Renown HEALTH
MEDICAL PROGRAM

SUMMARY PLAN DESCRIPTION
PLAN YEAR 2022

As Amended and Restated as of January 1, 2022

ARTICLE I INTRODUCTION **2**
ARTICLE II DEFINITIONS **3**
ARTICLE III ELIGIBILITY AND PARTICIPATION **15**
ARTICLE IV BENEFIT REQUIREMENTS **21**
ARTICLE V COVERED MEDICAL EXPENSES **26**
ARTICLE VI CLAIMS PROCEDURES **56**
ARTICLE VII ERISA RIGHTS AND NOTICES **63**
ARTICLE VIII STATEMENT OF ERISA RIGHTS **65**
ARTICLE IX PLAN AMENDMENT AND TERMINATION **66**
ARTICLE X THIRD-PARTY LIABILITY AND COORDINATION OF BENEFITS **67**
ARTICLE XI PRIVACY OF HEALTH INFORMATION **71**
ARTICLE XII COBRA CONTINUATION COVERAGE **73**

RENOWN HEALTH
MEDICAL PROGRAM

SUMMARY PLAN DESCRIPTION

PLAN YEAR 2022

ARTICLE I
INTRODUCTION

The Renown Health Medical Program (the "Medical Program") is designed to provide employees of Renown Health ("Renown") who have satisfied the conditions of eligibility with the medical benefits covered under the Plan. The Medical Program is a component of the Renown Welfare Benefit. Some general provisions that apply to benefits under this Medical Program Component are found in the Welfare Benefit Plan.

This Summary Plan Description ("Summary" or "SPD") is intended to:

1. Provide you with an overview of the Plan;

2. Describe the eligibility provisions;

3. Inform you of the covered benefits; and

4. Provide you with important information regarding your rights and obligations under the Plan.

If you have any questions after reading this Summary, please contact

Renown Health Welfare Benefits Committee
1155 Mill Street, Mail Stop Z-3
Reno, NV 89502
(775-982-6477)

By accepting participation in this Plan, you and your covered Dependents agree and consent to participate in the Plan's case management program that is described in this Summary, and that the Plan Administrator has the authority to determine the Illnesses and Injuries appropriate for case management.

ARTICLE II
DEFINITIONS

There are capitalized terms used in this SPD that have the specific meanings in this Article II. There may also be capitalized terms that are not defined here but may be defined later in the SPD or in the Welfare "Wrap" Plan document.

2.01 **Acute** means a short Illness or Injury, generally of a sudden onset and/or infrequent occurrence, in which Illness or Injury is not always present. An Acute condition may become Chronic

2.02 **Ambulance** means a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

2.03 **Approved Clinical Trial** means phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

(a) Federally funded or approved;

(b) Conducted under a Food and Drug Administration (FDA) investigational new drug application; or

(c) Drug trials which are exempt from the requirements of an FDA investigational new drug application.

2.04 **Assignment of Benefits** means an arrangement whereby the Covered Person assigns their right to seek and receive payment of eligible Covered Services, in accordance with the terms of this Plan, to a provider.

2.05 **Behavioral Health Provider** means an individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for mental disorders and substance abuse under the laws of the jurisdiction where the individual practices.

2.06 **Body Mass Index** means a degree of obesity and calculated by dividing weight in kilograms by height in meters squared.

2.07 **Chronic** means an Illness, condition, or Injury that continues or is expected to continue for at least six months that can recur frequently or is always present. Chronic conditions may have Acute episodes.

2.08 **Chronic Pain** means ongoing pain that is due to non-life threatening causes may continue for the remainder of life and that has not responded to currently available treatment methods.

2.09 **Claims Administrator** means Hometown Health or any subsequent Claims Administrator appointed by the Employer for the purposes of determining medical care claims.

2.10 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act, as amended.

2.11 **Co-insurance** means the percentage of Covered Expenses that the Covered Person pays after the annual Deductible is met.

(a) Coinsurance is presented in the Summary of Benefits as a percentage of the maximum allowable amount that is due and payable by the Participant to a Provider upon receipt of covered services.

(b) Coinsurance applies after all Deductibles have been paid unless otherwise noted in the Summary of Benefits.

2.12 **Co-Payments** means the specific amount payable by the Participant to a provider of care at the time of service for certain covered services. If the Benefit Plan has a deductible for a service, the copayment and the deductible both apply to the service. Once the deductible has been satisfied the copayments for a particular service apply until the Out-of-Pocket maximum for the plan is reached. If there is no deductible for a particular service, and a copayment is listed, the Participant's cost sharing for that service will be that copayment. Copayments apply to the Out-of-Pocket maximums..

2.13 **Cosmetic** means services, drugs or supplies that are primarily intended to alter, improve or enhance appearance.

2.14 **Covered Expenses** means those expenses, charges or fees for Eligible Health Services that meet the requirements for coverage under the Plan, including without limitation that the Eligible Health Services are Medically Necessary and have been pre-certified if required.

2.15 **Covered Member** means an individual who is or was provided coverage under the Plan because of the individual's employment or previous employment with the Employer.

2.16 **Covered Person** means a Covered Member or a covered eligible Dependent.

2.17 **Covered Services** means the medical services and supplies listed Article V of this SPD and not otherwise limited or excluded under this Medical Program. Covered Services must:

(a) Be Medically Necessary or otherwise specifically listed as in Article V as a Covered Service;

(b) Rendered by Provider duly licensed by the state within which the Covered Service is provided and within the scope of the license of the Provider performing the service;

(c) Have received Prior Authorization if required; and

(d) Not be Experimental or Investigational or otherwise limited or excluded under the Medical Program.

2.18 **Covered Supply** means a medical supply or medical equipment listed in Article V that is eligible for coverage under this Medical Program and not otherwise limited or excluded under this Medical Program. Covered Supplies must:

(a) Be Medically Necessary and prescribed or authorized by a duly licensed Provider acting within the scope of their license;

(b) Have received Prior Authorization if required; and

(c) Not be Experimental or Investigational or otherwise limited or excluded under the Medical Program.

2.19 **Criminal Act** means any action for which a person is convicted of a misdemeanor or felony or any action for which a person is not charged or convicted but for which clinical evidence or a statement in a police report indicates that a law has been broken.

2.20 **Custodial Care** means services and supplies mainly intended to assist with the activities of daily living or other personal needs that:

(a) Do not seek a cure,

(b) Are provided during periods when Acute care is not required or when the medical condition of a Participant is not improving,

(c) Do not require continued administration by licensed medical personnel, or

(d) Assist in the activities of daily living.

Care may be custodial care even if it prescribed by a Physician or given by trained medical personnel.

2.21 **Deductible** means the set amount that must be paid by a Participant (the "**Individual Deductible**") or a Participant's family (the "**Family Deductible**") each calendar year (the "**Calendar Year Deductible**" or "**CYD**") before the Medical Program pays for Covered Services. Some Covered Services are not subject to the Deductibles such as Preventative Care and other named Copayment specific Covered Services. Please see the Schedule of Benefits to see which Covered Services are subject to the Deductible and those that are paid by the Medical Program before the Deductible.

2.22 **Dependent** means an Eligible Employee's Spouse, Child, or other Dependent that qualify as the Eligible Employee's dependent as under the U.S. Tax Code.

2.23 **Detoxification** means the process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the (i) intoxicating alcohol or drug, (ii) alcohol or drug-dependent factors or (iii) alcohol in combination with drugs, done by metabolic or other means determined by a Physician or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a

minimum, if it takes place in a Facility, the Facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

2.24 **Developmental Care** means services or supplies that:

(a) Are provided to a Participant who has not previously reached the level of intellectual, speech, motor, or physical development normally expected for the Participant's age, and such conditions were not a result of an Injury or Illness;

(b) Are primarily provided to assist in the development of those skills described above; and

(c) Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Illness).

2.25 **Domiciliary Care** means services or supplies that:

(a) Primarily provide a protective environment and assistance with basic personal needs for a Participant;

(b) Are primarily provided because the Participant's own home arrangements are not appropriate; and

(c) Are not part of an active treatment plan intended to or reasonably expected to improve the Participant's condition of functional ability.

2.26 **Durable Medical Equipment** means equipment and the accessories needed to operate it, that is:

(a) Made to withstand prolonged use

(b) Mainly used in the treatment of an Illness or injury

(c) Suited for use in the home

(d) Not normally used by people who do not have an Illness or injury

(e) Not for altering air quality or temperature

(f) Not for exercise or training

2.27 **Eligible Employee** includes a Full-Time Employee, Part-Time Employee, and a Per Diem Employee who has worked 30 Hours of Service during the Measurement Period immediately preceding a Stability Period. For more information regarding Measurement Periods and Stability Periods, please see Section III below and the Welfare Benefit "Wrap" documents. "Eligible Employee" also includes an individual who satisfied the foregoing requirements as of

the date of termination of employment with the Employer and who elects to continue coverage under the Plan pursuant to COBRA.

2.28 **Emergency Admission** means an admission to a Hospital or treatment Facility ordered by a Physician within 24 hours after receipt of Emergency Services.

2.29 **Emergency Medical Condition** means a medical condition manifesting itself by symptoms of sufficient severity (including severe pain) that a Participant, as a prudent layperson with an average knowledge of health and medicine, could reasonably believe that the absence of immediate medical attention could result in serious:

(a) Jeopardy to the health of the Participant,

(b) Jeopardy to the health of an unborn child,

(c) Impairment of a bodily function, or

(d) Dysfunction of any bodily organ or part.

2.30 **Emergency Services** means treatment given in a Hospital's emergency room for an Emergency Medical Condition. This includes evaluation of, and treatment to stabilize an Emergency Medical Condition.

2.31 **Employee** means an individual who is treated as a regular active employee of the Employer who is (i) paid a salary, wages or other compensation by the employer; (ii) considered by the Employer to be an employee at the time of the payment of such salary, wages or other compensation; and (c) whose salary, wages or other compensation is treated by the Employer at the time of such payment as being subject to statutorily required payroll tax withholding, such as withholding of federal or state income or withholding of the employee's share of Social Security and Medicare tax. All other individuals will not be included within the definition of "Employee", even if one or more of such other individuals is determined by a court, the internal revenue service or any other entity under any federal or state law, rule or regulations to be (or have been) a common law or statutory employee of the Employer for some or all of the period of time in question. Without limiting who is excluded, the following individuals are expressly excluded from the definition of the term "Employee":

(a) any nonresident alien employee with no U.S. sourced income, or undocumented resident alien employee;

(b) any individual who is performing services under an independent contractor or consultant agreement or arrangement (even if a court, the internal revenue service, or any other entity determines that such individual is a common law employee), unless a program document specifically provides coverage for such individuals;

(c) any individual who must be treated as an employee for limited purposes under the leased employee provisions of section 414(n) of the code;

(d) any individual covered by a collective bargaining agreement that does not provide for coverage under the plan, provided that the type of benefits provided under the Plan was the subject of good faith bargaining between the individual's bargaining representative and the Employer;

(e) any individual classified by the Employer as a temporary or contract employee to the extent consistent with the law;

(f) any individual providing services for the Employer pursuant to an agreement between the Employer and a third party (even if a court, the internal revenue service, or any other entity determines that such individual is a common law employee);

(g) a person who performs services for the Employer but who is treated for payroll purposes as other than an employee of the Employer (even if a court, the internal revenue service, or any other entity determines that such individual is a common law employee); or

(h) any individual who is otherwise eligible for coverage under the Plan but has committed a fraud or misrepresentation on the plan.

(i) "Employee" shall also mean an individual who satisfied the foregoing requirements as of the date of their termination of employment with the Employer and who elects to continue their coverage under the Plan pursuant to COBRA or for whom the Employer is required to provide coverage pursuant to a purchase agreement, merger and acquisition, or other contractual relationship.

2.32 **Employer** means Renown Health.

2.33 **ERISA** means the Employee Retirement Income Security Act of 1974 as amended from time to time.

2.34 **Experimental or Investigational** means a drug device, procedure or treatment where:

(a) There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the Illness or injury involved

(b) The needed approval by the FDA has not been given for marketing

(c) A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes

(d) It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services

(e) Written protocols or a written consent form used by a Facility provider state that it is experimental or investigational.

2.35 **Facility** means any one of the following:

(a) A Facility owned and operated by a Hospital or under written contract with a Hospital;

(b) A distinct part of a Hospital; or

(c) A Facility or distinct part of a Facility that meets the requirements for approved operation under Medicare.

(d) A skilled twenty-four (24) hour a day inpatient nursing services. A full-time Registered Nurse (R.N.) or other nursing staff under the supervision of a Physician or Registered Nurse on duty at least eight (8) hours per day;

(e) The Facility must:

(i) Be operated, including any necessary licensing, according to the laws of the state or locality in which it is located;

(ii) Be primarily engaged in providing care for persons recovering from Illness or Injury;

(iii) Be under the supervision of a Physician or staff of Physicians on call at all times; and

(iv) Provide all of the following:

(v) Room and Board;

(vi) Adequate daily medical records for each patient; and

(vii) Necessary and customary special services.

(f) A Facility is not an institution that is mainly a clinic, rest home, home for the aged, or place for Custodial care.

2.36 **FMLA** means the Family and Medical Leave Act of 1993, as amended from time to time.

2.37 **FMLA Leave** means a Leave of Absence that is required to be furnished to a Covered Member under the terms of the FMLA.

2.38 **Food and Drug Administration (FDA) Approved** means drugs, medications, and biologicals that have been approved by the FDA and listed in the United States Pharmacopoeia, the American MA Drug Evaluations, or the American Hospital Formulary.

2.39 **Full-Time Employee** means an Employee regularly scheduled to work 36 or more hours per week.

2.40 **Generic Prescription Drug** means prescription drug with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

2.41 **Genetic Information** means information about genes, gene products and inherited characteristics that may derive from the Covered Person or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

2.42 **Health Professional** means a person who is licensed, certified or otherwise authorized by law to provide health care services to the public, such as Physicians, nurses, and physical therapists.

2.43 **Hospice Care** means care designed to give supportive care to Participants in the final phase of a terminal Illness and focus on comfort and quality of life, rather than cure.

2.44 **Hospice Facility** means an institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care.

2.45 **Hospital** means a legally operated facility defined as an Acute Care or Tertiary Care hospital that is licensed by the state and may be approved by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission or JCAHO), the American Osteopathic Association (AOA) or by Medicare.

Hospital does not include a:

(a) Convalescent Facility

(b) Nursing Facility

(c) Facility for the aged

(d) Residential treatment Facility

(e) Intermediate care Facility

(f) Skilled nursing Facility

2.46 **Illness** means poor health resulting from disease of the body or mind.

2.47 **Injury** means physical damage done to a person or part of their body.

2.48 **Inpatient Care** means treatment received by a Covered Person who is confined in a Hospital. Inpatient Care includes Room and Board and general nursing care.

2.49 **L.P.N** means a licensed practical nurse or a licensed vocational nurse.

2.50 **Medical Pharmacy** means drugs, pharmaceuticals, immunizations, or biologics whose distribution, administration or supply of pharmaceuticals is generally in a healthcare facility, Physician's office, and not in a retail pharmacy setting. A complete list of pharmaceuticals that are covered under the Medical Pharmacy benefit is available at www.hometownhealth.com.

2.51 **Medically Necessary or Medical Necessity** means health care services determined by a Provider exercising prudent clinical judgment, provided to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that the Claims Administrator determines are:

(a) In accordance with generally accepted standards of medical practice

(b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, injury or disease

(c) Not primarily for the convenience of the patient, Physician, or other health care Provider

(d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, injury or disease

(e) Generally accepted standards of medical practice means:

(i) Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;

(ii) Following the standards set forth in the Claims Administrator's clinical policies and applying clinical judgment

2.52 **Medicare** means the Part A and Part B plans described in Title XVIII of the United States Social Security Act, as amended, which is a federally sponsored healthcare option for individuals 65 or older and for people with disabilities.

2.53 **Mental Disorder** means a disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

2.54 **Network, Network Provider, or In-Network Provider** means a group of healthcare providers who contract with the Plan to provide services at negotiated rates for Participants. Providers include doctors, Hospitals, and other healthcare professionals and Facilities.

2.55 **Non-Network Provider or Out-of-Network Provider** means any health care Facility or health care provider which is not designated by the Plan as having contracted with the Plan to provide services at negotiated rates.

2.56 **Out-of-Area Services** means services provided outside the Service Area.

2.57 **Out-of-Network** means Providers that have not contracted with the Medical Program to provide Covered Services or Covered Supplies. In most cases you will more for Out-of- Network Covered Services or Covered Supplies.

2.58 **Out-of-Pocket Maximum (OOP)** - means the maximum amount a Participant must pay in Coinsurance and Deductibles for Covered Expenses incurred during a Plan Year. When the Out-of-Pocket Maximum is reached, the Medical Program pays at 100% of Covered Expenses received from In-Network Providers and 100% of Usual, Customary, and Reasonable Charges of Covered Expenses received from Out-of-Network Providers.

Different OOP maximums apply for individuals and families and different OOP maximums also apply for In-Network and for Out-of-Network Covered Expenses. Deductibles count towards the OOP maximums for In-Network benefits.

However, Deductibles for Out-of-Network benefits do not apply to your OOP maximums. Also, the difference between the Out-of-Network Provider's bill for Covered Services and the Usual and Customary Amount for such Covered Services (as determined by Hometown Health) does not count towards the Out-of-Pocket maximum.

Copayments and Coinsurance amounts for Covered Services requiring Prior Authorization for which you not receive Prior Authorization, also will not be applied toward the OOP maximums.

2.59 **Partial Hospitalization** means the continuous treatment for at least four hours but not more than 12 hours in any period of 24 consecutive hours. Partial Hospitalization services can be performed in a Hospital or treatment center facility.

2.60 **Part-Time Employee** is an Employee regularly scheduled to work between 20 and 35 hours per week.

2.61 **Participant** refers to an Eligible Employee and eligible covered Dependents, if any participating in the Medical Program.

2.62 **Per Diem Employee** is an Employee hired to work on a per diem basis and who is not classified as a Full-Time Employee or Part-Time Employee by the Employer

2.63 **Physician** means a skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice including specifically, doctors of medicine

or osteopathy. Physician will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if they are:

(a) Operating within the scope of their license, and

(b) Performing a service for which benefits are provided under this Medical Program when performed by a Physician.

(c) Physician shall not include the Participant, or anyone related by blood, marriage or adoption to the Participant.

2.64 **Payment Percentage** means the specific percentage the Plan pays for a health care service listed in the Schedule of Benefits attached hereto.

2.65 **Physician** means a skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice including specifically, doctors of medicine or osteopathy. Physician will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if they are:

(a) Operating within the scope of their license, and

(b) Performing a service for which benefits are provided under this Plan when performed by a Physician.

(c) Physician shall not include the Participant, or anyone related by blood, marriage or adoption to the Participant.

2.66 **Plan Administrator** is the Renown Health Employee Benefits Review Committee appointed by the Company (the "**Committee**").

2.67 **Preferred or Participating Provider** means a Provider who is listed in our current Provider directory and who is directly or indirectly under contract with the Medical Program to provide Covered Services to Participants. A Participating Provider provides services within our Network. Primary Care Providers and Specialty Providers are Participating Providers. Participating Providers are only located in the Licensed Area or out-of-state within 50 miles from the Licensed Area.

You can find our current provider directory on our web site at www.hometownhealth.com under the Provider Directory link or you can request one by contacting our customer service department.

A Participating Provider's agreement with the Medical Program or the association of a particular Professional with a Participating Provider may terminate, and, in such a case, a Participant will be required to use another Participating Provider in order to receive in- Network benefits. Not all Physicians, organizations or associations of Physicians, Hospitals, skilled nursing facilities, organizations licensed by the state to render home health services, or other licensed institutions or health Professionals who have contracts with the Medical Program are Participating Providers. The Medical Program does not guarantee the continued availability of any particular

Participating Provider. Participating Providers cannot determine whether a service is a Covered Service under this Medical Program or on behalf of the Medical Program.

2.68 **Precertification or Precertify** means a determination by Plan as to whether the service is Medically Necessary and an Eligible Health Expense.

2.69 **Prior Authorization** means our determination of medical necessity and benefit coverage using utilization management and quality assurance protocols prior to the services being rendered. All benefits listed in this Summary of Benefits may be subject to prior authorization requirements and concurrent review depending upon the circumstances associated with the services. Refer to your plan-specific summary of benefits for services that require prior authorization. You may find a full list of services that require prior authorization by visiting our website at www.hometownhealth.com.

2.70 **Professional** means a Physician or other health care professional, including a pharmacist, Physician's assistant, nurse practitioner, or autism behavioral interventionist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

2.71 **Provider(s)** means a Professional who delivers health care services or an institution that supervises the rendering of such care. Physician, organization or association of Physicians, Hospital, skilled nursing facility, any organization licensed by a state to render home health services, or any other licensed institution or Professional. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

2.72 **Room and Board** means all charges commonly made by a Hospital on its own behalf for a bed, meals and for all general services and activities essential for the care of registered bed patients.

2.73 **Schedule of Benefits** means the schedule of medical benefits attached hereto as Exhibit A, as such Exhibit A may be amended from time to time in the sole and absolute discretion of the Plan Administrator.

2.74 **Service Area** means northern Nevada.

2.75 **Specialist** means a Physician who practices in any generally accepted medical or surgical sub-specialty.

2.76 **Summary of Benefits and Coverage** or **SBC** means the documents attached to, and hereby incorporated by reference into, this document that summarize the benefits payable under various coverage options offered under the Medical Program.

2.77 **Telemedicine** means a consultation by a Provider who is performing a clinical medical or Behavioral Health Service. Services can be provided by:

(a) Two-way audiovisual teleconferencing;

(b) Telephone calls, except for behavioral health services

(c) Any other method required by state law

2.78 **Terminal Illness** means a medical prognosis that a Covered Person is not likely to live longer that twelve (12) months.

2.79 **Tertiary Care** - the highest or most complex level of care for the treatment of a particular medical condition and not generally available in a community Hospital. Tertiary Care is specialized consultative care, usually on referral from primary or secondary medical care personnel, by Specialists working in a center that

2.80 **Urgent Care Facility** means a Facility licensed as a freestanding medical Facility by applicable state and federal laws to treat an urgent condition.

2.81 **Urgent Care** means an Illness or injury that requires prompt medical attention but is not an Emergency Medical Condition.

2.82 **Usual and Customary (U&C)** means the lesser of:

(a) A Provider's usual charge for furnishing a treatment, service, or supply;

(b) The charge the Medical Program determines to be the general rate charged by others who render or furnish such treatment, service, or supply to person who reside in the same geographic area and whose condition is comparable in nature and severity; or

(c) What Medicare would pay for such treatment, service, or supply.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.01 Eligibility.

(a) If you are a Full-Time Employee or a Part-Time Employee and you are not an "Excluded Employee" (as described in below), you are eligible to participate in the Medical Program on the first day of the month following your date of hire.

(b) If you are a Per Diem Employee:

(i) During your first 12-months of employment (your "**Initial Measurement Period**"), Renown will determine if over that time, you worked an average of 30 or more hours per week.

(A) If you averaged 30 or more hours per week during your Initial Measurement Period, you will continue to be eligible under the Medical Program for the next 12-months (your "Initial Stability Period"), regardless of the number of hours you actually

work per week provided you remain employed and continue to pay your share of the premiums during your Initial Stability Period.

(B) If you did not average 30 hours per week during your Initial Measurement Period, you will not be eligible for coverage during your Initial Stability Period.

(ii) On an ongoing basis, if you are employed by Renown prior to the first day of the Plan Year (January 1st), Renown will determine if you averaged 30 or more hours per week during the Medical Program's 12-month "Standard Measurement Period" (January 1st – December 31st).

(A) If you average 30 Hours of Service per week during the Standard Measurement Period, you will be eligible under the Medical Program for the next 12-month "Standard Stability Period" regardless of the number of hours you work per week provided you remain employed and continue to pay your share of the premiums.

(B) If you did not average 30 Hours of Service per week during a Standard Measurement Period your coverage will end. You will become eligible again on the first day of the Standard Stability Period following Standard Measurement Period during which you average 30 hours per week.

Hours of Service include all hours for which you receive your regular wages, including paid vacation and sick time. If you are on an approved unpaid FMLA or military leave, or is on jury duty, then the weeks of unpaid time will be included in the calculation of the average hours of service and credited with the average Hours of Service the Employee worked preceding the leave for the purposes of determining eligibility for coverage. If you are on any other type of unpaid leave, the weeks of unpaid leave time shall be credited with zero (0) Hours of Service during the applicable Initial or Standard Measurement Period.

(c) If you stop working for Renown for a period of at least 13 consecutive weeks, and then you resume services for Renown, you may be treated as a new employee for purposes of medical coverage eligibility. If you take a shorter break in service, upon your resumption of services, Renown will treat you as a continuing employee, with the same status you had prior to your termination. In this event, you will be offered medical coverage no later than the first day of the calendar month following resumption of services.

(d) If you and your Dependent(s) are each eligible to participate in the Plan as Eligible Employees, you may enroll separately for coverage as Eligible Employees or one of you may enroll as the Eligible Employee and the other(s) as a Dependent, but Eligible Employees may not be enrolled as both a Dependent and an Eligible Employee. Further, Dependents may only be enrolled as Dependents of one Eligible Employee. Your online enrollment form must confirm your agreement to pay the portion of the cost of your Medical Program benefits which is determined by Renown

(e) Where both Spouses are Eligible Employees and are enrolled under the Plan and one of them terminates employment or is no longer eligible for benefits, the terminating

Spouse may immediately enroll under the remaining Employee's coverage as a Dependent to continue prior coverage.

(f) Eligible Dependent. An enrollment application with respect to an Eligible Dependent must be completed by the related Employee and submitted to the Employer no later than 30 days following the date on which the Employee becomes eligible for coverage. An Eligible Dependent commences participation in the Plan, if Dependent coverage is elected, on the same date on which Eligible Employee coverage commences provided no individual shall commence participation as a Dependent in this Plan until the Claims Administrator receives:

(i) Appropriate verification, as determined by the Claims Administrator and/or the Plan Administrator in their sole and absolute discretion, of such individual's status as a Dependent; and

(ii) Satisfactory evidence of the related Eligible Employee's agreement to pay such portion of the cost of the Eligible Dependent's Plan benefits as shall be determined by the Employer. Such evidence must be submitted within 30 days of the date the dependent becomes an Eligible Dependent. Cost of Coverage

3.02 Cost of Coverage. The Employer shall pay the percentage of the cost of premiums for Employees and their Dependents as shall be determined from time to time in the sole and absolute discretion of the Employer, and the Employees shall pay the balance. All Plan Participants are responsible for the Co-insurance amounts, Deductibles, and copayments for Covered Expenses under the Plan up to the Out-of-Pocket Maximum as set forth on the appropriate Schedule of Benefits, and Schedule of Prescription Drug Benefits. All Plan Participants are fully responsible for medical or prescription drug expenses that are not Covered Expenses under the Plan.

3.03 Determination of Eligibility.

(a) The Plan Administrator shall delegate to the Claims Administrator the authority to determine the eligibility of each Employee and Eligible Dependent for participation in the Plan based upon any information to which it has access and such other information furnished by the Employee subject to the approval of the Plan Administrator. The determination shall be conclusive and binding upon all persons. In determining eligibility for participation, the Claims Administrator and the Plan Administrator shall make such determination in accordance with this Plan and the Employee Retirement Income Security Act of 1974, as amended.

(b) In enrolling an individual as a Covered Person or in determining or making any payments for benefits of an individual as a Covered Person, the fact that the individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

3.04 Enrollment

(a) Initial Enrollment. You must enroll in the Medical Program within thirty (30) of your date of hire or the date you first become eligible to participate in the Medical Program. prior to the first day of coverage following your date of hire by submitting all required forms and following Renown's enrollment procedures. *If you do not make enroll in the Medical Program or*

affirmatively waive coverage under the Medical Program within the thirty (30) day enrollment window, you will automatically be enrolled in the lowest cost "Employee Only" option under the Medical Program for the rest of the Plan Year.

(b) Open Enrollment. The Company will hold an annual Open Enrollment Period prior to each new Plan Year during which you may change your Medical Program elections, including adding or dropping coverage or you and/or your Dependents for the upcoming Plan Year. The elections you make during the Open Enrollment generally take effect each January 1st - the first day of the new Plan Year.

(i) Your enrollment materials will contain important tips on how to enroll during Open Enrollment. Be sure to read the information carefully.

(ii) During Open Enrollment you have the opportunity to switch from one medical option or dental option to another (if more than one option is offered), add or drop Dependents, or decline or add medical, dental or vision coverage for the next Plan Year.

(iii) PLEASE NOTE: If you fail to actively enroll in the Medical Program, your coverage elections currently in effect will automatically carry over for the next Plan Year.

(c) Dependent Enrollment. You must enroll your eligible Dependent(s) no later than 30 days following the date on which you become eligible for coverage or the date you acquire an eligible Dependent. In order for your Dependents to commence participation, the Claims Administrator may request appropriate verification of your Dependent's status as eligible under the Plan, as determined by the Claims Administrator and/or the Plan Administrator in their sole and absolute discretion.

(d) Cost of Coverage. The cost of coverage for you and your Dependents under the Medical Program will be provided with your enrollment materials when you first become eligible and each year during Open Enrollment. *The cost of your share of the premiums under this Medical Program may change from year to year.*

(e) Special Enrollment Rights. Once you make your Medical Program elections, you may not change your elections for the remainder of the Plan Year outside of an Open Enrollment Period, except in certain circumstances. The Welfare Wrap Plan documents detail the events and circumstances that will allow you to make changes to your Medical Program elections outside of an Open Enrollment Period such as gaining a new Dependent or moving your primary residence outside of a coverage area.

3.05 Loss of Coverage and Re-enrollment.

(a) If you lose coverage under the Medical Program because you move to a position that is not benefit eligible, you will become covered again on the first day of the month that follows your change to benefit eligible employment status, provided you meet all of the eligibility requirements set forth above, and provided you complete the enrollment procedures established by Renown within 30 days of your change to benefit eligible employment status.

(b) If you lose coverage under the Medical Program because you do not pay a required premium, then, unless you are on a qualified family or medical leave (See Section XII), you will become covered again on the first day after the conclusion of any Open Enrollment Period, provided that you are then eligible to participate, you have submitted such appropriate forms as determined by Renown, and you have paid Renown all back premiums that you owe, if any.

(c) If you have a change in family status you may add or delete Employee or Dependent coverage under the Medical Program, provided you notify Renown within 30 days of such change (or a longer period of time are prescribed under Federal law). Your request to add or delete Employee or Dependent coverage must be consistent with the family status change. The change will be effective on the first day of the month following the date of the change unless an earlier effective date applies to your new Dependent.

Benefit forms and materials are available on the Renown Employee Benefit Portal through Hometown Health.

3.06 Termination of your Coverage

You will no longer be a Covered Member in the Medical Program on the earliest to occur of the following:

(a) The end of month in which your employment with Renown terminates;

(b) The end of the month in which you work less than 20 hours per week if you are a Part-Time Employee;

(c) If you are a Variable Hour Employee, the last day of the Stability Period you do not work an average thirty (30) hours per week during the corresponding Measurement Period.

(d) The date the Medical Program is terminated;

(e) The end of the month for which the last premium payment is made on your behalf;

(f) The date you fail to make any required premium payment or contribution during an approved leave of absence;

(g) The date your approved leave of absence ends and you fail to return to active service;

(h) The date your approved leave of absence extends beyond the date

(i) The date you no longer meet the eligibility requirements for coverage;

(j) The date you enter the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding thirty-days;

(k) The date you fail to maintain full-time residence in the United States;

(l) If there is fraud or an intentional false statement of an important fact, your coverage will end retroactively (on a date before the fraud or false statement is discovered).

However, if you lose coverage under this Medical Program as a result of a Qualifying Event you have a right to elect Continuation Coverage (see Article XII below).

Nevertheless, if you cease to be a Covered Member in the Medical Program because the Medical Program is terminated by Renown or because you fail to pay required premiums prior to your Qualifying Event, you will not be entitled to elect Continuation Coverage.

3.07 Termination of Dependent Coverage

Your Dependent's coverage under the Medical Program will terminate on the last day of the month in which occurs the earliest of:

(a) The date you cease to be a Participant;

(b) The end of the period for which the last Medical Program contribution is paid for your Dependent. The termination of coverage will be retroactive to the end of that month;

(c) The date you no longer meet the Medical Program eligibility requirements;

(d) The date your Dependent ceases to qualify as a Dependent under the terms of the Medical Program;

(e) The date Renown terminates the Medical Program;

(f) The date the Dependent enters the military, naval or air force of any country or international organization on a full time active duty basis;

(g) The date the Dependent ceases to maintain full time residence in the United States;

(h) The date Dependent coverage terminates under the Medical Program; or

(i) If there is fraud or an intentional false statement of an important fact, Dependent coverage will end retroactively (on a date before the fraud or false statement is discovered).

However, benefit coverage will not be terminated for your Dependent child solely because the child exceeds the maximum age limit for a Dependent if the child (1) is not capable of self-support because of mental disability, physical disability or Illness which began before the maximum age limit was reached, and (2) is chiefly Dependent upon you for financial support and maintenance. You must provide the Plan Administrator with proof of your Dependent child's condition within thirty (30) days of the date your child would otherwise cease to be a Dependent. During the two years after your child reaches the maximum age, the Medical Program may ask for

regular proof (which may include a Physician's exam) of the child's continued disability or Illness. Thereafter, you may be asked to submit proof of your child's continued disability or Illness, but not more frequently than once a year.

If your Dependent loses coverage under this Medical Program as a result of a Qualifying Event your Dependent (shall have a right to elect Continuation Coverage (see Article XII below). Nevertheless, if Renown terminates this Medical Program or if the required premiums are not paid on behalf of your Dependent prior to a Qualifying Event, your Dependents will not have the right to elect Continuation Coverage.

ARTICLE IV
BENEFIT REQUIREMENTS

4.01 Payment of Medical Expenses. This Medical Program provides medical benefits for certain Covered Expenses when incurred for services or supplies recommended by a Physician and rendered to you on or after your first day participation under the Medical Program and on or before your last day of participation under the Medical Program. A Covered Expense is incurred at the time the service or supply is actually provided.

4.02 Utilization Management Program. The utilization management program for the Medical Program is provided by the Claims Administrator. The utilization management program uses set criteria and protocols to ensure that the most cost-effective preventive, Acute, and Tertiary Care is provided to our Participants consistent with the provision of quality care. You may be subject to a reduction in benefits if you do not comply with this utilization management program. Our utilization program is conducted with our written policies and procedures under the direction of the Claims Administrator's Medical Director.

4.03 Delivery of Covered Services and Covered Supplies. Medically Necessary Covered Services and Covered Supplies are covered under this Medical Program if they are generally and customarily:

(a) Provided in our Service Area,

(b) Performed or ordered by a Participating Provider, and

(c) You have received prior authorization (as described below) according to the Program's utilization management and quality assurance protocols, if applicable.

4.04 Scope of Utilization Management. Under the utilization management program, Prior Authorization is required for referrals to Physicians and Providers for certain services. Prior Authorization means our determination of medical necessity and benefit coverage using utilization management and quality assurance protocols prior to the services being rendered. All benefits listed in this Plan may be subject to Prior Authorization and concurrent review depending upon the circumstances associated with the services. Refer to the applicable Summary of Benefits for services that require Prior Authorization. You may

find a full list of services that require Prior Authorization by visiting our website at www.hometownhealth.com

(a) Prior Authorization. In certain cases, as set forth below, in order for a benefit to be covered, Prior Authorization is required. You are subject to a 50% reduction in benefits if you do not obtain a required Prior Authorization for the service even if the service is Medically Necessary. The Plan uses nationally recognized criteria and internal medical plan guidelines, as reviewed periodically by our Utilization Management and Quality Improvement Committee, as the standard measurement tool to determine whether benefits will be granted Prior Authorization. The following services are subject to Prior Authorization:

(i) All inpatient stays and services in any Facility type, including Acute and Skilled Care, mental health care, drug or alcohol Detoxification, or physical or mental rehabilitation;

(ii) Hospital Admissions - You are responsible for notifying the Plan of a Hospital stay at least five business days before elective admission to a Hospital to ensure that it is covered. Your Physician or other Provider may notify the Plan but it is ultimately your responsibility to make sure the Plan is notified. We will review the Provider's recommendation to determine level of care and place of service. If we deny authorization for Hospital admission as not covered or we determine that the services does not meet our criteria and protocols, we will not pay Hospital or related charges for the care that is not Medically Necessary or does not meet our criteria or protocols.

(iii) Inpatient, or same day surgical services - You are responsible for making sure the Plan is notified at least five business days before elective inpatient or outpatient surgery is performed to ensure that it is covered. Your Physician or other Provider may notify the Plan but it is ultimately your responsibility to make sure the Plan is notified. The Plan will review the Physician's recommended course of treatment. The Plan will pay benefits only for inpatient/outpatient surgeries that are authorized. The Plan will not pay for inpatient or outpatient surgery or related charges if determined that such charges are not a Covered Service or do not meet the Plan's criteria and protocols.;

(iv) Healthcare services and supplies including but not limited to oxygen, oxygen-related equipment and all durable medical equipment with a cost greater than $100;

(v) Prosthetic and orthopedic devices with a cost greater than $100;

(vi) Transplant services;

(vii) Gastric restrictive services;

(viii) Certain medications and complex radiology and cardiac imaging services, a list of which is set forth on our website at www.hometownhealth.com and which you can obtain by calling Customer Services at the number found on the back of your membership card;

(ix) All out-of-area services, except that Out-Of-Area Services will be provided without a Prior Authorization in accordance with the terms of the applicable Summary of Benefits;

(x) Anesthesiology and physiatry services including pain management;

(xi) Certain laboratory and diagnostic tests;

(xii) Genetic counseling and testing; and

(xiii) Second-opinion services.

(b) Emergency and Urgent Care Approvals.

(i) An Emergency Hospital admission means an admission for Hospital confinement that results from a sudden and unexpected onset of a condition that requires medical or surgical care. In the absence of such care, you could reasonably be expected to suffer serious bodily Injury or death. Examples of Emergency Hospital admissions include, but are not limited to, admissions for heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal Injuries, and other Acute conditions.

(ii) An urgent Hospital admission means an admission for a medical condition resulting from Injury or serious Illness that is less severe than an Emergency Hospital admission but requires care within a short time.

(iii) For all Emergency or Urgent Hospital admissions, you are responsible for making sure that the Plan is notified within 24 hours, the next business day, or as soon as reasonable after admission. If you are incapacitated and you (or a friend or relative) cannot notify the Plan within the above stated times, the Plan must receive notification as soon as reasonably possible after the admission or you may be subject to reduced benefits as provided in the applicable Summary of Benefits.

Please Note: Services of all non-Participating Providers except that, in the case of an Emergency Medical Condition or for Urgent Care, payment for services will be provided without a Prior Authorization in accordance with the terms of the applicable Summary of Benefits.

(c) Healthcare Services and Supplies review. A Participating Provider may notify the Plan on your behalf to obtain Prior Authorization for the services described above. Non-Participating Providers may not know or attempt to notify the Plan to obtain Prior Authorization for services. In such a case, you must confirm that the Plan has given Prior Authorization in order to assure that the service is covered.

(d) The Plan will pay for Covered Services and Covered Supplies only if authorized as outlined above. The Plan will not pay for any healthcare services or supplies that are not Covered Services or Covered Supplies or do not meet our criteria and protocols.

4.05 Care Review and Case Management.

(a) After admission to a Facility, the Plan will continue to evaluate the patient's progress to monitor appropriate level of care and services. If, after consulting with the Physician or a representative of your treatment team or the Hospital case management team, the Plan determines a lower level of care is appropriate or a service does not meet our criteria standards, the Plan will not extend continued authorization. The Plan uses nationally recognized criteria and internal medical plan guidelines as the standard measurement tool for this process for Acute care facilities. The Plan also uses nationally recognized criteria as the standard assessment tool for skilled nursing Facilities, rehabilitation Facilities and mental health and substance abuse Facilities and programs.

(b) Case management is a service provided by the Plan to coordinate all services or alternate methods of medical care or treatment that may be used in replacement of or in combination with Hospital confinement. Our case managers will work in coordination with the attending Physician or other Professionals and community resources to develop a plan of treatment per the benefit level of this Plan. Discharge planning may be initiated at any stage of the process, and begins immediately upon identification of post discharge needs during Prior Authorization or concurrent review.

(c) The Plan will review and evaluate medical records if you did not receive Prior Authorization or a concurrent care review. The Plan will pay the benefits only for the Covered Expenses that you would have been approved under the Utilization Management Program.

4.06 Second Opinions. The Plan will authorize a second opinion upon your request in accordance with the terms of the applicable Summary of Benefits. Examples of instances where a second opinion may be appropriate include:

(a) Your Physician has recommended a procedure and you are unsure whether the procedure is necessary or reasonable;

(b) You have questions about a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions;

(c) You are unclear about the clinical indications about your condition;

(d) A diagnosis is in doubt due to conflicting test results;

(e) Your Physician is unable to diagnose your condition; and

(f) A treatment plan in progress is not improving your medical condition within a reasonable period of time.

4.07 Benefits When Traveling. If you are traveling out of state or out of the United States and require medical treatment from an Out-of-Network Physician Provider (excluding when you traveled to such location for the primary purpose of obtaining medical services, drugs or supplies), benefits shall be payable at In-Network Physician Provider Co-payment and Co-

insurance levels subject to Reasonable and Allowed Amount (after satisfaction of the applicable Calendar Year Deductible).

4.08 Deductible.

(a) No Deductible shall apply to Covered Services provided by Renown Hospital Services & Renown Providers. With respect to services provided by an In-Network Physician Provider, a Facility or an Out-of-Network Physician Provider, the Plan Year Deductible shall be as shown in the Schedule of Medical Benefits. The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.

(b) The Out-of-Network Physician Providers Deductibles are separate from and do not co- accumulate with any other provider Deductibles. Eligible expenses which track toward the Out-of-Network Physician Providers Deductible will not be credited toward satisfaction of the Renown Hospital Providers & Facility Services or In-Network Physician Provider and All Other Facility Based Services Deductible and vice versa.

(c) The Deductible shall be waived for the Preventive Services indicated on the schedule of benefits.

4.09 Out-of-Pocket Maximum

(a) The Out-of-Pocket Maximums are shown in the Schedule of Medical Benefits. The Out-of-Pocket Maximum excludes Excess Charges for Facility- Based Services or charges in excess of the Reasonable and Allowed Amount for Out-of-Network Physician Providers, Prescription Drug Co-payments, Co-insurance or Deductibles and any penalties for failure to follow Preadmission/ Precertification Requirements.

(b) The Renown Hospital Providers & Facility Services, In-Network Physician Provider, and All Other Facility Based Services Out-of-Pocket Maximum are combined. Eligible expenses which track toward the Renown Hospital Providers & Facility Service and In-Network Physician Provider Out-of-Pocket Maximum will be credited toward satisfaction of the All Other Facility Based Services Out-of-Pocket Maximum and vice versa.

(c) The Out-of-Network Physician Providers Out-of-Pocket Maximums are separate from and do not co-accumulate with any other provider Out-of-Pocket Maximums. Eligible expenses which track toward the Out-of-Network Physician Providers Out-of-Pocket Maximum will not be credited toward satisfaction of the Renown Hospital Providers & Facility Services or In-Network Physician Provider and All Other Facility Based Services Out-of-Pocket Maximum and vice versa.

4.10 Complex Case Management/Alternate Treatment Coverage.

(a) If a Covered Person's condition is, or is expected to become, serious and complex in nature, the Plan Administrator may arrange for review and/or case management

services from a professional qualified organization. The purpose of the case management service is to help plan necessary, quality care in the most cost-effective manner with the approval and cooperation of the Covered Person, family and attending Physician(s). This is a voluntary service to help manage both care and cost of a potentially high-risk or long term medical condition, and neither Covered Persons nor treating Physicians are required to participate in complex case management.

(b) If a case is identified as appropriate for complex case management, then the case management organization will contact the treating Physician(s) and Covered Person to develop and implement a mutually agreeable treatment plan. If either the attending Physician or the Covered Person does not wish to follow the treatment plan, benefits will continue to be paid as stated in the Medical Program.

(c) If the Physician(s) and Covered Person agree to the treatment plan, in some cases services not normally covered by the Medical Program may be eligible for coverage. If it appears that the most appropriate and cost-effective care will be rendered in a setting or manner not usually covered under the terms of the Medical Program, such care may be covered under the auspices See Schedule of Medical Benefits for additional important information about coverage levels, limitations, and precertification and preauthorization requirements of a complex case management treatment plan. In such cases, all Medically Necessary services included in the approved treatment plan will be covered under the terms of the Medical Program. However, the coverage of services under a complex case management plan that are not otherwise covered under this Medical Program does not set any precedent or create any future liability for coverage of such services with respect to either the Covered Person who is the subject of the plan or any other Covered Persons. Benefits provided under this section are subject to all other Medical Program provisions.

ARTICLE V
COVERED MEDICAL EXPENSES

Covered Expenses under the Medical Program must be prescribed by a Physician and incurred for medical treatment of an Illness or Injury. Covered Expenses may be subject to the annual Deductible, Co-insurance, Co-payments and other limits as shown in the Schedule of Medical Benefits attached as Appendix A for the following:

5.01 Professional Services.

The following services are Covered Services when provided by a Professional.

(a) *Alcohol and substance abuse services (inpatient and outpatient)*. Medically Necessary inpatient and outpatient alcohol and substance abuse services will be provided under the same terms as medical and surgical benefits, with no additional financial or treatment limitations.

(b) *Allergy testing and treatment.* Coverage is provided for Medically Necessary allergy testing, preparation of serum, serum, and administration of injections.

(c) *Alternative medicine*. Alternative medicine is a Covered Service for therapeutic procedures and approaches to medical diagnosis and therapy that currently may not be considered part of conventional medical practice. These generally include, but are not limited to: acupressure, acupuncture, aromatherapy, herbal medicine, vitamin or supplement therapies, homeopathic medicine, holistic medicine, and other non-traditional therapies or managements for Illnesses, diseases, or conditions. Office visits, procedures, and therapies for alternative medicine by a licensed Provider and related medications are covered up to 20 visits per calendar year.

(d) *Autism spectrum disorders.* Coverage is provided for Medically Necessary screening for and diagnosis of autism spectrum disorders and for the Medically Necessary treatment of autism spectrum disorders to individuals under the age of 18 (or under the age of 22, for individuals enrolled in high school).

(i) "Autism spectrum disorder" means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified. Treatment must be identified in a treatment plan prescribed by a licensed Physician or psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst. Subject to the other requirements of this Plan, treatment may include Medically Necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy, or therapeutic care that is:

(A) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed Physician or licensed psychologist; and

(B) Provided to a person diagnosed with an autism spectrum disorder by a licensed Physician, licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst, certified autism behavior interventionist, or other Provider that is supervised by the licensed Physician, psychologist, or behavior analyst.

(ii) The Plan may request and review a copy of the treatment plan.

(e) *Blood services for surgery.* Medically Necessary blood and related supplies provided during a surgical or other procedure that requires blood replacement are Covered Services.

(f) *Chemotherapy.* Chemotherapy and other drug therapies that are Medically Necessary to treat cancers and other diseases and conditions are Covered Services.

(g) *Clinical trials*. The routine medical treatment costs, including all items and services that are otherwise generally available to our Participants, received as part of a clinical trial or study, may be covered. A clinical trial is the process for testing of new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases.

(i) Covered Clinical Trial Expenses.

(A) The medical treatment is provided in a Phase I, Phase II, Phase III, or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III, or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

(B) The clinical trial or study is:

(1) Approved by an agency of the National Institutes of Health as set forth in applicable law;

(2) Approved by a cooperative group, a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health;

(3) FDA-Approved as an application for a new investigational drug

(4) Approved by the United States Department of Veterans Affairs; or

(5) Approved by the United States Department of Defense.

(C) In the case of:

(1) A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or

(2) A Phase II, Phase III, or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a Provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;

(D) There is no medical treatment available that is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;

(E) There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

(F) The clinical trial or study is conducted in Nevada;

(G) You have signed, before your participation in the clinical trial or study, a statement of consent indicating that you have been informed of, without limitation:

(1) The procedure to be undertaken,

(2) Alternative methods of treatment, and

(3) The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks; and

(H) The medical treatment is limited to:

(1) Coverage for any drug or device that is FDA-Approved for sale without regard to whether the approved drug or device has been approved for use in your medical treatment;

(2) The cost of any reasonable necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III, or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III, or Phase IV clinical trial or study, to the extent that such health care services would otherwise be Covered Services;

(3) The cost of any routine health care services that would otherwise be Covered Services for your participation in a Phase I clinical trial;

(4) The initial consultation to determine whether you are eligible to participate in the clinical trial or study; or

(5) Health care services required for the clinically appropriate monitoring of you during a Phase II, Phase III, or Phase IV clinical trial or study.

(ii) Services for the following clinical trial services are excluded:

(A) Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical, or medical industry;

(B) Coverage for a drug or device described above that is paid for by the manufacturer, distributor, or Provider of the drug or device;

(C) Health care services that are specifically excluded from coverage in this Plan, regardless of whether such services are provided under the clinical trial or study;

(D) Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to participants in the trial or study;

(E) Extraneous Expenses related to you in the clinical trial or study including but not limited to travel, housing, and other Expenses that you may incur;

(F) Any Expenses incurred by a person who accompanies you during the clinical trial or study;

(G) Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of you; and

(H) Any costs for the management of research relating to the clinical trial or study.

(h) *COVID-19 Coverage*. The Plan will provide coverage for the cost of testing to determine if you have been infected with SARS-CoV-2 or the diagnosis of COVID-19 ("COVID Tests"), including tests that detect antibodies against SARS-CoV-2 virus, when medically appropriate, as determined by your attending health care provider as required by the Families First Coronavirus Response Act (FFCRA) as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act at no cost to you. The "cost of testing" includes the cost of health care provider office visits (including in-person and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a COVID Test, but only to the extent the items and services relate to the furnishing or administration of the test or your evaluation for purposes of determining if you need a diagnostic COVID Test. The Plan does not cover the cost of COVID Tests for employment purposes, travel, or any reason other than as required under FFCRA and the CARES Act.

(i) *Diabetic services for type 1 and 2 and gestational diabetes*.

(i) Coverage is provided for the Medically Necessary management and treatment of diabetes, including infusion pumps and related supplies, medication, equipment, supplies, and appliances for the treatment of diabetes.

(ii) Coverage is provided for the Medically Necessary self-management of diabetes for training and education provided after you are diagnosed with diabetes for the care and management of diabetes, including, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.

(iii) Insulin is excluded unless covered under the Prescription Drug Coverage provisions of Section 6.

(j) *Family planning*. Coverage is provided for vasectomies and tubal ligations. Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals are excluded.

(k) *Enteral formulas and special food products.* Enteral formulas and special food products are covered if they are Medically Necessary for the treatment of an inherited metabolic disease. An inherited metabolic disease is a disease caused by an inherited abnormality of the body chemistry of a person characterized by congenital defects or defects arising shortly after birth resulting in deficient metabolism, or malabsorption originating from, of amino acid, organic acid, carbohydrate, or fat. Inherited metabolic diseases do not include obesity. Special food products do not include foods that are naturally low in protein.

(i) Special food products are only covered if they are specially formulated to have less than one gram of protein per serving and are consumed under the direction of a Physician for the Medically Necessary dietary treatment of an inherited metabolic disease.

(ii) Special formulas, food supplements, or special diets including, but not limited to, total parenteral nutrition, except for Acute episodes, are not covered.

(l) *Gastric restrictive services.* Covered Services include Prior Authorized Medically Necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese with associated Illnesses, including but not limited to:

(i) Cardiac disease,

(ii) Sleep apnea,

(iii) Diabetes,

(iv) Hypertension,

(v) Disorders of the pituitary gland and its hypothalamic control,

(vi) Disorders of the adrenal glands, or

(vii) Cushing' s syndrome

(viii) Benefits for gastric restrictive services are subject to Prior Authorization requirements and are limited to the following benefit maximums:

(ix) Benefits for gastric restrictive services are subject to Prior Authorization requirements and are limited to one medically necessary gastric restrictive surgery at a Bariatric Center for Excellence per lifetime. This designation is at the Plan Administrator's discretion.

(x) Limits include complications directly resulting from gastric restrictive services.

(m) *Genetic counseling/testing*.

(i) Covered Services include Medically Necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests solely for research, or for the benefit of individuals not covered under the Plan.

(ii) Covered Services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk and review testing options, where available.

(iii) Genetic testing may only be done after consultation with an appropriately certified genetic counselor and/or, in our discretion, as approved by a Physician that the Plan may designate to review the utilization, medical necessity, clinical appropriateness, and quality of such genetic testing.

(iv) Medically Necessary genetic counseling will be covered in connection with pregnancy management with respect to the following individuals:

(v) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(vi) Parents of a child with mental retardation, autism, Down syndrome, trisomy conditions, or fragile X syndrome;

(vii) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein test, test for sickle cell anemia, or tests for other genetic abnormalities, have been told their pregnancy may be at increased risk for complications or birth defects; or

(viii) Parents affected with an autosomal dominant disorder who are contemplating pregnancy; or

(ix) Women who are known to be, or who are likely to be, carriers of an X-linked recessive disorder.

(x) Covered Services include genetic testing of heritable disorders as Medically Necessary when the following conditions are met:

(A) The results will directly impact clinical decision-making and/or clinical outcome for the individual;

(B) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(C) One of the following conditions is met:

(D) The Participant demonstrates signs/symptoms of a genetically-linked heritable disease, or

(E) The Participant or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically-linked heritable disease.

(xi) Additional genetic testing will be covered with regard to Federal or state mandates.

(xii) In the absence of specific information regarding advances in the knowledge of mutation characteristics for a particular disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the Participant.

(xiii) Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology, or mandated by federal or state law.

(n) *Gender reassignment surgery*. Covered Services include Medically Necessary gender reassignment surgery and related services, including pre- and post-surgical hormonal therapy. Prior Authorization is required for gender reassignment surgery. Gender reassignment surgery is the irreversible component of a treatment regime for gender dysphoria which also includes psychotherapy and hormone therapy. "Gender dysphoria" is defined as severe discomfort or distress that is caused by a discrepancy between an individual's gender identity and the gender assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Gender reassignment surgery may be considered Medically Necessary when all of the following criteria are met.

(i) The individual must:

(A) Have persistent, well-documented gender dysphoria;

(B) Be at least 18 years old; and

(C) Have the capacity to make a fully informed decision and to consent for treatment.

(D) If significant medical or mental health concerns are present, documentation must support that they are reasonably well controlled.

(ii)

(A) Requirements for mastectomy for female-to-male patients: One referral letter from a qualified mental health Professional. Note that hormone therapy is not a prerequisite to mastectomy.

(B) Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female reassignment) or genital reconstructive surgery (vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and erectile prosthesis in female-to-male; penectomy, vaginoplasty, labiaplasty and clitoroplasty in male-to-female):

(C) Two referrals from two separate qualified mental health Professionals. One therapist may be in a purely evaluative role;

(D) At least 12 months of continuous hormone therapy as appropriate to the individual's gender goals (unless the individual has a medical contraindication or is otherwise unable or unwilling to take hormones); and

(E) Twelve months of living in a gender role that is congruent with the individual's gender identity across a wide range of life experiences and events that may occur throughout the year.

(iii) Surgery or medical procedures done to enhance the physical appearance, or to more closely meet secondary sex characteristics of the reassigned gender, are considered Cosmetic and not Medically Necessary. Excluded cosmetic procedures, in addition to those listed in Section 10 of Part 4, include but are not limited to:

(A) Calf implants

(B) Cheek/malar implants

(C) Chin/nose implants

(D) Jaw shortening/sculpturing/facial bone reduction

(E) Nipple/areola reconstruction

(F) Nose implants

(G) Pectoral implants

(H) Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics

(I) Thyroid cartilage shaving

(J) Voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords)

(K) Voice therapy/voice lessons.

(o) *Home Health Care.* Medically Necessary home health care is covered if such care is provided by an organization or Professional licensed by the state to render home health services. Such care will not be available if it is substantially or primarily for the Participant's convenience or the convenience of a caregiver. Home care is covered in the home only on a part-time and temporary basis and to the extent that such care is performed by a licensed or registered nurse or appropriate therapist. See the section entitled "Other Services and Supplies" for coverage for other Home Health Care services.

(p) *Infertility Treatment.* Medically Necessary services to diagnose problems of infertility are covered for one workup per year up to three evaluations per lifetime. Up to six cycles of artificial insemination are covered per lifetime for covered members. For the covered

female, services include the preparation of the sperm and insemination, provided that the sperm has not been purchased or the donor compensated for his biological material or services, and that the donor has benefits under Hometown Health, costs related to the actual insemination of a non-covered person, are not covered under the terms of this benefit plan.

The following services are not covered:

(i) All other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) except services directly related to artificial insemination services up to the maximum benefit limit. This includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy.

(ii) The promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; maternity services related to a Participant serving in the capacity of a surrogate mother, sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval;

(iii) Any services related to a Participant serving in the capacity of a surrogate mother, including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the Participant's ability to become pregnant or to carry a pregnancy to term, or maternity services; and

(iv) Any payment made by or on behalf of a Participant who is contemplating or has entered into a contract for surrogacy to a Provider or individual related to any services potentially included in the scope of surrogacy services described above.

(q) *Mastectomy reconstructive Surgery.* Breast reconstructive surgery and the internal or external prosthetic devices are covered for Participants who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the Physician and the Participant.

(i) Subject to all the terms and conditions of this Plan, if a covered mastectomy or other breast cancer treatment is performed, the Plan will also provide coverage for:

(A) All stages of reconstruction of the breast on which the mastectomy has been performed;

(B) Surgery and reconstruction of the other breast to produce a symmetrical structure;

(C) Prostheses; and

(D) Physical complications for all stages of mastectomy, including lymphedemas.

(ii) If reconstructive surgery is begun within three years after a mastectomy, the amount of the benefits for that surgery will equal the amounts provided for in the Plan at the time of the mastectomy. If the surgery is begun more than three years after the mastectomy, the benefits provided are subject to all the terms, conditions, and exclusions contained in the Plan at the time of reconstructive surgery.

(r) *Maternity care and care of newborns.* Medically Necessary services for pregnant Participants are covered, including prenatal and postpartum care, related delivery room and ancillary services and newborn care. Newborn care includes care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of newborn to and from the nearest facility staffed and equipped to treat the newborn's condition.

(i) Notwithstanding anything in this Plan to the contrary, a Participant does not need Prior Authorization from the Plan or from any other person in order to obtain access to obstetrical or gynecological care from a Professional in our Network who specializes in obstetrics or gynecology. The Professional, however, 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 Professionals who specialize in obstetrics or gynecology, go to www.hometownhealth.com or contact our customer services.

(ii) Notwithstanding anything in this Plan to the contrary, in the case of a person who has a child enrolled in coverage, the Plan will permit such person to designate any pediatrician as a primary care physician if such pediatrician is a Participating Provider.

(iii) Services that are not covered include:

(A) Amniocentesis to the extent that it is performed to determine the sex of the child.

(B) Non-newborn circumcisions after eight weeks of age unless Medically Necessary and Prior Authorized.

(s) *Medical care*. Medically Necessary medical care and services, performed by a Physician or other Professional on an inpatient and outpatient basis, are covered, including:

(i) Office visits and consultations;

(ii) Hospital and skilled nursing facility services;

(iii) Ambulatory surgical center services;

(iv) Home health care services;

(v) Surgery; and

(vi) Other Professional services.

(t) *Mental health services*. Medically Necessary mental health services provided by a Physician, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, Physician assistant, or other qualified mental health care Professional are covered.

(u) *Oral surgery, dental services, and Temporomandibular Joint Disorder*. Medically Necessary oral surgery procedures are covered (inpatient or outpatient) related to the following:

(i) Accidental Injury to the jaw bones or surrounding tissues when the Injury occurs and the repair takes place while a Participant. Services must commence within 90 days after the accidental Injury. (Services that commence after 90 days are not covered.);

(ii) Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth;

(iii) Non-dental surgical procedures and hospitalization required for newly born and children placed for adoption or newly adopted to treat congenital defects, such as cleft lip and cleft palate;

(iv) Repair and restoration of sound and natural teeth;

(v) Extraction of teeth when related to radiation therapy or in advance of an organ transplant (other than a corneal transplant);

(vi) Medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including treatment of fractures;

(vii) Temporomandibular Joint Disorder (TMJ) and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures.

(viii) Dental general anesthesia for a dependent child when services are rendered in a Hospital or outpatient surgical facility, when enrolled dependent child is being referred because, in the opinion of the dentist, the child:

(A) Is under 18 and has a physical, mental, or medically compromising condition;

(B) Is under 18 and has dental needs for which local anesthesia is ineffective because of an Acute infection, an anatomic anomaly or an allergy; or

(C) Is under age five.

(ix) Prior Authorization is required for dental general anesthesia in a Hospital or outpatient surgical facility. Dental anesthesiology services are covered only for

procedures performed by a qualified Specialist in pediatric dentistry, a dentist educationally qualified in a recognized dental specialty for which Hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate Hospital training to be granted Hospital privileges.

(x) Only the services and supplies described above are covered, even if the condition is due to a genetic, congenital, or acquired characteristic. Exclusions include:

(A) Except as described above as an inclusion, services involving treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of Injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; and repairs and restorations except for appliances that are Medically Necessary to stabilize or repair sound and natural teeth after an Injury as set forth above;

(B) Dental and or medical care including mandibular or maxillary surgery, 01ihodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth above;

(C) Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; or

(D) Other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

(v) *Orthopedic devices and prosthetic devices*. Coverage for orthopedic devices is limited to Medically Necessary braces for problems requiring complete immobilization or for support, or if the braces are custom fitted or have rigid bar or flat steel supports and stays, splints, devices for congenital disorders, post and pre-operative devices.

(i) One Medically Necessary prosthetic device including repair and replacement once every three years, approved by the Centers for Medicare & Medicaid, is covered for each missing or non-functioning body part or organ.

(ii) Coverage is limited to:

(A) Devices that are required to substitute for the missing or non-functioning body part or organ;

(B) Devices provided in connection to an Illness or Injury that occurred subsequent to your effective date of coverage;

(C) Adjustment of initial prosthetic device; and

(D) The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.

(w) *Ostomy care supplies*. Coverage is provided for Medically Necessary care and supplies after colon, ileum, or bladder surgery to assist in carrying on normal activities with a minimum of inconvenience. Limited to 30 days of therapeutic supplies per month.

(x) *Podiatry services*

(i) Podiatry services are covered for the Medically Necessary treatment of Acute conditions of the foot such as infections, inflammation, or Injury and other foot care that is disease related.

(ii) The following services are not covered:

(A) Non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and Chronic foot strain.

(B) Routine foot care.

(y) *Preventive Services*.

(i) Covered preventive services include but are not limited to:

(A) Periodic physical examinations and routine immunizations;

(B) Routine gynecologic examination (one per calendar year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination;

(C) Screening mammograms including an initial baseline mammogram for female Participants 35-39 and annually for women 40 years of age or older;

(D) Well-baby care, including immunizations in accordance with the American Academy of Pediatrics and other federal agencies;

(E) Prostate and colorectal cancer screening in accordance with:

(1) The guidelines concerning such screening that are published by the American Cancer Society or

(2) Other guidelines or reports concerning such screening that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data.

(F) Influenza, pneumovax, haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, and tetanus immunizations; and

(G) Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.

(ii) Notwithstanding anything to the contrary in this Plan, the Plan will cover the following services without any Participant cost-sharing requirements if such services are provided by a Participating Provider:

(A) Preventive services described in the Public Health Service Act, Section 2713 (a) (as amended by the Patient Protection and Affordable Care Act).

(B) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, provided that, with regard to breast cancer screening, mammography, and prevention, the current recommendations of the United States Preventive Services Task Force will be the most current other than those issued in or around November 2009;

(C) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(D) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services; and

(E) With respect to women, such additional preventive care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

(z) *Radiation therapy.* Medically Necessary Professional services related to radiation therapy are covered.

(aa) *Short-term rehabilitative therapy*. Coverage is provided for Medically Necessary physical, speech, occupational, cardiac, and pulmonary therapy rehabilitation services that are performed by a Physician or by a therapy Provider licensed in accordance with state regulations for that therapy discipline. Long-term physical therapy and long-term rehabilitative services for Acute conditions evolving into conditions present after 90 days or for Chronic conditions are not covered unless an Acute event has aggravated the Chronic condition.

(bb) *Skin lesions.* Coverage is provided for Medically Necessary removal of skin lesions and related pathological analysis of such lesions.

(cc) *Medical Pharmacy*. This benefit includes the distribution, administration, and/or supply of pharmaceuticals and immunizations, frequently in conjunction with other services, that are provided at a Medical Pharmacy. To the extent benefits are payable under the Prescription Drug Coverage provisions of this SPD, no benefits are payable under this provision.

(i) Medically Necessary immunizations, biologics, injectables, or other special pharmaceuticals, and contraceptive diaphragms (one device per a 12-month period, unless otherwise prescribed by a participating Physician) distributed, administered, or supplied by a Medical Pharmacy (except as described below) are covered.

(ii) Special pharmaceuticals, which include injectables, oral medications, and medications given by other routes of delivery, may be delivered in any setting. Special pharmaceuticals are pharmaceuticals that typically have a cost greater than $200 per dosage unit or per prescription. The Plan maintains and updates on an ongoing basis a list of special drugs classified as special pharmaceuticals, which may be found on our website at www.hometownhealth.com. Special pharmaceuticals may have a separate Out-Of-Pocket Maximum. Copayments for special pharmaceuticals do not apply toward Out-Of-Pocket Maximum.

(iii) Immunizations related to foreign travel or employment are excluded.

(dd) *Spinal manipulations(non-surgical)*. Coverage is provided for up to 20 visits per calendar year and a maximum of 100 visits per lifetime for Medically Necessary spinal manipulations and adjustments, except for treatment for Chronic or recurring conditions. Spinal manipulation and adjustment means the detection, treatment, and correction of structural imbalance, subluxation, or misalignment of the vertebral column in the human body, for the purpose of alleviating pressure on the spinal nerves and its associated effects related to such structural imbalance, misalignment, or distortion, by physical or mechanical means.

(ee) *Transplant services*.

(i) Medically Necessary organ transplants at a contracted or Hometown Health approved facilities are covered at the Preferred benefit level when you are the organ recipient in the following cases:

(A) Bone marrow

(B) Cornea,

(C) Heart

(D) Heart and lung

(E) Intestinal and liver

(F) Kidney

(G) Liver

(H) Lung

(I) Pancreas

(J) Pancreas and kidney,

(K) Stem cell.

(ii) Organ transplants are only covered where the organ donor's suitability meets the OPTN/UNOS (Organ Procurement and Transplantation Network/United Network for Organ Sharing) donor evaluation and guideline criteria, when applicable.

(iii) Coverage for related transplant services are limited to:

(A) Tests necessary to identify an organ donor;

(B) The reasonable Expense of acquiring the donor organ;

(C) Transportation of the donor organ (but not the donor), and life support where such support is for the sole purpose of removing the donor organ;

(D) Storage costs of an organ, but only as part of an authorized treatment protocol; and

(E) Follow-up care.

(iv) Services excluded from coverage include, but are not limited to:

(A) Services provided at a facility that the Plan does not designate;

(B) Services provided to an organ donor;

(C) Services provided in connection with purchasing or selling organs;

(D) Transplants utilizing any animal organs;

(E) Any transportation of the donor (as opposed to transportation of the donor organ only);

(F) Any expenses associated with an organ transplant where an alternative remedy is available;

(G) Artificial heart implantation;

(H) Services for which government funding or other insurance coverage is available;

(I) Any expenses for transportation, lodging, and meals for services associated with the transplant including evaluations and the transplant and post-transplant periods for the donor, donor's family, recipient, or recipient's family; and

(J) Tissue transplants (whether natural or artificial replacement materials or devices are used) or oral implants, including the treatment for complications arising from tissue or organ transplants or replacement, except as described above.

(ff) *Hospital, Skilled Nursing Care, and Services in an Outpatient Surgical Center*.

(i) Inpatient Care. Medically Necessary inpatient Hospital care is covered. Services include, but are not limited to:

(A) Services for medical conditions treated in an Acute care Hospital inpatient environment;

(B) Semi-private room and board (private room when Medically Necessary);

(C) General nursing care facilities, services, and supplies on an inpatient basis;

(D) Diagnostic services that are provided in a facility, whether such facility is a Hospital or a freestanding facility (see "Other Services and Supplies for related Covered Services);

(E) Surgical and obstetrical procedures, including the services of a surgeon or Specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care;

(F) Maternity and newborn care for up to 48 hours of inpatient care for a mother and her newborn child following a vaginal delivery and up to 96 hours of inpatient care for a mother and her newborn child following a Cesarean delivery. The time-periods will commence at the time of the delivery. Any decision to shorten the length of inpatient stay to less than those time-periods will be made by the attending Physician after conferring with the mother.

(G) Inpatient, short-term rehabilitative services, limited to treatment of conditions that are subject to significant clinical improvement over a continuous 60-day period from the date inpatient therapy commences in a distinct rehabilitation unit of a Hospital, skilled nursing facility, or other facility approved by the Plan (limited to 60 days per calendar year);

(H) Inpatient alcohol and substance abuse rehabilitation services in a Hospital, residential treatment facility, or day treatment program; and

(I) Inpatient mental health services.

(ii) Outpatient Care.

(A) Medically Necessary outpatient Hospital or outpatient surgical center care is covered. Services furnished in a Hospital's or outpatient surgical center premises are covered, including use of a bed and periodic monitoring by a Hospital's nursing or other staff that are Medically Necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital. If a Hospital intends to keep a patient in observation status for more than 48 hours, observation status will become an inpatient admission for administration of benefits.

(B) Outpatient services include, but are not limited to:

(1) Services for medical conditions treated in an Acute care Hospital outpatient environment;

(2) Semi-private room and board (private room when Medically Necessary) if patient is in observation status;

(3) General nursing care facilities, services, and supplies on an outpatient basis;

(4) Diagnostic services that are provided in a facility, whether such facility is a Hospital or a freestanding facility;

(5) Surgical and obstetrical procedures, including the services of a surgeon or Specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care;

(C) Outpatient, short-term rehabilitative services;

(D) Outpatient alcohol and substance abuse rehabilitation services in a Hospital, Hospital residential treatment facility, or day treatment program; and

(E) Outpatient mental health services.

(iii) Also covered is Medically Necessary short-term outpatient rehabilitative services for:

(A) Short-term speech, physical, and occupational rehabilitative therapy (limited to 60 visits for all modalities of therapy combined per calendar year) and

(B) Services for cardiac rehabilitation and pulmonary rehabilitation (limited to 60 visits/sessions per calendar year for all modalities of therapy combined.).

(C) Medically Necessary services such as radiation therapy and chemotherapy (including chemotherapy drugs), are covered to the extent that such services are delivered in the most appropriate clinical manner and setting as part of a treatment plan.

(D) Medically Necessary care at a skilled nursing facility (limited to 100 days per calendar year) for non-Custodial Care is covered. A skilled nursing facility is a facility that is duly licensed by the state of Nevada and/or federal government and that provides inpatient skilled nursing care, rehabilitation services, or other related health services that are not custodial or convenience in nature. Skilled nursing care includes Medically Necessary services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse.

(E) Prior care in a Hospital is not required before being eligible for coverage for care in a skilled nursing facility.

(iv) Services that are not covered under this benefit include:

(A) Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution;

(B) Private duty nursing and private rooms in an inpatient setting;

(C) Personal, beautification, or comfort items for use while in a Hospital or skilled nursing facility; and

(D) Services related to psychosocial rehabilitation or care received as a custodial inpatient.

(gg) *Emergency Services*

(i) Medically Necessary medical and/or Hospital services are covered in the case of an Emergency.

(ii) Services must be provided at a contracted facility unless the time requirement to reach one of our Providers would result in a significant risk of permanent health damage.

(iii) Unanticipated complications of pregnancy or premature delivery are covered outside our Service Area. Services furnished by a Physician, oral surgeon, or Hospital or Emergency facility personnel for Covered Services are covered during the Emergency.

(iv) Emergency medical and Hospital services (inside or outside our Service Area) are limited to situations that require immediate and unexpected treatment. You should notify our customer services department as soon as possible following receiving Emergency services. If you are outside our Service Area at the time of your Emergency, you should notify our customer services department as soon as possible upon your return to our Service Area to avoid a denial of your claim.

(v) Coverage at the Renown benefit level will be limited to situations in which care is required immediately and unexpectedly.

(vi) Notwithstanding anything in this Plan to the contrary, coverage for Emergency services will be provided:

(A) Without requiring a Prior Authorization, even if the emergency services are provided out-of-network, without regard to whether the provider furnishing the emergency services is a Participating Provider,

(B) If the Emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency services received from Participating Providers;

(C) If the Emergency services are provided out-of-Network, by complying with the cost sharing requirements promulgated pursuant to the Affordable Care Act; and

(D) Without regard to any other term or condition of the coverage other than the exclusion of or coordination of benefits, an affiliation or waiting period permitted under applicable federal law, or applicable cost-sharing.

(vii) Medically Necessary Emergency medical care is available through participating Physicians seven days a week, 24 hours a day.

(viii) Medically Necessary Emergency services out of our Service Area will be covered. Out- of-area Emergency services are provided only if the Plan is notified before the receipt of those services or as soon as possible after such Emergency services, but no more than 24 hours after onset of the Emergency, except as provided in this section.

(ix) Extended notification. If you are unable to contact the Plan before you receive Emergency medical services or within 24 hours of the Emergency due to shock, unconsciousness, or otherwise, you must, at the earliest time reasonably possible, contact our customer services department to provide the Plan with information about the event and relevant circumstances.

(x) Follow-up care (outside our Service Area/non-contracted facility). Continuing or follow-up treatment for an Emergency service outside of our Service Area or from a non-Network facility is limited to care required before you can, without harmful or injurious consequences, return to our Service Area and receive care from Participating Providers as determined by the Plan. Benefits for continuing or follow-up treatment(s) are otherwise covered only in our Service Area from Participating Providers, subject to all provisions of this Plan. Routine or non-Emergency follow-up care at a non-Participating Provider emergency room facility is not covered.

(hh) *Urgent Care Services*

(i) Medical care and notification.

(A) Medically Necessary medical care on an Urgent Care basis is available through participating Physicians seven days a week. Medically Necessary out-of-area Urgent Care services are also covered.

(B) Out-of-area elective or specialized care required due to circumstances that could reasonably have been foreseen prior to departure from our Service Area is only covered as set forth in your Plan-specific Summary of Benefits.

(ii) Follow-up care if temporarily outside our Service Area. Continuing or follow-up care for Urgent Care is limited to care required before you can, without medically harmful or injurious consequences, return to our Service Area to receive services from Participating Providers as determined by the Plan. Routine follow- up care is not a covered Urgent Care service. You should notify our customer services department upon your return to our Service Area to avoid a denial of your claim.

(iii) Limitations.

(A) Urgent Care services obtained at a Hospital emergency facility may have a maximum benefit limit and/or a higher Copayment. Please refer to your Summary of Benefits.

(B) All Urgent Care services obtained while in our Service Area must be through a contracted Urgent Care Provider. Urgent Care services obtained from a non-contracted, in-Service Area Provider will only be covered in accordance with the applicable Summary of Benefits.

(ii) *Other Services and Supplies*

(i) Ambulance services. Ambulance services are covered if the services are Medically Necessary and they are:

(A) Provided in an Emergency or

(B) Provided in a non-Emergency setting with Prior Authorization.

(ii) Durable medical equipment. Coverage is provided for the purchase, rental, repair, or maintenance of durable medical equipment prescribed by a Provider for a Medically Necessary condition other than kidney dialysis. Durable medical equipment is equipment that:

(A) Can withstand repeated use,

(B) Is not disposable,

(C) Is appropriate for use in the home, and

(D) Is not useful in the absence of an Illness or Injury. Durable medical equipment includes, but is not limited to:

(iii) Oxygen equipment all oxygen and oxygen related equipment, except for oxygen while traveling on an airline),

(iv) Wheelchairs,

(v) Hospital beds,

(vi) Glucose monitors (although benefits may be available under the Prescription Drug Coverage provisions of Section 6), and

(vii) Warning or monitoring devices for infants (defined as a child 24 months old or less) suffering from recurrent apnea is limited to 90 days.

(viii) Coverage will be based on an amount equal to the generally accepted cost of durable medical equipment that provides the Medically Necessary level of care at the lowest cost. In determining our liability, the Plan will be guided by nationally established standards of the rental or purchase of such equipment.

(ix) Items not covered under this benefit include, but are not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, hearing aids, and any other primarily non-medical equipment, except as otherwise covered and described within this Plan.

(x) Also excluded is exercising equipment, vibratory or negative gravity equipment, swimming or therapy pools, spas, and whirlpools (even if recommended by a Professional to treat a medical condition).

(jj) *Enteral formulas and special food products*.

(i) Enteral formulas and special food products are covered if they are Medically Necessary for the treatment of an inherited metabolic disease. An inherited metabolic disease is a disease caused by an inherited abnormality of the body chemistry of a person characterized by congenital defects or defects arising shortly after birth resulting in deficient metabolism, or malabsorption originating from, of amino acid, organic acid, carbohydrate, or fat. Inherited metabolic diseases do not include obesity. Special food products do not include foods that are naturally low in protein.

(ii) Special food products are only covered if they are Medically Necessary and specially formulated to have less than one gram of protein per serving and are consumed under the direction of a Physician for the Medically Necessary dietary treatment of an inherited metabolic disease.

(iii) Special formulas, food supplements, or special diets including, but not limited to, total parenteral nutrition, except for Acute episodes, are not covered.

(kk) *Home health care*.

(i) Home health care covered under this section includes skilled nursing care, therapies, and other health related services provided in the home environment for other than convenience for patient or patient's family, personal assistance, or maintenance of activities of daily living or housekeeping. Covered home health care services under this part include home health care provided by a Professional as the nature of the Illness dictates.

(ii) Excluded from coverage as home health care are:

(A) Personal care, Custodial Care, Domiciliary Care, or homemaker services;

(B) In-home services provided by certified nurse aides or home health aides;

(C) Over-the-counter medical equipment, over-the-counter supplies, or any prescription drugs, except to the extent that they are covered under Part 6, Prescription Drug Coverage; or

(ll) *Hospice services*.

(i) The following hospice care services are covered for Participants with a life expectancy of six months or 185 days or less as certified by his or her Provider (limited to a lifetime benefit maximum of 185 days):

(A) Part-time intermittent home health care services totaling fewer than eight hours per day and 35 or fewer hours per week.

(B) Outpatient counseling of the Participant and his or her immediate family (limited to six visits for all family members combined if they are not otherwise eligible for mental health benefits). Counseling must be provided by:

(C) A psychiatrist,

(D) A psychologist, or

(E) A social worker.

(ii) Participants who are eligible for mental health benefits should refer to the applicable Summary of Benefits to determine coverage.

(iii) Respite care providing nursing care for a maximum of eight inpatient respite care days per calendar year and, 37 hours per calendar year for outpatient respite

care services. Inpatient respite care will be provided only when determined that home respite care is not appropriate or practical.

(iv) Medically necessary mental health services may be covered under this plan in addition to the outpatient counseling benefits describe above.

(mm) *Kidney dialysis services*. Kidney dialysis services and related therapeutic services and supplies, (e.g., epogen) are not if covered by Medicare or other federal or state programs, other than the Medicaid program.

(nn) *Lab and diagnostic services*. Coverage is provided for Medically Necessary laboratory and diagnostic procedures, services, and materials, including:

(i) Diagnostic x-rays;

(ii) Fluoroscopy;

(iii) Electrocardiograms; and

(iv) Laboratory tests.

(v) Coverage is also provided for other laboratory and diagnostic screenings as well as Physician services related to interpreting such tests.

5.02 Exclusions. The following services and benefits are excluded from coverage. Additional exclusions that apply to only a particular service or benefit are listed in the description of that service or benefit.

(a) Services not Medically Necessary or not required in accordance with accepted standards of medical practice or applicable law are excluded.

(b) Charges for care or services provided before the effective date or after the termination of coverage are excluded.

(c) Any loss, Expenses, or charges resulting from the Participant's participation in a riot or Criminal Act; and losses related to an act of war, insurrection, or terrorism are excluded.

(d) Testing and treatment for educational disorders, non-medical ancillary services such as vocational rehabilitation, work-hardening programs, and employment training and counseling, are excluded, including services rendered by or billed by a school or member of its staff.

(e) Care for military service-connected disabilities and conditions for which you are legally eligible to receive from governmental agencies and for which facilities are reasonably accessible to you are excluded.

(f) Care for conditions that federal, state, or local law requires be treated in a public facility, care provided under federally or state funded health care programs (except the

Medicaid program), care required by a public entity, care for which there would not normally be a charge are all excluded.

(g) Routine examinations primarily for insurance, immigration, travel, licensing, school sports, adoption purposes, employment, and other third-party physicals are excluded.

(h) Expenses for medical reports, including presentation and preparation are excluded.

(i) Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, and other services including hospitalizations or Partial Hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless determined that such services are independently Medically Necessary. Laboratory and other diagnostic testing provided in connection with this exclusion are also excluded.

(j) Cosmetic surgery or procedures are excluded. Cosmetic surgery generally includes any plastic or reconstructive surgery or medical procedure done primarily to improve the appearance of any portion of the body or restore bodily form without materially correcting a bodily malfunction.

(k) Excluded procedures include:

(A) Cosmetic surgery, including but not limited to surgery for sagging or extra skin; any augmentation or reduction procedures; electrolysis; liposuction; liposculpting; body contouring or recontouring to remove excess skin on any part of the body including but not limited to: tummy tucks, belt lipectomies, breast reductions or lifts;

(B) Any off-labeled use of growth hormone;

(C) Cosmetic laser treatments, rhinoplasty and associated surgery, epikeratophakia surgery, kerato-refractive eye surgery including but not limited to implants for correction of presbyopia, correction of facial or breast asymmetry (except that breast asymmetry will be provided pursuant to coverage as provided in this Plan for mastectomy benefits), treatment of male-pattern baldness, electrolysis, waxing or other methods of hair removal, or hair treatment, keloid scar therapy, any procedures utilizing an implant that cannot be expected to substantially alter physiologic functions are additionally not covered under this Plan; and

(D) Cosmetics, dietary supplements, anti-aging treatments (even if FDA-Approved for other clinical indications), vitamins, diet pills, health or beauty aids, vitamin B-12 injections (except for pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (except as otherwise covered and described within this Plan).

(ii) Additional cosmetic surgery or medical procedures exclusions include:

(A) Complications resulting from excluded cosmetic surgery;

(B) Complications of medical procedures that result in conditions that affect the appearance of the body without commensurate impairment of bodily function;

(C) Cosmetic treatment or service related complications, insertion, removal or revision of breast implants (including complications) unless provided post mastectomy;

(D) Treatment for the removal, ablation, injection, or destruction of varicose veins;

(l) Psychological and physical factors including but not limited to self-image, difficult social or peer relations, embarrassment in social situations, inability to exercise or participate in recreational activities comfortably, or impact on ability to perform one's job duties; and

(m) Charges that result from appetite control, food addictions, eating disorders (except documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by the Plan and present significant symptomatic medical problems) or any treatment of obesity, unless otherwise provided in this Plan.

(n) All Experimental or Investigational medical, surgical, or other health care procedures and all transplants are excluded except as otherwise described within this Plan. The Plan will consider a procedure or treatment as Experimental or Investigational at our discretion:

(i) If outcome data from randomized controlled clinical trials, recommendations from consensus panels, national medical associations, or other technology evaluation bodies and from authoritative, peer-reviewed US medical or scientific literature is insufficient to show that the procedure or treatment is:

(ii) Safe, effective, or superior to existing therapy, or

(iii) Conclusive in that the evidence demonstrates that the service or therapy improves the net health outcomes for total appropriate population for whom the service might be rendered or proposed over the current diagnostic or therapeutic interventions, even in the event that the service, drug, biological, or treatment may be recognized as a treatment or service for another condition, screening, or Illness;

(iv) If the procedure or treatment has not been deemed consistent with accepted medical practice by the National Institutes of Health, the Food and Drug Administration, or Medicare;

(v) When the drug, biologic, device, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the Food and Drug Administration or any other state or federal regulatory agency, and such final approval has not been granted for that particular indication, condition, or disease;

(vi) When a nationally recognized medical society states in writing that the procedure or treatment is Experimental; or

(vii) When the written protocols used by a facility performing the procedure or treatment state that it is Experimental.

(viii) Coverage for clinical trials may still be covered even if the procedure or treatment is otherwise Experimental or Investigational. Refer to the Clinical Trials section of this Plan for more information.

(o) Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution are excluded.

(p) Travel expenses, accommodations, travel insurance are not covered. Oxygen provided while traveling on an airline is excluded as are portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements.

(q) Any services received outside the United States are excluded unless deemed to be urgent or Emergency care.

(r) The fitting and cost of hearing aids including both surgical implanted bone conduction hearing aids and externally worn hearing aids are excluded regardless of the etiology of the deafness.

(s) Except as otherwise provided in this Plan, drug, medicines, procedures, services, and supplies, for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.

(t) Termination of pregnancy is excluded, other than medically indicated abortions necessary to save the life of the mother.

(u) Services related to job, vocational retraining, or c9mmunity re-entry are excluded.

(v) Sleep therapy (except for central or obstructive apnea when Medically Necessary and with Prior Authorization), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electrosleep therapy, electronarcosis, massage therapy, and gene therapy are excluded.

(w) Therapies, psychological services, counseling, or tutoring services for Developmental Delay or learning disabilities are excluded except for the limits related to habilitative services.

(x) Treatment of mental retardation, Down syndrome, or autism (unless covered and described within this Plan) that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency is excluded.

(y) Care or treatment of marital or family problems, occupational, religious, or other social maladjustments, behavior disorders, situational reactions, and hypnotherapy is excluded.

(z) Prescription Drugs

(aa) Medically Necessary prescription drugs are only covered as set forth in this Plan under Part 6, Prescription Drug Coverage or under the Medical Pharmacy benefit.

(bb) Exclusions for prescription drugs under this Plan include, but are not limited to:

(i) Over-the-counter drugs, whether or not prescribed by a Physician;

(ii) Medicines and other substances not requiring a prescription even if ordered by a Physician;

(iii) Drugs consumed in a Physician's office other than immunizations, allergy serum, and chemotherapy drugs;

(iv) Self-injectable drugs are not covered except as otherwise covered and described within this Plan; and

(v) Prescription drugs purchased from outside of the United States except Canadian pharmacies licensed by the Nevada State Board of Pharmacy. (Licensed Canadian pharmacies are listed on the Nevada State Board of Pharmacy Web site at www.bop.nv.gov.)

(vi) Physician services, supplies, and equipment relating to the administration or monitoring of a prescription drug are excluded unless the prescription drug is a Covered Service or covered under Part 6, Prescription Drug Coverage.

(cc) Experimental, ecological, or environmental medicine is excluded, including, but not limited to the use of chelation or chelation therapy except for Acute arsenic, gold, mercury, or lead poisoning; orthomolecular substances; use of substance of animal, vegetable, chemical or mineral origin not FDA-Approved as effective for such treatment; electrodiagnosis; Hahnemannian dilution and succussion; prolotherapy, magnetically energized geometric patterns, replacement of metal dental fillings, laetrile, and gerovital.

(dd) Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or chiropractor's office, or at a retail location are excluded, unless otherwise specified in the description of Alternative Medicine benefits.

(ee) Charges related to the acquisition or use of marijuana are excluded, even if used for medicinal purposes.

(ff) Over-the-counter support hose or compression socks are excluded even if ordered by a Physician. (Custom hose that must be measured and made specifically for the patient will be covered only for the treatment of burns or lymphedema.)

(gg) Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses except as covered and described within this Plan; eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery); and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded.

(hh) Cryopreservation or storage charges for collection and storage of biologic materials for any purpose are excluded, including with respect to artificial reproduction.

(ii) Stress reduction therapy or cognitive behavior therapy for sleep disorders is excluded.

(jj) Coverage for human growth hormone or equivalent is excluded unless specifically covered and described within this Plan.

(kk) Barrier-free and other home modifications are excluded.

(ll) Services provided by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists are excluded (even if recommended by a Professional to treat a medical condition).

(mm) Religious or spiritual counseling is excluded.

(nn) Any services or supplies not specifically listed in this Plan as covered benefits, services, or supplies, including but not limited to charges for missed appointments, telephone calls, travel, transportation, or lodging.

(oo) Treatment of benign skin lesions that consist of destruction or removal by any surgical technique. Examples of benign skin lesions are:

(i) cavernous hemangiomas;

(ii) dermatofibromas;

(iii) warts (verruca vulgaris);

(iv) keloids;

(v) skin tags (acrochordon);

(vi) epidermal inclusion cysts;

(vii) sebaceous cysts; or

(viii) benign nevi.

(pp) Charges that are rendered by a member of the Participant's immediate family or person residing in the same household as the Participant.

(qq) Any services related to a Participant serving in the capacity of a surrogate mother, including but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the Participant's ability to become pregnant or to carry a pregnancy to term, or maternity services: and

(rr) Any payment made by or on behalf of a Participant who is contemplating or has entered into a contract for surrogacy to a Provider or individual related to any services potentially included in the scope of surrogacy services described above.

5.03 Limitations. If the provision of Covered Services provided under this Plan is delayed or rendered impractical due to circumstances not within our control, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Provider's personnel, or similar causes, the Plan will make a good faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and our Providers will render the Covered Services provided under this Plan insofar as practical and according to their best judgment; but the Plan and our Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

ARTICLE VI

CLAIMS PROCEDURES

In order to receive benefit payments, you must follow the rules and procedures as prescribed by the applicable Claims Administrator, and file a written claim application on the form furnished by the Claims Administrator together with any supporting documents and any required written authorizations.

6.01 Initial Claims.

The Claims Administrator will approve or deny your claim within the appropriate time period, depending on the type of claim involved:

(a) *Claims Involving Urgent Care* are claims which would seriously jeopardize your life or health or would cause severe pain (under a physician's opinion) which cannot be adequately managed if decided within the time frames of making non-urgent decisions.

(b) *A Claim Involving Urgent Care* will be decided within 72 hours after receipt of your claim by the Plan. If the Claims Administrator needs more information from you in order to make a determination on the claim, the Claims Administrator will notify you within 24 hours after receipt of your claim. You will have at least 48 hours from the receipt of such notice to provide the additional information to the Claims Administrator. If you have failed to follow the proper procedure for filing a Claim Involving Urgent Care, the Claims Administrator will contact

you within 24 hours following the failure. The Plan Administrator will contact you of the Plan's decision within 48 hours of receiving a completed claims application or 48 hours after the end of the time period you were given to complete your application.

(c) *Pre-service Claims* are claims made for benefits that require approval by the Plan prior to obtaining medical care.

(d) *A Pre-service Claim* will be decided within 15 days after receipt of your claim by the Plan. The Claims Administrator may extend the initial period by up to 15 days, provided the Administrator determines (1) an extension is necessary due to matters beyond its control, and (2) notifies you of such circumstances and the date it expects to render a decision prior to the end of the initial 15 day period. If you have failed to follow the proper procedure for filing a Pre-service claim, the Claims Administrator will contact you within five days following the failure. If the Claims Administrator needs more information from you in order to make a determination on the claim, the Claims Administrator will notify you of the information it needs, and you will have at least 45 days from the receipt of such notice to provide the information to the Claims Administrator.

(e) *Post-service Claims* are any claims for benefits which are not Pre-service claims.

(f) *A Post-service Claim* will be decided within 30 days after receipt of your claim by the Plan. The Claims Administrator may extend that period by up to 15 days, provided the Administrator determines (1) an extension is necessary due to matters beyond its control, and (2) notifies you of such circumstances and the date it expects to render a decision prior to the end of the 30 day period. If the Claims Administrator needs more information from you in order to make a determination on the claim, the Claims Administrator will notify you of the information it needs and you will have at least 45 days from the receipt of such notice to provide the information to the Claims Administrator.

(g) *Concurrent Care Decisions* are made where the Plan has approved an ongoing course of treatments to be provided over a period of time. If the Plan reduces or terminates the course of treatment, it will notify you in advance so that you will have sufficient time to appeal and obtain a determination on review before the ongoing benefit is reduced or terminated.

(h) In the case of a Claim Involving Urgent Care to extend a course of treatment beyond the original period of time or number of treatments, the claim will be decided within 24 hours after receipt of the claim, provided the claim was submitted to the Plan at least 24 hours before the expiration of the original period of time or number of treatments.

6.02 Notification of a Claims Decision.

If your claim for benefits is denied, in whole or in part, you will receive a written or electronic notice from the Claims Administrator informing you of the denial. The notice will be written in a manner calculated to be understood by you and shall include:

(a) The specific reason(s) for the denial,

(b) References to the specific plan provisions on which the benefit determination was based,

(c) A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeals,

(e) Whichever of the following that applies:

(i) if an adverse benefit determination is based on an internal rule, guideline, or protocol, then such rule will be provided or a statement that such rule was relied upon and that the rule will be provided free of charge upon request, or

(ii) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;

(iii) In the case of a Claim Involving Urgent Care, a description of an expedited review process applicable to your claim. In such a case, the benefit denial information above may be provided to you orally with written or electronic notice to follow in 3 days; and

(iv) The name of the appropriate Plan fiduciary to whom you may appeal the denial.

6.03 Appeals.

The Plan has two levels of appeal. First, if your claim for benefits is denied in whole or in part, you must appeal the denial in writing to the appropriate Plan representative listed in the denial letter you receive from the Plan. This Plan representative may be an individual employed by the Claims Administrator or another representative of the Plan appointed by the Plan Administrator. You will have 180 days from receipt of the written notice of denial of your initial claim to submit an appeal for a full and fair review of your claim. You may submit with your appeal any written comments, documents, records and any other information related to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. Additionally, any medical or vocational experts whose advice was obtained in the initial determination will be disclosed, even if their advice was not relied upon to make the initial determination.

The appropriate Plan representative deciding your appeal will take into account all the comments, documents, records and other information you submit to support the appeal without regard to whether it was submitted during the initial benefit determination. The appropriate Plan representative deciding your appeal is not involved in the initial benefit determination and the review on appeal will not afford any deference to the initial benefit determination.

If your claim is based in whole or in part on a medical judgment, the Plan representative deciding your appeal will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Health Care Professional consulted with will not be an individual who was consulted for the initial claim or who is the subordinate of any Health Care Professional who was initially consulted.

Finally, in the case of a Claim Involving Urgent Care, an expedited review process will be allowed which gives you the right to submit your appeal orally or in writing and which provides that the exchange of any information will be available by telephone, facsimile or similarly speedy method.

(a) How Long it Takes for the Plan to Review an Appeal.

The appropriate Plan representative deciding your appeal will notify you of the Plan's determination according to the type of claim involved:

(i) A Claim Involving Urgent Care will be decided within 72 hours after receipt of your request for review by the Plan.

(ii) A Pre-service Claim will be decided within 15 days after receipt of your request for review by the Plan.

(iii) A Post-service Claim will be decided within 60 days after receipt of your request for review by the Plan.

(b) Notification of Appeal Decision.

The Plan representative deciding your appeal will notify you of the decision in writing or electronically. If your claim is denied on appeal, the notice from the Plan will include the following:

(i) The specific reason(s) for the adverse determination and reference to the specific Plan provisions on which the decision was made;

(ii) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to your claim;

(iii) A statement that you have a right to bring an action under Section 502(a) of ERISA;

(iv) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, or a statement that a copy of such rule will be provided free of charge upon your request;

(v) If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment,

applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon your request; and

(vi) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation." One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency.

(c) Second Level of Appeal.

If your first level of appeal is denied by the appropriate Plan representative, you may appeal the denial to the Renown Appeals Committee, the Plan's named Plan fiduciary listed in the first level appeal denial letter you receive from the Plan. The Renown Appeals Committee will provide a full and fair review of the claim, your first appeal and the denial letters you received with respect to the claim for benefits. The contact information for the Renown Appeals Committee provided in the notification of denial of your first appeal and will not be the individual who made the original decision regarding the denial of your first appeal or a subordinate of such individual. The full and fair review will be subject to the same requirements and procedures for the first appeal.

(d) External Review Process for Certain Denied Claims.

The Plan has a standard External Review and an expedited External Review, which are described below. Both types of External Review apply only to (i) a benefit denial that involves medical judgment (such as an expense that is determined to be not medically necessary or effective, or is determined to be experimental or investigational); or (ii) a retroactive cancellation of coverage for reasons other than fraud, intentional misrepresentation, or failure to timely pay required premiums. External Review is not available if the denial is based on a decision that an individual fails to meet the eligibility requirements of the Plan.

If you wish to file a request for an External Review with the Plan, you must do so within four months after the date you receive notice of a final internal benefit denial.

Standard External Review

Within five business days following the date of receipt of the External Review request, the Plan will complete a preliminary review of the request to determine whether:

(i) You are (or were) covered under the Plan at the time the health care item or service was requested or, in the case of a post-service claim, were covered under the Plan at the time the health care item or service was provided;

(ii) The final internal benefit denial involves medical judgment that is subject to External Review.;

(iii) You provided all the information and forms required to process an External Review; and

(iv) You exhausted the Plan's internal appeal process, or the Plan failed to follow the significant internal claim and appeal requirements described above, with respect to your claim. (You may request a written explanation of any failure by the Plan to follow these requirements, and the Plan will provide an explanation within 10 days.)

Within one business day after completing the preliminary review, the Plan will send you a written or electronic notice. If the request is complete but not eligible for External Review, the notice will include the reasons the request is not eligible and contact information for the Employee Benefits Security Administration. If the request for External Review is not complete, the notice will describe the information or materials needed to make the request complete, and you may complete the request for External Review within the four month filing period or within the 48 hour period following the receipt of the notice, whichever is later.

If the request is complete and eligible for External Review, the Plan will assign an Independent Review Organization (IRO) to conduct the External Review.

IRO Procedures

The IRO will notify you in writing of the request's eligibility and acceptance for External Review. You may then submit in writing to the IRO, within ten business days following receipt of the notice, additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Upon receipt of the information you provide, the IRO will forward the information to the Plan within one business day. The Plan may reconsider its benefit denial, but this will not delay the External Review. If the Plan does not decide to reverse the benefit denial, the External Review will continue.

The IRO will review all of the information and documents timely received from you and from the Plan. If available and considered appropriate by the IRO, the IRO will also consider: (i) your medical records; (ii) the attending health care professional's recommendation; (iii) reports from appropriate health care professionals and other documents submitted by the Plan, you, or the your treating provider; (iv) the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law; (v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (vi) any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and (vii) the opinion of the IRO's clinical reviewers after considering the information that is available and considered appropriate by the clinical reviewers.

IRO Decision

The IRO will provide you and the Plan written notice of the final External Review decision within 45 days after it receives the request for External Review. The notice will include: (i) a general description of the reasons for the request for External Review, including enough information to identify the claim; (ii) the dates the IRO received the assignment and made its

decision; (iii) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision; (iv) a discussion of the principal reasons for the IRO's decision, including the rationale and any evidence-based standards that were relied on; (v) a statement that the IRO's decision is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to you; (vi) a statement that judicial review may be available to you; and (vii) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

To the extent that the IRO reverses a benefit denial, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

You may make a request for an expedited External Review with the Plan at the time you receive one of the following:

A benefit denial that involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

A final internal benefit denial, if you have a medical condition where the timeframe for completing a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal benefit denial concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

The Plan will determine whether your request meets the reviewability requirements immediately upon receipt of the request for expedited External Review. The Plan will immediately send you a notice of its eligibility determination that meets the requirements set forth above.

If your request is eligible for expedited External Review, the Plan will assign an IRO to your request. The Plan will provide all necessary documents and information considered in making the benefit denial to the IRO electronically or by telephone or facsimile or any other available quick method.

The IRO will consider available and appropriate information or documents as described above. The IRO will provide notice of its final External Review decision as quickly as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO will provide written confirmation of the decision to you and the Plan. The written notice will include the information described above.

6.04 Claims Deadline. Unless pursuant to applicable law, **a claim for benefits under this Plan must be made within one year after the date the expense was incurred that gives**

rise to the claim, unless such failure is due to the Participant's incapacity. It is the responsibility of the Participant to make sure this requirement is met.

ARTICLE VII
ERISA RIGHTS AND NOTICES

This Medical Program will provide benefits in accordance with the requirements of applicable laws, such as COBRA, HIPAA, HITECH, USERRA, GINA, MHPAEA, WHCRA and the No Surprises Act.

7.01 Notice of Rights Under the Mothers & Newborns Health Protection Act. Group health plans and health insurance issuers or third party administrators 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 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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

7.02 Notice of Women's Health & Cancer Rights Act. Group health plans, insurance companies, and health maintenance organizations offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

7.03 HIPAA Special Enrollment Rights. HIPAA requires that we notify you about your right to enroll in the Medical Program under "special enrollment rights" if you marry, acquire a new Dependent, or if you decline coverage under the plan for an eligible Dependent while other coverage is in effect and later the Dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event or as required by state or federal law (60 days if enrollment in or eligibility for, or loss of eligibility for Medicaid or CHIP). Coverage will begin no earlier than the date of enrollment, except in the case of coverage of a newborn.

7.04 Uniformed Services Employment and Reemployment Rights Act ("USERRA"). The Plan Administrator will also permit you to continue benefit elections as required under the USERRA and will provide such reinstatement rights as required by such law. The Plan Administrator will also permit you to continue benefit elections as required under any other applicable state law to the extent that such law is not preempted by federal law.

7.05 Military Caregiver Leave under FMLA. If you are the spouse, son, daughter, parent or next of kin (that is, nearest blood relative) of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty you are entitled to up to 26 weeks of leave in a single 12-month period to care for the service member. You can also take leave

to care for certain veterans with a serious illness or injury incurred or aggravated in the line of duty while on active duty and that manifested itself before or after the veteran left active duty. Military caregiver leave is also allowed to care for current service members with serious injuries or illnesses that existed prior to service and that were aggravated by service in the line of duty while on active duty. Military caregiver leave is available during a single 12-month period during which you are entitled to a combined total of 26 weeks of all types of FMLA leave. See U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, for Fact Sheets #28 and #28A, which provide further details on FMLA (http://www.dol.gov/compliance/laws/comp-fmla.htm).

7.06 Genetic Information Nondiscrimination Act of 2008 ("GINA") GINA prohibits the Plan from discriminating against you on the basis of genetic information in providing any the benefits included in the Welfare Programs. GINA generally prohibits the collection or use of genetic information (including family medical history information) by the Company, the Plan, or "business associate" of the Plan. One exception to this rule is that a minimum amount of genetic testing results may be used if necessary, to make a determination regarding a claims payment. GINA also permits the Plan to request, but not require, that you or your covered family members undergo a genetic test for research purposes or for a wellness program but only if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements.

Where GINA applies, genetic information is treated as PHI under HIPAA. The Company cannot request or require that you reveal whether you have ever had genetic testing. Neither can the Company require you to undergo a genetic test. The Company cannot use genetic information to set contribution rates or premiums.

7.07 No Surprises Act. The No Surprises Act is a Federal law that protects you from getting surprise medical bills from out of network providers unless you give written consent. A detailed notice regarding your rights to be protected from surprise billing will be posted with this SPD on the Company's internal benefits site.

7.08 Participant's Responsibilities. You and your covered Dependents are responsible for providing the Plan Administrator and the Claims Administrator with your current address. Any notices required or permitted to be given to you or your covered Dependents will be deemed given if it is mailed to the address you or your covered Dependent most recently provided by first class United States mail.

7.09 Right to Verification of Eligibility. The Plan Administrator may require you to provide information and documents necessary to determine you eligibility under the Plan as a condition for receiving benefits including but not limited to proof of Dependent status.

7.10 No Right to Employment. Nothing contained in this Plan will be construed as a contract of employment between the Company and you, or as a right of any employee to continue

in the employment of the Company, or as a limitation of the right of the Company to discharge any of its employees, with or without cause "at will".

ARTICLE VIII
STATEMENT OF ERISA RIGHTS

ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and if the group has 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the plan with the US Department of Labor.

- 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, if 100 or more participants) and updated Summary Plan Description.

- 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 a summary annual report.

Continue Group Health Plan Coverage

- Continue group health coverage for yourself and your covered family members if there is a loss of coverage under the Plan as a result of a qualifying event. You or your covered family members may have to pay for such coverage.

Foreign Language

This document contains a summary in English of your plan rights and benefits under the group health plan. If you have difficulty understanding any part of this document, contact the Plan Administrator indicated above.

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 interests 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 (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension/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 you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court but only after you have exhausted the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. No legal action can be brought to recover a benefit under the plan after three years from the deadline for filing claims. The deadline for filing claims is 90 days after the services are incurred.

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 US 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 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 Benefit Security Administration (EBSA) US 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 N.W., Washington, DC 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 at 1-866- 444-3727, logging on to www.dol.gov or contacting the EBSA field office nearest you.

ARTICLE IX
PLAN AMENDMENT AND TERMINATION

9.01 The Company reserves the right to amend, modify, or discontinue the Plan at any time and in any respect, including but not limited to, implementing a change in the amount or

percentage of premiums or cost that must be paid by the Participant. To the extent required by law, the Company will give Participants 60-days' written notice.

9.02 No Participant shall have any vested right to any benefits under the Plan, subject to any duty to bargain that may exist. The Company shall have the right to amend the Plan at any time and to any extent deemed necessary or advisable; provided, however, that no amendments shall have the effect of discriminatorily depriving, on a retroactive basis, you or your covered family members or beneficiaries, of any beneficial interest that has become payable prior to the date such amendment is effective; or have the result of diverting the assets of the Plan to any purpose other than those set forth in this Plan.

The Company shall promptly notify the Plan Administrator and all interested parties of any amendment adopted pursuant to this Section and shall execute any instruments necessary in connection therewith. An officer, as designated by the Company, may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

ARTICLE X
THIRD-PARTY LIABILITY AND COORDINATION OF BENEFITS

10.01 Maximum Benefits under All Plans. If you or your covered Dependents are also covered under one or more other plans and the sum of the benefits payable under all the plans involved will not exceed the eligible charges for such period as determined under this Plan. Benefits payable under another plan are included, whether or not a claim has been made.

10.02 For these purposes:

(a) "Claim Determination Period" means a Plan Year, and

(b) "Eligible Charge" means any necessary, reasonable, and customary item of which at least a portion is covered under this Plan, but does not include:

(i) Charges specifically excluded from benefits under this Plan that also may be eligible under any Other Plans covering the Covered Person for whom the claim is made

(ii) Charges related to retail or mail-order prescription drug claims which are administered by the Prescription Drug Manager for this Plan

(c) "Other Plan" means the following plans providing benefits or services for medical and dental care or treatment:

(i) Group insurance or any other arrangement for coverage for Employees in a group, whether on an insured or uninsured basis;

(ii) any other prepayment coverage, including health maintenance organizations ("HMOs"), Medicare, or Medicaid; or

(d) Vehicle insurance. When medical payments are available under any vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy Deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. For purposes of this Plan, in states with compulsory no-fault automobile insurance laws, each Employee will be deemed to have full no-fault coverage to the maximum available in that state, whether or not the Employee is in compliance with the law, or whether or not the maximum coverage is carried.

10.03 Determining Order of Payment. If you or your covered Dependents are covered under two or more health plans, the order in which benefits are paid will be determined is as follows:

(a) The Plan covering the Covered Person other than as an Eligible Dependent, for example as an Employee, member, subscriber, policyholder or retiree, pays benefits first. The Plan covering the Covered Person as an Eligible Dependent pays benefits second.

(b) If no Plan is determined to have primary benefit payment responsibility under (1), then the Plan that has covered the Covered Person for the longest period has the primary responsibility.

(c) A Plan that has no coordination of benefits provision will be deemed to have primary benefit payment responsibility.

(d) The Plan covering the parent of the eligible Dependent child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the year. The Plan covering the parent of an Eligible Dependent child pays second if the parent's birthday falls later in the year.

(e) In the event that the parents of the eligible Dependent child are divorced or separated, the following order of benefit determination applies:

(i) The Plan covering the parent with custody pays benefits first;

(ii) If the parent with custody has not remarried, then the Plan covering the parent without custody pays benefits second;

(iii) If the parent with custody has remarried, then the Plan covering the step-parent pays benefits second and the Plan covering the parent without custody pays benefits third; and

(iv) If a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the Plan covering that parent pays benefits first.

(f) The Plan covering the Covered Person as an Employee (or as that Employee's Eligible Dependent) pays benefits first unless the Employee is laid-off or retired. The Plan covering the Covered Person as a laid-off or retired Employee (or as a laid-off or retired Employee's Eligible Dependent) pays benefits second.

(g) The Plan covering a Covered Person as an Employee (or as an Eligible Dependent of the Employee) pays benefits first if such an individual is also being provided COBRA continuation coverage under another Plan, and such Other Plan pays benefits second for such an individual. Conversely, this Plan pays secondary benefits for any Employee who is provided COBRA continuation under this Plan and who also is covered simultaneously under another Plan as an Employee (or as an Eligible Dependent of an Employee). In the event of conflicting coordination provisions between this Plan and any Other Plan, this Plan will pay primary benefits for an individual only if this Plan has provided coverage for a longer period of time.

10.04 Facilitation of Coordination. For the purpose of Coordination of Benefits, the Claim Administrator:

(a) May release to, or obtain from, any other insurance company or other organization or individual any claim information and any individual claiming benefits under the Plan must furnish any information that the Plan sponsor may require.

(b) May recover on behalf of the Plan any benefit overpayment from any other individual, insurance company, or organization.

(c) Has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the Plan have been made by such organization.

10.05 Persons Covered by Medicare.

(a) A Covered Person who becomes entitled to medical benefit coverage under Medicare shall remain eligible for benefits under this Plan on the same terms and conditions as any other Covered Person. This Plan will coordinate benefits with Medicare in accordance with the rules of the Medicare Secondary Payor (MSP) Program as promulgated by the Centers for Medicare & Medicaid Services (CMS) as may be amended from time to time. The Medicare secondary payor rules under Social Security Act §1862(b) (42 U.S.C. §1395y(b)(5)), as may be amended from time to time, and applicable Federal regulations are hereby incorporated by reference and shall supersede any inconsistent provision(s) of this Plan. These rules will determine when this Plan will be the primary payer of covered Medical benefit expenses and when Medicare will be the primary payer.

(b) In the event that the Plan would otherwise be allowed (as in accordance with the Medicare secondary payor rules) to be a secondary payor of covered medical expense benefits for Covered Persons who are eligible for Medicare, but who have not applied for entitlement to Medicare Part A or Part B or who have applied for entitlement to Part A and/or Part B, but have chosen not to elect Part B, the Covered Person's benefits under this Plan will be determined on an assumptive basis, whereby benefits will be calculated as if Medicare provided reimbursement for the expenses being claimed.

10.06 Medicare Benefits End-Stage Renal Disease. Medicare benefits shall also be secondary to benefits under this Plan for a period of time not to exceed 30 consecutive months in

the case of a Covered Person where such Covered Person's eligibility for Medicare is due solely to end-stage renal disease.

10.07 Rights of Recovery and Direct Payment. The Employer has the right to recover from Other Plans or persons any payments made by the Plan which exceed those required by these provisions. The Employer also has the right to make direct payment to plans or persons of amounts paid by them which should have been paid by the Plan. Such payment will be deemed benefits under this Plan and will discharge the Employer's liability to the extent of the payment.

10.08 Eligibility for State Plan of Medical Assistance. In determining or making any payments for benefits of an individual as a Covered Person or covered Dependent, the fact that the individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

10.09 Acknowledgement.

(a) Upon accepting payment of benefits, you and your covered Dependents agree to do whatever is necessary to fully secure and protect, and nothing to prejudice, the Plan's right to subrogation. This action shall include, but not be limited to, providing the Employer with a lien to the extent of the benefits provided. The lien may be filed with the person whose act caused the injuries, their agent or a court having jurisdiction in the matter. You shall provide the Plan Administrator written notice of any and all demand letters, complaints and other claims made against any third party within ten (10) days of the date such demand letter, complaint or other claim is made against the third party. The written notice required under this Section 10,9 shall include a copy of such demand letter, complaint or other claim.

(b) The Plan shall have the right to reduce benefits otherwise payable by the Plan or recover benefits previously paid by the Plan to the extent any payments resulting from a judgment or settlement, or other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers, regardless of whether the payment is designated as payment for such damages, including, but not limited to, pain and/or suffering, loss of income, medical benefits or any other specified damages; or any other damages made or to be made by any person.

(c) The Plan's right to reduce or recover benefits shall not be reduced or otherwise affected by the amount of any attorneys' fees, court costs, or any other payment or obligation. Furthermore, the Plan shall not be responsible, without its written consent, for any fees or costs incurred by a Covered Person in pursuit of a claim against a third party.

(d) Notwithstanding anything to the contrary, the Plan shall have the right of first reimbursement out of any payment, damages, or other recovery described in this Section 10.09 even if the Covered Person was not made whole.

(e) If it is unclear whether third party liability exists with respect to a condition or occurrence which causes a Covered Person to incur medical expenses not in excess of five hundred dollars ($500), the Plan Administrator may, in its sole and absolute discretion, decide to not seek reimbursement from the Covered Person. Nevertheless, in the event that such expenses at any time exceed five hundred dollars ($500), the Plan Administrator shall investigate whether third

party liability exists, and, if the Plan Administrator determines that such third party liability exists, the Plan Administrator shall (i) impose a reduction of Plan benefits and (ii) seek reimbursement from the Covered Person or any other person for all such expenses.

ARTICLE XI
PRIVACY OF HEALTH INFORMATION

11.01 Will my Protected Health Information be kept confidential?

Federal regulations require the Plan to safeguard the privacy of your "Protected Health Information." However, as explained in Question 3 below, the Plan may use and disclose Protected Health Information, including your Protected Health Information, in some cases.

11.02 What is Protected Health Information?

Protected Health Information is data about a medical condition, treatment received, or payment for health care that also identifies the person it relates to.

11.03 When can the Plan use or disclose my Protected Health Information?

The Plan is allowed to use or disclose Protected Health Information in the following cases:

(a) The Plan may use or disclose Protected Health Information for purposes related to medical treatment, payment, or health care operations, except that psychotherapy notes will not be used or disclosed without your authorization. The Plan has made available to you a Notice of Privacy Practices that provides specific examples of what constitutes treatment, payment and health care operations.

(b) The Plan may use or disclose your Protected Health Information if you sign a written authorization allowing the specific use or disclosure.

(c) If you agree, the Plan may disclose to relatives, friends, or other persons Protected Health Information relevant to that person's involvement with your care or payment for your care.

(d) If you agree, the Plan may use or disclose Protected Health Information to notify a relative or other person responsible for your care of your location, general condition, or death.

(e) The Plan may disclose Protected Health Information to Renown for Plan-related purposes. The Employer will not use or disclose the information for employment-related actions or in connection with any other employee benefit, except in certain cases for worker's compensation as allowed under state law. The Employer will restrict access to the Protected Health Information as described in this Part of the Summary.

(f) The Plan may use or disclose Protected Health Information for public health activities or as otherwise required by law or regulation.

11.04 Do I have access to my Protected Health Information?

You may request to inspect or copy the Protected Health Information the Plan has about you. Generally, within 30 days after receiving your request, Renown will grant or deny your request. In some cases, Renown may have up to 60 days to respond. You may be required to pay a reasonable fee for copies of Protected Health Information. If your request for access is denied, you will be provided an explanation of the reasons for the denial and any appeal or complaint rights you may have.

11.05 Can I correct errors in my Protected Health Information?

You may submit a written request that the Plan amend your Protected Health Information. After receiving your request, the Plan will act on it within 60 days (90 days if the Plan notifies you within 60 days of the reasons for the delay and the date it will respond to your request).

If the Plan agrees that correction is necessary, the Plan will amend your Protected Health Information and attempt to provide the amendment to (i) the persons you identify as needing the amendment, and (ii) persons the Plan knows have received the incorrect Protected Health Information and could use it in a way that is harmful to you.

11.06 What if the Plan denies my request to correct Protected Health Information?

If the Plan denies your written request to amend your Protected Health Information, you will be provided with a written explanation of the reasons for the denial, your right to submit a written statement disagreeing with the denial, your right to have your request for amendment and the denial provided with any future disclosures of the Protected Health Information, and your right to complain about the denial to the Plan or to the U.S. Secretary of Health and Human Services. If you submit a statement of disagreement, the Plan may prepare a written rebuttal.

Your Protected Health Information that is the subject of the dispute will be linked to your request for an amendment, the Plan's denial of the request, your statement of disagreement if you filed one, and the Plan's rebuttal. All of this information, or an accurate summary, will be included in any subsequent disclosure of the Protected Health Information that is in dispute.

11.07 Can I obtain an accounting of the disclosures of my Protected Health Information?

You may request an accounting of the disclosures of your Protected Health Information that occur within six years before your request, except for the types of disclosures described in Question 3, above, and disclosures made to you.

After receiving your request for an accounting, the Plan will respond within 60 days (90 days if the Plan notifies you within 60 days of the reasons for the delay and the date the Plan will respond to your request). The first accounting provided to you in any 12-month period is free. Reasonable fees may be charged if you make more than one request for an accounting within a 12-month period. You will be informed of the fee in advance, and you may withdraw or modify your request to avoid or reduce the fee.

11.08 May I file a complaint about the use of my Protected Health Information?

The Plan has established a complaint procedure concerning the handling of Protected Health Information. The Notice of Privacy Practices that was made available to you explains the complaint procedure. If you would like an additional copy of this Notice, please contact the Human Resources Department.

11.09 Will I be notified if there is a harmful disclosure of my Protected Health Information?

The Plan has procedures in place to safeguard your Protected Health Information. In the unlikely event that there is an unlawful disclosure of your Protected Health Information that causes a significant risk of harm to you or your finances or reputation ("Breach"), the Plan will notify you and the Secretary of Health and Human Services. The notice will describe what happened and when; the types of information involved; any steps you should take to protect yourself; the steps the Plan is taking to investigate, limit the harm, and protect against future Breaches; and who you can contact for additional information.

ARTICLE XII
COBRA CONTINUATION COVERAGE

This Section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

12.01 What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying

event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

12.02 When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days.

12.03 How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

12.04 Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options

may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

12.05 Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

12.06 If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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

Plan contact information

The Plan Administrator has delegated authority for administering COBRA continuation coverage to the following COBRA Administrator:

Health Equity/WageWorks, Inc.
Phone: 1-888-678-4881
Email: mybenefits.wageworks.com
Address:
P.O. Box 223684
Dallas, TX 75222-3684

SCHEDULE OF BENEFITS

Summary of Benefits for Renown Employee Health Plan

All Essential Health Benefits			
Lifetime Maximum Benefits			**Unlimited**
Total Plan benefits for each covered person are not limited. However, utilization limits may apply to all or certain periods of Plan coverage, or to certain conditions or types or levels of care. Such limits are included in this summary. **NOTE:** Any use of the term "lifetime" refers to all periods an individual is covered under the Plan. It does not mean a covered person's entire lifetime.			
Deductible	**Renown/WCA**	**HTH In-Network**	**Out-of Network**
Individual	None	$750	$4,000
The individual Deductible is an amount a covered person must contribute toward payment of covered charges. The deductible is due and payable by the covered person upon receipt of certain covered services. Where applicable, the deductible must be met before benefits are paid by the Plan. See "†" notations in the columns for instances where the Calendar Year Deductible does not apply.			
Family	None	$1,500	$8,000
If covered charges equal to the Family Maximum Deductible are incurred collectively by family members during a calendar year and are applied toward Individual Deductible, the Family Maximum Deductible is satisfied. A "family" includes a covered employee and his covered dependents. **NOTE:** The preferred and non-preferred deductibles are separate. Expenses applied toward the preferred provider deductibles will not apply toward the non-preferred deductibles or vice versa.			
Maximum Out-of-Pocket			
Medical and Prescription Drug benefit expenses are subject to the same Maximum Out-of-Pocket maximum. **NOTE:** The non-preferred provider out-of-pocket maximums do not apply to or include expenses which become the covered person's responsibility for failure to comply with the requirements of the Utilization Management Program (see Part 4 of the Summary Plan Description).			
Individual	$5,000		Unlimited
Except as noted, in any calendar year a covered person will not be required to pay more than the Individual Out-of-Pocket Maximum toward their deductible, copay and/or coinsurance obligations. Once the individual has paid the out-of-pocket maximum, their covered charges will be paid at 100% benefit level for the balance of the calendar year.			
Family Unit	$10,000		Unlimited
Except as noted, in any calendar year a covered family (employee and dependents) will not be required to pay more than the Family Out-of-Pocket Maximum toward their deductibles, copay and/or coinsurance obligations. Once the family has paid their out-of-pocket maximum, their covered charges will be paid at 100% benefit level for the balance of the calendar year.			
Plan Features	**Applies to the Renown & Affiliate providers Out-of-Pocket Maximum?**	**Applies to the In Network Out-of-Pocket Maximum?**	**Applies to the Out Network Out-of-Pocket Maximum?**
The following table identifies what does and does not apply toward the Network and Non-Network Out-of-Pocket Maximums:			
Payments toward the annual Deductible	Yes	Yes	Yes
Coinsurance payments, including those for covered services available in the Prescription Drug Benefits section.	Yes	Yes	Yes
Copayments	Yes	Yes	Yes
Charges for non-covered services	No	No	No
The amounts of any Pre-Certification penalties "You are subject to a 50% reduction in benefits if you do not obtain a required Prior Authorization for the service even if the service is Medically Necessary."	No	No	No
Charges that exceed Allowable Expenses	No	No	No
Covered Medical Expense	**Renown/WCA**	**HTH In-Network**	**Out-of-Network**
Alternative Care (acupuncture, homeopathies), per visit	$40	$50	50% after deductible
Limited to 20 visits per calendar year.			
Ambulance (ground/water/air), per trip	See Preferred	$100	50% after deductible
See referral and prior authorization requirements.			
Ambulatory Surgical Center, per admit	10%	30%	50% after deductible
Bariatric Surgery	Benefits based on types of services provided		
Limited to one medically necessary gastric restrictive surgery at Bariatrics Center of Excellence per lifetime. Limits include complications directly resulting from gastric restrictive services.			
Cataract Lenses (one set)	$25	30%	50% after deductible
Chiropractic Care, per visit	See Preferred	$65	50% after deductible
Limited to 20 visits per calendar year and 100 lifetime visits.			
Chemotherapy (in office), per visit	$25	$50	50% after deductible
Durable Medical Equipment (DME)	See Preferred	$50	50% after deductible
Limited to one purchase of a specific item of DME, including repair and replacement every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The rental of warning or monitoring decives for infants (defined as a child 24 months old or less) suffering from recurrent apnea is limited to 90 days.			
Food Products, Special (as definied by Nevada Statute)	$0	$0	50% after deductible
Limited to a maxmum benefit of 4, 30 days of therapeutic supplies per member per calendar year.			
Gender Assignment/Reassignment	Benefits based on types of services provided		
Genetic Counseling, per visit	$40	30%	50%
Genetic Testing	$0	$0	50% after deductible
If medically necessary as determined by the plan. If mandated by PPACA for high risk BRCA testing and counseling.			
Home Health Care, per visit	$40	30%	50% after deductible

Covered Medical Expense	Renown/WCA	HTH In-Network	Out-of-Network
Home Hospice Care (inluding family bereavement counseling)	$0	30%	50% after deductible
Limited to 185 day period of patient care beginning on the first day of services. Benefits for outpatient counseling services for the patient and their immediate family are limited to 6 visists for all family memebers combined, if they are not otherwise eleigbile for mental health benefits under another policy. Respite care providing nursing care is limited to a maximum of 8 inpatient respite care days per calendar year and 37 hours per calendar year for outpatient respite care services.			
Hospital, Inpatient, per admit	10%	30%	$500 and 50% after deductible
Hospital, Observation	10%	30%	50% after deductible
Hospital, Rehabilitation Facility, per admit	10%	30%	50% after deductible
Inpatient accommodation is limited to a semi-private room except when confinement in an Intensive Care Unit is medically necessary. Requires prior authorization. See Utilization Management Program.			
Imaging (CT, MRI, nuclear medicine, PET scans), per visit	$250	30%	50% after deductible
Infertility	Benefits based on types of services provided		
Limited to medically necessary services to diagnose problems of infertility for a covered individual. One diagnostic evaluation for infertility every year up to 3 per lifetime and 6 artificial inseminations per lifetime. Exclusions apply and are detailed in Medical Plan Component.			
Kidney Dialysis Services, per visit	See Preferred	$80	50% after deductible
Mental Health and Substance Abuse Residential Treatment Facility, per admit	10%	30%	$500 and 50% after deductible
Mental Health and Substance Abuse Outpatient Services, per visit	$20	$40	50% after deductible
Benefits for inpatient alcohol and substance abuse care are subject to review for medical necessity and level of care determination. Requires prior authorization. See Utilization Management Program.			
Office Visit, Primary Care Physician, per visit	$20	$40	50% after deductible
Office Visit, Specialist, per visit	$40	$80	50% after deductible
OB/GYN, per visit	$20	$40	50% after deductible
Orthopedic/Prosthetic Devices	$25	$25	50% after deductible
Ostomy Care Supplies	$0	$0	50% after deductible
Limited to 30 days of theraputic supplies per month.			
Outpatient Diagnostic X-ray or ultrasound, per visit	$0	30%	50% after deductible
Outpatient Emergency Room Services, per visit	$250	$250	$250
Copay waived if admitted to hospital from ER.			
Outpatient Infusion/Chemotherapy	$25	$50	50% after deductible
Outpatient Lab Services, per visit	$0	30%	50% after deductible
Outpatient Surgery, per admit	10%	30%	50% after deductible
Pharmaceuticals, special	$75	30%	50% after deductible
Requires prior authorization. See Utilzation Management Programs.			
Pharmaceuticals, other medical	$40	30%	50% after deductible
Requires prior authorization. See Utilzation Management Programs.			
Pregnancy, Birth (vaginal or cesearean), per admit	10%	30%	$500 and 50% after deductible
Pregnancy, Physician Services during Birth, per admit	10%	30%	50% after deductible
Prenatal Screening, as defined under Women's Preventative Services in ACA	$0	$0	50% after deductible
Preventative Care, per visit	$0	$0	50% after deductible
Preventive Care includes, but is not limited to: One (1) physical exam each calendar year and immunizations in accordance with medical practice guidelines, including influenza immunizations; One (1) routine GYN exam each calendar year including a Pap smear, pelvic exam, urinalysis and breast exam; Mammogram screening; Colorectal cancer screening; Prostate screening (PSA); Well-baby care during the first 2 years of life, including immunizations in accordance with the American Academy of Pediatrics and other federal agencies; Hearing and vision screening for children through age 17 to determine the need for hearing or vision correction. The latest covered preventive care services can be found by visiting https://www.healthcare.gov/coverage/preventive-care-benefits. Plan will cover the following services without any Member cost-sharing requirements if a Participating Provider provides such services: Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendation of the United States Preventive Services Task Force, provided that, with regard to breast cancer screening, mammography, and prevention, the current recommendations of the United States Preventive Services Task Force will be the most current other than those issued in or around November 2009; Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention with respect to the individual involved.			

Covered Medical Expense	Renown/WCA	HTH In-Network	Out-of-Network
Physician Services, Inpatient, per admit	10%	30%	50% after deductible
Physician Services, Same Day Surgery, per admit	10%	30%	50% after deductible
Port Wine Stain Removal	$20	$50	50% after deductible
Radiation Therapy	$0	$0	50% after deductible
Second Surgical Opinions	$40	$80	50% after deductible
Skilled Nursing Facility, per admit	10%	30%	$600 and 50% after deductible
Limited to 100 days per calendar year. Requires prior authorization. See Utilization Management Services.			
Telahealth, Mental Health Services, per visit	$20	$40	50% after deductible
Telahealth, Primary Care Physician, per visit	$20	$40	50% after deductible
Telahealth, Specialist, per visit	$40	$80	50% after deductible
Teladoc, per visit	$0	30%	50% after deductible
Temporomandibular Joint Discorder (TMJ)	depends of type of services	30%	50% after deductible
Annual maximum of 1 surgery and lifetime maximum of 2 surgeries.			
Tertiary Care	Benefits based on types of services provided		
Tertiary Care: Highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. Examples of tertiary care services are specialist cancer care, neurosurgery (brain surgery), burn care and plastic surgery. A Travel Benefit is established to offset the cost of travel for patients and/or their support person or family members when Hometown Health Utilization Management provides the physician and/or covered person, as an option for Tertiary Care (evaluation and/or treatment), authorization to receive treatment at an in-network benefit level. Referral and authorization for all levels of care are required prior to the approved service. Tertiary Care will be considered but not a guarantee of benefit when no available in the Hometown Health service area. To qualify for the Travel Benefit, the following must apply: 1. Covered Person and/or their treating physician has requested a referral to a specific facility/provider for Tertiary Care. Service may or may not be in the primary PPO network and will require travel to Utah or in some cases to southern Nevada. 2. Utilization Management has determined that the requested services are medically necessary and Tertiary Care cannot be provided in the primary PPO network. 3. Utilization Management has provided the physician and/or Covered Person, as an option, to receive Tertiary Care at an approved provider or facility. Utilization Management may indicate an alternate care provider for requested services and the care must be authorized at an in-network benefit level. 4. Covered Person has agreed to be in Case Management and followed by Case Manager while in Tertiary Care. 5. Prior to travel for Tertiary Care, the covered person must advise the RN Case Manager of travel to receive the benefit and the travel benefit must be approved. Travel Benefit Travel Expenses Per Day, Per Trip: $250* per patient, support person/caregiver or parent as defined below. Travel Expenses Maximum, Per Trip: $10,000* Per calendar year * Per diem rates. No exclusions, no receipts necessary.			
Therapy Services, Autism Spectrum Disorder Treatment, per visit	$20	$40	50% after deductible
Therapy Services, Cardiac Rehabilitation, per visit	$10	30%	50% after deductible
Therapy Services, Occupational, per visit	$25	30%	50% after deductible
Therapy Services, Physical, per visit	$25	30%	50% after deductible
Therapy Services, Pulmonary Rehabilitation, per visit	$25	30%	50% after deductible
Therapy Services, Speech, per visit	$25	30%	50% after deductible
Speech, occupational and physical therapy coverage is limited to 60 visits/sessions for all modalities combined per calendar year. Cardiac and pulmonary rehabilitation is limited to 60 visits/sessions for all modalities combined per calendar year. Coverage for these therapies are provided for rehabilitative and habilitative separaretely, as per the medical necessity of these services. Habilitative therapy does not require that an injury or illness preceded the need for service.			
Transplants, Recipient and donor expenses	Benefits based on types of services provided		
Requires prior authorization. See Utilzation Management Programs.			
Urgent Care Facility, per visit	$30	30%	50% after deductible
Varicose Veins	$40	$80	50% after deductible
Requires prior authorization. See Utilzation Management Programs.			
Wigs	See Preferred	$50	50% after deductible
Wound Care	$40	30%	50% after deductible

REFERRAL AND PRIOR AUTHORIZATION REQUIREMENTS

- All inpatient stays and services in any type of facility, including acute and skilled care, mental health care, and drug or alcohol detoxification, rehabilitation.
- Inpatient, same day, or in-office surgical services with a cost greater than $750.00 (total billed charges) (excluding diagnosti c and screening colonoscopies)
- Air ambulance transportation
- Anesthesiology and physiatrist, including pain management
- Cardiac and pulmonary rehabilitation
- Certain infertility laboratory and diagnostic tests
- Chemotherapy
- Dialysis
- Gastric restrictive services
- Genetic counseling services
- Hearing Aids (review plan document for coverage)
- Healthcare services and supplies including but not limited to oxygen, oxygen-related equipment and all durable medical equipment (DME) with the exception of Prosthetic and Orthopedic devices with a cost greater than $1000
- Prosthetic and Orthopedic devices (DME) with a cost greater than $850
- Hospice
- Infusion therapy
- Ostomy Supplies
- Outpatient speech, occupational and physical therapy greater than 20 visits per calendar year
- Radiation Therapy
- Special food products
- Second-opinion services
- Specialist office visits for plastic surgery and genetic counseling services
- Transplant Services
- Wound therapy in an outpatient setting
- Certain medications specified by Hometown Health Specialty Drugs (see hometownhealth.com)
- Certain high cost pharmaceuticals and biological meds. A current list of these are available on the website; www.hometownhealth.com

Contracted providers are required to obtain certification/pre-certification from Hometown Health Providers. However, to avoid possible penalties, a covered person should verify that the referral and certification requirements have been met. Prior-Authorization by Hometown Health Providers does not guarantee that all charges are covered under the policy. Charges submitted for payment are subject to all of the terms of the policy.

Members may elect to seek services from non-preferred healthcare providers provided the member pays the additional deductible and coinsurance amounts and any additional charges over a usual and customary charge for the service provided. Members also may be required to obtain prior authorization before seeking services from non-preferred providers. It is the member's responsibility to ensure that the appropriate prior authorizations are in place for both in-network and out of network non-emergency services.
For an emergency or urgent hospital admission or treatment (including all complications of pregnancy) where a non-contracted provider is used, the covered person is responsible for making sure his/her Primary Care Physician and Hometown Health Providers is notified within 24 hours or as soon as reasonably possible after admission or treatment. Non-contracted physicians and providers may not know or attempt to notify Hometown Health Providers to obtain pre-certification for such services. All emergency care not reported to the covered person's Primary Care Physician and certified by Hometown Health Providers will be reviewed retrospectively to determine coverage.

If the covered person or a family member is unable to contact his or her Primary Care Physician and Hometown Health Providers before receipt of emergency or urgent medical services or within 24 hours of onset of the condition due to shock, unconsciousness, or otherwise, the covered person must, at the earliest time reasonably possible, contact his/her Primary Care Physician and Hometown Health Providers.

Benefits will be provided only for certified services and supplies. No Plan benefits will be provided for care that is determined not a covered benefit or not meeting the Plan's criteria and protocols.

It is the obligation of the covered person to comply and cooperate with the referral and pre-certification requirements.

Pre-certification does not guarantee that all charges are covered. Benefits are subject to all of the terms of the Plan.

See Utilization Management Program in the Summary Plan Description for more information.