

Salem Health Hospitals & Clinics EMPLOYEE BENEFITS PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Amended and Restated Effective as of January 1, 2026

Salem Health Hospitals & Clinics (the "Employer") maintains the Group Insurance Plan for Salem Health Hospitals and Clinics (the "Plan") for the exclusive benefit of the participants and their eligible dependents as defined by the underlying insurance certificate(s) of coverage.

This information together with your Summary of Benefits Booklet/Insurance Certificates issued by an insurance company and other plan documents issued by your employer or a third-party administrator give you important information about your benefits under the Group Insurance Plan for Salem Health Hospitals and Clinics, called the "Plan." These documents, together, make up the "summary plan description" or "SPD" for the Plan, as required by ERISA.

The purpose of these documents and materials is to provide information for you and your eligible family members about benefits available under the Plan and explanations of your rights and responsibilities so that you may fully enjoy the benefits. A "wrap-around" document is a single, all-inclusive plan document and summary plan description. It permits the Employer to meet information disclosure requirements by incorporating independent documents such as benefit summaries and literature provided by insurance companies into a single document by reference. However, inclusion of a benefit in this document does not confer ERISA status on that benefit.

This document is an excellent source to learn about the benefits available to you through this Plan. For the most part, this document will provide information for a number of topics ranging from eligibility to who must pay for coverage to various laws affecting the benefits provided under this plan. However, in some instances, an insurance company that provides a benefit policy for you may have requirements, such as for eligibility to participate in a plan, that differ somewhat from what is stated in this document. Therefore, it is important to carefully read this document as well as all information and literature regarding a specific benefit when you want to understand your rights and obligations under the plan.

To Non-English Speaking Employees of the Employer:

This Plan Document – Summary Plan Description contains a summary in plain English of your rights and benefits under the Health and Welfare Plan. If you have difficulty understanding any part of this document or if you have any questions regarding your benefits, rights or obligations under the Plan, contact the individual listed in the contact section for the Plan Administrator, located in Appendix A and incorporated by reference, who acts on behalf of the Plan Administrator.

The Plan Sponsor reserves the right to amend this Plan at any time or from time to time without the consent of any employee or participant. Although the Plan Sponsor expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan feature or component at any time without liability.

The terms "you" and "your" as used in this document refer to an individual who is otherwise eligible to participate in the Plan. Receipt of this document does not guarantee that the recipient is in fact eligible to participate in the Plan or any Plan feature or component.

IMPORTANT DISCLAIMERS

Conflicting Terms

Plan benefits are provided pursuant to the various insurance contracts and pursuant to governing plan documents adopted by the Employer. If the terms of this document conflict with the terms of such insurance contracts or governing plan documents, then the terms of the insurance contracts or governing plan documents will control, rather than this document, unless otherwise required by law.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time or otherwise affect any employment at will relationship.

Compliance with State and Federal Laws

To the extent required by law, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, as amended, including the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998 (WHCRA), the Family and Medical Leave Act of 1993 (FMLA), the Mental Health Parity Act (MHPA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Health Information Technology for Economic and Clinical Health Act (HITECH), Michelle's Law, the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Affordable Care Act (PPACA).

Amendment or Termination

The Employer may modify, amend or terminate the Plan at any time at its sole discretion. The right to modify, amend or terminate also applies to the insurance contract between the Employer and the Insurer/Third Party Administrator. Any modification, amendment, or termination will be communicated to participants under the Plan.

1. Introduction

The Employer maintains this group health and welfare plan to provide benefits to you and when applicable, your eligible dependents as defined by the underlying insurance certificate(s) of coverage and plan documents. Your benefits are provided under insurance contracts between the Employer and the insurance carriers and third party administrators except that the benefits identified as "self-insured" in Appendix A are paid through your employer's general assets (up to any applicable stop loss limits). The list of component benefit insurance carriers and third party administrators is located in Appendix A. Each of these certificates and plan documents are incorporated herein by reference.

This document and the incorporated certificate of insurance booklets/summary plan descriptions/plan documents from the Insurers/Third Party Administrators make up your summary plan description (SPD). Please read this document, including Appendix A, Appendix B and the incorporated certificate of insurance booklets/summary plan descriptions/plan documents from the Insurers/Third Party Administrators to learn about your health and welfare plan benefits. The benefit programs may require you to make an annual election to enroll for coverage and may require you to pay a portion of the premiums. It is your responsibility to understand your benefits under the Plan and ask questions if you need more information. Please keep your health plan documents in a safe place for future reference.

Please note that this document does not provide any substantive rights to benefits that are not included in the incorporated certificate of insurance booklets/summary plan descriptions.

If you have any questions regarding the Plan, including whether you are eligible to participate in the Plan, please contact the Employer. If you have questions regarding benefits payable under the Plan, please contact the Insurer/Third Party Administrator.

2. General Information About the Plan

Plan Name

Group Insurance Plan for Salem Health Hospitals and Clinics

Plan Sponsor

Salem Health Hospitals & Clinics
890 Oak Street SE
Salem, OR 97301
503-814-1850

Plan Sponsor's Employer Identification Number

93-0823471

Type of Plan

Welfare plan providing benefits as detailed in Appendix A.

Plan Year

The plan year is January 1st – December 31st. The last day of the plan year is December 31st

Plan Number

The plan number is 501.

Effective Date

The effective date of this SPD is January 1, 2026. The Plan was originally established October 1, 1969.

Funding Medium and Type of Plan Administration

Some of the component benefit plans may be fully insured and some may be self insured. See the funding methods described in Appendix A. For any self-funded plans, claims are sent to the administrator, which is responsible for administering the payment of claims according to the plan benefits. Any claims for self-funded benefits are paid out of your employer's general assets, up to any stop-loss limits. For any fully insured programs, the insurance companies, and not the Employer, are responsible for paying claims. The Employer shares responsibility with the insurance companies for administering program benefits.

Benefits furnished hereunder are provided through the purchase of insurance policies and other provider contracts, unless otherwise indicated in Appendix A. The Plan Sponsor will collect the applicable employee premiums and will pay when due all premiums required to keep such policies and contracts in force. Funding is derived from the funds of the Plan Sponsor and contributions made by the employees. To the extent you are required to make contributions toward the cost of a particular benefit feature, your contributions will be used in their entirety prior to using Plan Sponsor contributions to pay for the cost of such benefit. Accordingly, any claims experience dividends, refunds, or other adjustments in premiums, fees, or other Plan costs related to benefits provided under the Plan may be used to reduce the amount of contributions made by the Plan Sponsor. The level of any employee contributions is set by the Plan Sponsor, which will be communicated to you when you first enroll in the Plan, and during each open and special enrollment period. The Plan Sponsor reserves the right to modify employee contribution amounts. Employee contributions will be used to fund, or reimburse the Plan Sponsor for funding, the cost of the Plan benefits as soon as practicable after they have been received from the employee or withheld from the employee's pay through payroll deduction.

Claims Administrator/ Insurance Companies

The Claims Administrators/Insurance Companies are listed in Appendix A.

Contributions and Pre-Tax Premiums

The cost of most benefits provided through the Component Benefit Programs will be funded in part by Employer contributions and in part by post or pre-tax Employee contributions. The Employer will determine and periodically communicate your share of the cost of the benefits required for each component benefit program, and it may change that determination at any time. The Employer will make its contributions in an amount that (in the Employer's sole discretion) is sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Employer will pay its contribution and your contributions to an insurance carrier or, for any benefits that may be self-insured, will use these contributions to pay benefits directly to or on behalf of you or your eligible family members from the Employer's general assets. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

An Employee who enrolls in a plan which requires an Employee contribution to participate will be subject to a salary reduction requirement under which the Employee contribution will be withheld. While the Employee participates in any Component Benefit Program to which this requirement applies, the amount of the salary reduction will be automatically adjusted by the Plan to reflect increases or decreases in Employee contributions without an election by the Employee. Employees may elect to pay the salary reduction withholding on a pretax or after-tax basis through the Employer's cafeteria plan. The election must be made prior to the first day of a Plan Year and may not be changed during the Plan Year except as permitted by the cafeteria plan and Treasury regulations. Once made, the election will be automatically continued from year-to-year without a further election by the Employee although the Employee may change the election by submitting a completed election form prior to the first day of any Plan Year.

3. Eligibility and Participation Requirements

Eligibility and Participation

An eligible employee with respect to the Plan will be any common-law employee of the Employer who is eligible to participate in and receive benefits under one or more of the component benefit programs. To be eligible to participate in the Plan, you must meet the requirement detailed in this SPD. You may need to pay a designated amount of the premium for coverage.

The benefit programs may require that you make an annual election to enroll for coverage. Eligibility to participate in a Component Benefit Program will depend upon a number of factors.

A chart specifying the eligibility requirements for each Component Benefit Program is part of Appendix A. To determine your eligibility to participate in a specific Component Benefit Program, please reference this chart in addition to the information included in this section. Please refer to Appendix B to determine if you meet the definition of a full-time employee under the Affordable Care Act.

An Employee may enroll in each of the Component Benefit Programs for which the employee is eligible by completing the required online or paper enrollment process and submitting any required documentation.

Eligible Dependents

In general, you may cover the following individuals as your dependents under the Plan:

- Your legally-married spouse, as defined by the state in which the marriage occurred;
- Your domestic partner
- Your dependent children who are under age 26, regardless of:
 - student status,
 - marital status,
 - financial dependency,
 - employment status, or
 - any combination of these factors.
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation) provided that the child was disabled prior to age 26.

Dependent children are your:

- natural children;
- stepchildren;
- legally adopted children;
- children who are placed in your home for adoption;
- foster children who have been placed in your home;
- children for whom you are appointed legal guardian and who are dependent on you for support and maintenance; and
- children of Your domestic partner

Ineligible Individuals

An individual who is not described as being eligible in this section is not eligible for the component benefit programs. A person the Plan Administrator determines is not an employee will not be eligible to participate in the Plan as an employee regardless of whether a court or tax or regulatory authority determines that the person is an employee.

Examples of Individuals who are not eligible:

- Employees covered by a collective bargaining agreement to which the Plan Sponsor is a party and which does not provide for participation in the Plan;
- "Leased employees" within the meaning of Internal Revenue Code Section 414(n); or
- Temporary employees
- individuals from whom the Plan Sponsor does not withhold federal income and employment taxes from such person's compensation.
- Individuals not on the Employer's US Payroll
- Children of your children are not dependent children under the Plan, unless they fall under another dependent child category listed above.

Effective Date of Coverage

Coverage for a Spouse, Domestic Partner, or Dependent shall take effect at the same time as the covered Employee.

Coverage for a newborn child or a newly adopted child will begin immediately, but you must first notify the Plan Administrator within 60 days of the birth or adoption. You may also be required to increase your contributions accordingly.

Termination of Participation

A participant shall cease being a Participant in the Plan and coverage under this Plan for the Participant, his or her Spouse, Dependents and Beneficiaries, if any, shall terminate in accordance with provisions of the component benefits, unless otherwise required by law. Coverage may also terminate in other circumstances, such as failure to pay required premiums, failure to meet eligibility requirements, submitting fraudulent claims and other reasons described in the incorporated certificate of coverage booklets. Coverage for your spouse and dependents terminates when your coverage ends and for other reasons described in the incorporated certificate of coverage booklet, such as divorce or reaching the Plan's limiting age for dependents.

A chart specifying the coverage termination for each component benefit is included in Appendix A. To determine the termination for a specific Component Benefit Program, please reference this chart in addition to the information included in this section.

Please see Appendix A and the documents and literature for an applicable Component Benefit Program for additional eligibility requirements.

NOTE: The Plan Administrator reserves the right to terminate your health care coverage prospectively without notice for cause (as determined by the Plan Administrator), or if you or a dependent are otherwise determined to be ineligible for coverage under the Plan. In addition, if you or your dependent commits fraud or intentional misrepresentation of a material fact (including, for example, in an application for health coverage under the Plan, in connection with a benefit claim or appeal, or in response to any request for information by the Plan Sponsor or its delegates (including the Plan Administrator

or a claims administrator), the Plan Administrator may terminate your coverage retroactively upon 30 days' notice. Failure to inform any such persons that you or your dependent is covered under another group health plan (if required by the Plan) or knowingly providing false information in order to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan. Coverage may also be terminated retroactively and without notice (unless required by law) if the Plan Administrator or its delegee determines that a spouse or dependent is ineligible for coverage under the Plan and such retroactive termination would not be considered a rescission under the Affordable Care Act. If coverage is terminated retroactively, you must reimburse the Plan or its delegee for the costs associated with providing coverage to any ineligible persons (including benefit claims, processing fees, administrative charges and all other costs), plus interest and any attorneys' fees incurred by them in order to collect such amounts. Additionally, you may be subject to further disciplinary action from the Plan Sponsor, including, but not limited to, termination of employment.

Special Enrollment Rights Notice

In certain special circumstances, you and/or your dependents may enroll in the Plan at times other than open enrollment. The incorporated certificate of insurance booklets/summary plan descriptions and this Special Enrollment Notice contain more information about potential special enrollment rights.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact:

Salem Health Hospitals & Clinics

Human Resources

benefits@salemhealth.org

(503) 814-1850

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order ("QMCSO") is an order by a court for a parent to provide a child or children with health insurance under a group health plan. The Plan Administrator will comply with the terms of any QMCSO it receives, and will:

- Establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders as defined under ERISA Section 609;
- Promptly notify you and any alternate recipient (as defined in ERISA Section 609(a)(2)(C)) of the receipt of any medical child support order, and the Plan's procedures for determining whether medical child support orders are qualified medical child support orders; and

Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify you and each alternate recipient of such determination.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)

The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor. During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by your Employer may result in the termination of coverage for you and/or your eligible Dependents. If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave. If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave. NOTE: If you work for an Employer that has fewer than 50 Employees, continuation of coverage under FMLA is not available to you. However, you may have continuation rights under a State family and medical leave law. Please contact the Plan Administrator for more information as to whether or not any such State family and medical leave law applies to you.

Continuation of Coverage under Federal, State or Municipal Family and Medical Leave Laws

To the extent this Plan is required to comply with a Federal, State, and/or Municipal family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such family and medical leave law, as well as under FMLA.

Continuation Coverage Under COBRA, Individual Marketplace and USERRA

If eligible coverage for you or your eligible family members ceases because of certain “qualifying events” specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child’s ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. If you have any questions about your COBRA rights, please read the benefit booklets as provided by the insurance companies. Please contact the Plan Administrator if you need another copy.

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. For more information about the Marketplace, visit www.healthcare.gov.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about coverage available pursuant to USERRA is included in the certificate of insurance, benefit booklet, or SPD for a particular component benefit.

4. Summary of Plan Benefits

Benefits and Contributions

The Plan provides benefits to you and your eligible spouse, domestic partner (as defined in the literature for an applicable Component Benefit Program) and dependents while you are eligible for and covered by the Plan. It provides the component benefits, which are detailed in Appendix A, subject to your enrollment (if required) in a particular component benefit.

For a detailed description of benefits available under the Plan, please review the incorporated certificate of insurance booklets/summary plan descriptions. It is your responsibility to understand your benefits under the Plan and ask questions if you need more information.

Benefits are no longer payable if your coverage is terminated for any reason. The Plan reserves the right to recover overpayments of benefits or benefits paid in error through the rights of subrogation and reimbursement as described more fully in the incorporated certificate of insurance booklets/summary plan descriptions.

Please review the incorporated certificate of insurance booklets/summary plan descriptions carefully for information on other situations that may affect your right to receive benefits under the Plan, such as applicable deadlines for submitting claims. **NOTE:** When an HSA qualified HDHP plan is offered and the employer makes HSA contributions that may otherwise be provided for as part of an employer policy are contingent on the eligible employee's establishment of a HSA, except where the employer establishes HSA accounts for eligible employees.

5. Notices And Disclosures

Special Rights on Childbirth

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Special Rule for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other medical or surgical benefits provided under the Group Medical Feature. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your medical benefits.

Genetic Information Nondiscrimination Act (GINA)

In no event shall the Employer make any premium adjustments or adjustments to contributions under any component program based on genetic information; request or require genetic testing; and request, require or purchase genetic information for underwriting purposes.

Health Insurance Portability and Accountability Act Privacy and Security/Health Information Technology for Economic and Clinical Health (HIPAA/HITECH)

Components of the Plan required to comply with HIPAA/HITECH are subject to the following rules and policies to the extent not in conflict with a separate privacy or security policy adopted by the Employer.

(a) Permitted Uses and Disclosures of Protected Health Information.

The Plan and the Plan Sponsor may use or disclose a Participant's "protected health information" (PHI), which is defined to include individually identifiable health information that is transmitted or maintained in any form or medium—electronic, oral or written—in accordance with all uses and disclosures permitted or required under HIPAA and other relevant guidance. Such uses and disclosures include, but are not limited to:

- i. Uses or disclosures necessary to facilitate "payment, treatment, and health care operations," as those terms are defined in the HIPAA regulations;
- ii. Uses or disclosures that are incidental to a permitted use or disclosure, provided reasonable safeguards are in place;
- iii. Uses by or disclosures to the Participant who is the subject of the information;

- iv. Uses or disclosures based on and in compliance with a valid authorization given by the Participant;
- v. Disclosure upon the request of a Participant to access his own PHI; and
- vi. Disclosures required by the U.S. Department of Health and Human Services to verify compliance with HIPAA.

(b) Required Uses and Disclosures of PHI.

The Plan and the Plan Sponsor may use or disclose a Participant's PHI for the following required purposes, to the extent not inconsistent with HIPAA:

- i. To the extent required by any federal, state or local law, including without limitation, the provisions under HIPAA regulation 45 C.F.R. § 164.512 and the terms of any lawful judicial or administrative process; and
- ii. To the extent necessary for the purpose of public health or public health oversight activities, or other governmental activities as permitted under HIPAA regulation 45 C.F.R. § 164.512.

(c) Restriction on Plan Disclosure to the Plan Sponsor.

Neither the Plan nor any insurer or "business associate" (as that term is defined under HIPAA) of the Plan will disclose PHI to the Plan Sponsor except upon the Plan's receipt of the Plan Sponsor's certification that the Plan documents have been amended to incorporate the agreements of the Plan Sponsor in accordance with the immediately following provision.

(d) Privacy Agreements of the Plan Sponsor.

As a condition for obtaining PHI from the Plan, the Plan Sponsor agrees to undertake the following activities and comply with the following restrictions with respect to any PHI (other than summary health information or enrollment or disenrollment information as provided for in 45 C.F.R.

§ 164.504(f)(ii) and (iii), or information that is disclosed as authorized under 45 C.F.R. § 164.508) received from the Plan (including PHI of Participants that is received from business associates acting for or on behalf of the Plan or from insurers or health maintenance organizations insuring the Plan):

- i. Not to use or further disclose such PHI other than as permitted or required by paragraphs (a) or (b), above, or by the Participant's authorization;
- ii. To ensure that any of its agents to whom it provides the PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- iii. Not to use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or Employee Benefit Plan of the Plan Sponsor;
- iv. To report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- v. To make the PHI of a particular Participant available for purposes of the Participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulations 45 C.F.R. §§ 164.524 and 164.526;
- vi. To make the PHI of a particular Participant available for purposes of a required accounting of disclosures by the Plan Sponsor pursuant to the Participant's request for such an accounting in accordance with HIPAA regulation 45 C.F.R. § 164.528;
- vii. To make the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- viii. If feasible, to return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and to retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

- ix. To ensure that there is adequate separation between the Plan and the Plan Sponsor by implementing the following:
 - A. Only limited Employees and/or employment classifications under the control of the Plan Sponsor may access PHI received from the Plan.
 - B. The access to and use of PHI by the individuals described in (A) immediately above, is limited to Plan Administration functions as defined in HIPAA regulation 45 C.F.R. § 164.504(a) that are performed by the Plan Sponsor for the Plan.
 - C. If the Plan Sponsor determines that any person described in (A) immediately above, has violated any of the restrictions of these HIPAA provisions, then such individual shall be disciplined in accordance with the policies of the Plan Sponsor established for purposes of privacy compliance, up to and including dismissal from employment.

(e) HIPAA Security Standards.

In accordance with the requirements of 45 C.F.R. Part 164, Subpart C, the Plan Sponsor agrees to undertake the following activities and comply with the following restrictions with respect to any electronic PHI (other than summary health information or enrollment or disenrollment information as provided for in 45 C.F.R. § 164.504(f) or information that is disclosed as authorized under 45

C.F.R. § 164.508) received from the Plan (including electronic PHI of Plan Participants that is received from business associates acting for or on behalf of the Plan or from insurers or health maintenance organizations insuring the Plan):

- i. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ii. To ensure that the adequate separation required by subparagraph (d)(ix) above is supported by reasonable and appropriate security measures;
- iii. To ensure that any of its agents to whom it provides this information agree to implement reasonable and appropriate security measures to protect the information;
- iv. To report to the Plan any security incident of which it becomes aware. For purposes of this subparagraph, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the electronic PHI; and
- v. Upon request from the Plan, to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the electronic PHI to the extent such information is available to the Plan Sponsor.

Medicare Part D

In the event that a component program provides prescription drug coverage either in conjunction with a component program or as a stand-alone component program, the Plan intends to comply with the requirements of Medicare Part D and will notify you of its "Creditable Coverage" status. Such disclosure requirement will be made under separate cover.

Mental Health Parity

All component programs subject to the MHPA/MHPAEA shall not discriminate against mental health and substance use disorder as related to any medical/surgical benefits provided under a component program when such mental health, substance disorder and medical/surgical benefits are provided. Such discrimination may not occur with regard to the component program's financial requirements or availability of out of network treatment under the program's terms and conditions. This provision shall not be valid in the event the Employer makes an election under the cost exemption provisions of the MHPA/MHPAEA, meets the small-employer exemption, or in the case of a self-funded plan, the Plan Sponsor opts out of the MHPA's/MHPAEA's requirements.

Notice Regarding Lifetime and Annual Dollar Limits

In accordance with applicable law, any lifetime or annual dollar limits set forth in the Group Medical feature shall not apply to “essential health benefits,” as such term is defined under Section 1302(b) of the Affordable Care Act. The law defines “essential health benefits” to include, at a minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services. A determination as to whether a benefit constitutes an “essential health benefit” will be determined under the benchmark plan designated by the Plan Administrator in its sole discretion.

The restrictions regarding lifetime and annual dollar limits under the Group Medical Feature do not apply to services (even services for essential health benefits) which are limited by the number of visits or other criteria. For example, a medical plan may provide that coverage for a physical therapist is limited to up to 30 visits per year per covered person.

Patient Protection Disclosure

If the Group Medical Feature in which you are enrolled requires the designation of a primary care provider, you have the right to designate any participating primary care provider who is available to accept you or your family members (for children, you may designate a pediatrician as the primary care provider). For information on how to select a primary care provider and for a list of participating primary care providers, contact the Plan Administrator. You do not need prior authorization from the Plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional; however, you may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

Tax Notes

Same-Gender Spouses. Pursuant to IRS Notice 2013-72, Federal tax law recognizes same-gender spouses effective September 16, 2013. However, some states do not recognize marriages between spouses of the same gender for state tax purposes. This means that the value of your same-sex spouse’s health coverage may still be taxable to you for state income tax purposes depending on your state of residence.

Domestic Partners. Federal law does not recognize “domestic partners” for specialized tax treatment under employer-sponsored group health plans. Unless your domestic partner and domestic partner’s child(ren) are your federal tax dependents for group health plan purposes, you will be subject to federal (and possibly state) tax on the imputed value of the coverage provided to the domestic partner and the domestic partner’s child(ren). You must notify the Plan Administrator if you believe your domestic partner meets the requirements for a federal tax dependent for group health plan purposes or a dependent under state tax law.

It is important that you understand the tax and legal issues set out above. Therefore, if the situations described above apply to you, you may want to consult your tax and legal advisors to determine the impact on you.

6. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The individual listed in the contact section for the Plan Administrator, located in Appendix A, is the person who has been designated to act on behalf of the Plan Administrator.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. All decisions by the Plan Administrator will be afforded the maximum deference permitted by law.

The Employer will bear its incidental costs of administering the Plan.

Power and Authority of Insurance Company

The insurance companies are responsible for (a) determining eligibility for and the amount of any benefits payable under their respective component benefit plans; and (b) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans. The insurance companies for each of the component benefits are listed in Appendix A.

Questions

If you have any general questions regarding the Plan or regarding your eligibility for, or the amount of any benefit, please contact the individual listed in the contact section for the Plan Administrator, located in Appendix A, who acts on behalf of the Plan Administrator. If you have any question regarding your eligibility for, or the amount of, any benefit payable under the Plan, please contact the appropriate insurance company.

7. Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See Section 3 and Appendix A.

Your benefits will also cease upon termination of the Plan. Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied under a certain benefit program if you have a preexisting condition and incur costs within the exclusionary period. In addition, certain benefits may be rescinded for fraud or an intentional misrepresentation of material fact. You should consult the incorporated certificate of insurance or booklet, SPDs and other governing documents among the applicable Attachments for additional information.

8. Claims Procedures

Claims for Benefits/ Insured Benefit

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or contract. To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance or contract, which may require you to complete, sign, and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company (or Plan Administrator) will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

See the incorporated certificate of insurance or booklet for more information about how to file a claim and for details regarding the insurance company's claims procedures.

9. Statement of ERISA Rights

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and Rights

You may be able to continue health care coverage for yourself or your eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per 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 which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 8), you may file suit in a state or 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.

Separate Benefits

The component plans referred to in this document are addressed collectively for the sole purpose of administrative convenience and not to combine these plans for other purposes. Each component benefit listed in this document remains a

separate plan for purpose of paying benefits, notwithstanding this document. Further, to the extent any component plan referred to in this document is not otherwise subject to ERISA, its inclusion in this document does not infer ERISA coverage.

Assistance With Your Questions


If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., 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.

Note that a premium only plan is not covered by ERISA and this Statement of the ERISA Rights does not apply to this program.

The Plan Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Plan Administrator are final, conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan to be executed in its name and on its behalf this 12th day of March, 2026 by a duly authorized officer of the Plan Sponsor.

Salem Health Hospitals & Clinics

By:  _____

Name: Sophia Heide

Title: Director of Total Rewards, Employee Relations & Development

Appendix A

1. Plan Contacts

Salem Health Hospitals & Clinics
890 Oak Street SE
Salem, OR 97301
503-814-1850
Attention: Human Resources Manager

Named Fiduciary

Salem Health Hospitals & Clinics
890 Oak Street SE
Salem, OR 97301
503-814-1850

Agent for Service of Legal Process

Salem Health Hospitals & Clinics
890 Oak Street SE
Salem, OR 97301
503-814-1850
Attention: Human Resources Manager

2. Component Benefits and Insurance Carriers/Administrators and Claims Addresses

	<u>Insurer / Third Party Administrator</u>	<u>Claims Address</u>	<u>Funding</u>	<u>Eligible Employee (minimum hrs. worked)</u>	<u>Eligible Spouse</u>	<u>Eligible Child(ren)</u>	<u>Coverage Begins/Waiting Period</u>	<u>Employer Contribution</u>	<u>Termination</u>
Medical, Rx Not Grandfathered	Moda	601 SW Second Ave. Portland, OR 97204 (888)-217-2365	Self-Insured*	Employees regularly scheduled a minimum of 20 hours per week / 0.5 FTE / 80 hours per month	Legal Spouse; Domestic Partner	Dependent child to age 26	First of Month following Date of Hire	Contribution varies by plan and tier selected	End of the month
Dental Plan	Moda/Delta Dental of Oregon	601 SW Second Ave. Portland, OR 97204 (888)-217-2365	Self-Insured*	Employees regularly scheduled a minimum of 20 hours per week / 0.5 FTE / 80 hours per month	Legal Spouse; Domestic Partner	Dependent child to age 26	First of Month following Date of Hire	Contribution varies by plan and tier selected	End of the month
Voluntary Vision Plan	VSP	3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195	Fully-insured	Employees regularly scheduled a minimum of 20 hours per week / 0.5 FTE / 80 hours per month	Legal Spouse; Domestic Partner	Dependent child to age 26	First of Month following Date of Hire	0%	End of the month
Employee Assistance Program	Modern Health	650 California St Floor 7 San Francisco, CA 94108 Office 07-128 Help@modernhealth.com	Fully-insured	All Employees regardless of hours worked	Legal Spouse; Domestic Partner	Dependent child to age 26	First of Month following Date of Hire	100%	End of the month
Basic Life & AD&D Plan	Standard Insurance Company	900 SW Fifth Avenue Portland Oregon 97204-1282 (503) 321-7000	Fully-insured	Employees regularly scheduled a minimum of 20 hours per week / 0.5 FTE / 80 hours per month	Legal Spouse; Domestic Partner	Dependent child to age 26	First of Month following Date of Hire	100%	Date of Termination
Voluntary Life and AD&D	Standard Insurance Company	900 SW Fifth Avenue Portland Oregon 97204-1282 (503) 321-7000	Fully-insured	Employees regularly scheduled a minimum of 20 hours per week / 0.5 FTE / 80 hours per month	Legal Spouse; Domestic Partner	Dependent child to age 26	First of Month following Date of Hire	0%	Date of Termination
Basic STD Plan - Physicians	Standard Insurance Company	900 SW Fifth Avenue Portland Oregon 97204-1282 (503) 321-7000	Self-Insured*	Physician employees regularly scheduled a minimum of 20 hours per week / 0.5 FTE / 80 hours per month	Not Included	Not Included	On Date of Hire	100%	Date of Termination
Voluntary STD Plan	Standard Insurance Company	900 SW Fifth Avenue Portland Oregon 97204-1282 (503) 321-7000	Fully-insured	Non-Physician Employees regularly scheduled a minimum of 20 hours per week / 0.5 FTE / 80 hours per month	Not Included	Not Included	First of Month following 90 days after Date of Hire	0%	Date of Termination
LTD	Standard Insurance Company	900 SW Fifth Avenue Portland Oregon 97204-1282 (503) 321-7000	Fully-insured	Employees regularly scheduled a minimum of 20 hours per week / 0.5 FTE / 80 hours per month	Not included	Not Included	First of Month following 90 days after Date of Hire	100%	Date of Termination
Health Flex Spending Account	Optum Financial	P.O. Box 60000 Newark, NJ 07101 (877) 292-4040	Self-insured*	Employees regularly scheduled a minimum of 20 hours per week / 0.5 FTE / 80 hours per month	Not Applicable	Not Applicable	First of Month following Date of Hire	0%	Date of Termination
Dependent Care Flex Spending Account	Optum Financial	P.O. Box 60000 Newark, NJ 07101 (877) 292-4040	Self-Insured*	Employees regularly scheduled a minimum of	Not Included	Not Applicable	First of Month following Date of Hire	\$2,500 ER when	Date of Termination

				20 hours per week / 0.5 FTE / 80 hours per month				elected by Employee	
<u>Voluntary Worksite Benefits</u>	Chubb	P.O. Box 716 Portland, ME 04104	Fully-insured	Employees regularly scheduled a minimum of 20 hours per week / 0.5 FTE / 80 hours per month	Legal Spouse; Domestic Partner	Dependent child to age 26	First of Month following Date of Hire	0%	End of the month

* These component benefits are self-insured, and payable by the Company out of its general assets.

Appendix B – Determination of Full-time Status of Salem Health Hospitals & Clinics (the “Employer”) Employees under the Affordable Care Act

Eligibility for the Group Insurance Plan for Salem Health Hospitals and Clinics

Employee Classifications and Measurement Methods			
Employee Classification	Measurement Method	Initial Measurement and Stability	Standard Measurement and Stability
All Employees	Monthly	N/A	N/A

Determination of Full-time Status of Employees

Monthly Measurement Method for Full-time Status Determination

Effective January 1, 2026 the Employer uses the monthly measurement method for all employees to determine who is a full-time employee for purposes of Plan coverage.

The monthly measurement method applies to all employees. Your hours of service during the current month will determine your Plan eligibility for the next month in accordance with the eligibility policy in Section 3. of the Summary Plan Description and the hourly minimums in Appendix A.