to furnish such Proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to furnish such Proof within such time. Such Proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one year from the time Proof is otherwise required.

c. Proof of continued loss, continued Disability or Partial Disability, when applicable, and Regular Attendance of a Physician must be given to the Plan within 30 days of the request for such Proof.

The Plan reserves the right to determine if your Proof of loss is satisfactory.

What are the Rights of Recovery?

The Employer has the right to recover any overpayment of benefits caused by, but not limited to, the following:

1. fraud;
2. any error made by the Employer in processing a claim; or
3. your receipt of any Other Income Benefits.

The Employer may recover an overpayment by, but not limited to, the following:

1. requesting a lump sum payment of the overpaid amount;
2. reducing any benefits payable under this Plan;
3. taking any appropriate collection activity available including any legal action needed; and

4. placing a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any Other Income Benefits, whether on a periodic or lump sum basis.

It is required that full reimbursement be made to the Plan.

What are the Rights of Subrogation and Reimbursement?

When your Injury appears to be someone else's fault, benefits otherwise payable under this Plan for loss

of time as a result of that Injury will not be paid unless you or your legal representative agree(s):

1. to repay the Plan, for such benefits to the extent they are for losses for which compensation is paid to you by or on behalf of the person at fault;

2. to allow the Plan, a lien on such compensation and to hold such compensation in trust for the Plan; and

3. to execute and give to the Plan, any instruments needed to secure the rights under 1. and 2. above.

Further, when the Employer has paid benefits to or on behalf of the injured Covered Person, the Employer will be subrogated to all rights of recovery that you have against the person at fault. These subrogation rights will extend only to recovery of the amount the Employer has paid. You must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the Plan.

How does the Contract Affect Workers' Compensation?

This Plan and the benefits provided are not in lieu of, nor will they affect any requirements for coverage under any Workers' Compensation Law or other similar law.

SECTION 9 - PLAN INFORMATION

Plan Name

SCL Health Short-Term Disability Plan

The SCL Health Short-Term Disability Plan is part of the SCL Health Associate Welfare Benefit Plan.

Plan Sponsor and ERISA Plan Administrator

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

As of January 1, 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.

Plan Number

522

Agent for Service of Legal Process

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

Service may also be made upon the Plan Administrator.

Type of Plan

Welfare benefit plan providing short-term disability benefits.

Plan Year

January 1 - December 31

Plan Funding

Benefits are paid from the general assets of the Employers. No employee contributions are required or permitted under the Plan.

Changing or Ending the Plan

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

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

- The President/Chief Executive Officer of the Plan Sponsor, in his or her sole discretion, may amend or modify the Plan to the extent such amendment or modification would not constitute a material change in the benefits design or philosophy of the Plan Sponsor or result in a material increase in costs to the Sponsoring Employer; provided, however, that the President/Chief Executive Officer of the Sponsoring Employer shall make any Plan amendment reasonably requested by 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.

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

Your Legal Rights

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

Receive Information About Your Plan and Benefits

ERISA provides that all Plan participants will be entitled to:

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

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest

annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Send written requests to:

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

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

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.