RENOWN HEALTH
WELFARE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

Note: This Summary Plan Description together with the applicable group insurance coverage information such as certificates of insurance, insurance booklets, brochures, provides a summary of the benefits provided under the Plan. The official terms and conditions are set forth in the legal Plan document and the component Welfare Programs.

Amended and Restated Effective Date: January 1, 2022

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1. INTRODUCTION

Renown Health , (the "**Company**") is pleased to offer you the benefits described in this Summary Plan Description ("**SPD**"). It is a valuable and important part of your overall compensation package. This document describes the benefits under the Renown Health Welfare Benefits Plan (the "**Plan**") as of January 1, 2022. The Plan provides benefits through the various "Welfare Programs" that are described in more detail in the Welfare Program documents included with this SPD. The Plan and the Welfare Program benefits may be changed from time to time by the Company.

A. About This Summary Plan Description

This SPD is an overview of your rights and obligations under the Plan. It is based on the legal Plan document, benefit booklets and insured policies that describe the specific benefits under the Plan.

While every effort has been made to give you correct and complete information about your benefits, in the event of any conflict or inconsistency between the SPD and relevant legal documents, the terms of the legal documents will control.

In addition, no person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company that alters the Plan document or any legal document maintained in conjunction with the Plan.

The Company intends to continue the Welfare Programs as described in this SPD indefinitely, but it has the right, at its discretion, to change or even terminate all or any part of this Plan, including the Welfare Programs at any time and in any manner as permitted by law. This SPD is not a contract, nor is it a guarantee of your benefits.

B. How To Use This SPD

Your SPD consists of this document, as well as the Welfare Program documents (also referred to as the "Attachments"). The SPD describes the general features of the Plan and includes legal disclosures required under federal employee benefit laws. The Welfare Program documents contain a description of the benefits available under each Welfare Program. You should refer to this SPD and the Welfare Program documents together to understand your rights and responsibilities with respect to the benefits under the Plan.

For additional information regarding the Plan, contact Shawna Lovett, Manager of Employee Benefits or refer to the Benefit Documents for each applicable Welfare Program Copies of the Benefit Documents are available free of charge from Renown on request.

As stated above, if the terms of this SPD conflict with the official Plan document, the Plan document shall govern. If the terms of this SPD conflict with an insured policy under the Plan, the

terms of the insured policy will govern. The Plan Administrator has the right to interpret and resolve any ambiguities or conflicts between the SPD and the Welfare Program documents.

C. Pre-Tax Payments

This Plan is designed so that you may not have to pay taxes on the cost of the qualified benefits you elect under the Plan, but there are some exceptions to this rule. This SPD and the enrollment materials contain general information regarding paying for your benefits, but the Company does not provide tax advice. If you have any questions regarding the tax consequences regarding your benefits, you should contact your own tax advisors.

2. DEFINITIONS

There are capitalized terms used in this SPD that have the specific meanings in this Section 2. *There may also be capitalized terms that are not defined here but may be defined later in the SPD or in the official Plan document.*

2.1. "**ACA**" is short for the Patient Protection and Affordable Care Act, as amended, including regulations and rulings issued under the ACA.

2.2. "**AD&D**" is short for accidental death and dismemberment insurance.

2.3. "**Attachments**" refers to the Welfare Program documents such as the benefit booklets, insurance policies and other summaries of the Welfare Programs under this Plan and that are considered a part of this SPD.

2.4. "**Child**" means your child through age twenty six (26) regardless of financial dependency, residency with you, marital status, or student status; and/or your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability. Unless otherwise defined by the Insurance Certificate for a Benefit Program, your child includes: your biological child; your stepchild; your legally adopted child (including any child under age eighteen (18) placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support); a child for whom you are responsible under court order; a child for whom you are appointed legal guardianship; a foster child; or an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order ("QMCSO") or a National Medical Support Notice ("NMSN").

2.5. "**Claims Administrator**" refers to the entities that administer claims for benefits under the self-insured Welfare Programs. Contact information for the Claims Administrators is provided on Appendix A.

2.6. "**COBRA**" is short for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2.7. "**Code**" is short for the Internal Revenue Code of 1986, as amended.

2.8. "**Company**" or "**Employer**" refers to Renown Health. If you work for an affiliate of the Company, "Employer" may also refer to your employer of record if they have adopted the Plan.

2.9. "**Dental Program**" is the Welfare Program that provides dental care under the Dental Program documents.

2.10. "**Dependent Care Flexible Spending Account**" is an account established by the Company that allows you to use pre-tax dollars to pay for the care of your eligible Dependents while you are at work. It is described in Section 7 of this SPD.

2.11. "**Dependent**" means an Eligible Employee's Spouse, Child, or other Dependents that satisfies the Dependent eligibility requirements of Welfare Programs.

2.12. "**Eligible Employee**" means an Employee who satisfies the eligibility requirements under the terms of the component Welfare Programs. Generally, Full-Time Employees and Part-Time Employees are Eligible Employees, however some Welfare Programs may have different eligibility requirements. Please refer to the Program Documents for specific eligibility rules. For purposes of Medical Program eligibility, a Per Diem Employee who has worked an average of thirty (30) or more hours per week during the first twelve (12) months following their date of hire or worked an average of thirty (30) hours per week during the Plan's twelve (12) month standard measurement period will be an Eligible Employee.

2.13. "**Employee**" means any current or in some cases a former employee of the Employer who is considered a regular employee of the Employer and who is paid by the Employer a salary, wages or other compensation subject to statutorily required payroll tax withholding, such as federal or state income tax. The determination of whether an individual is an Employee, versus an independent contractor or any other classification of worker or service provider and the determination of whether an individual is a member of any particular class of Employees shall be made solely by the Company and are not Dependent on, or change due to, the treatment of the individual for any purposes under the Code, common law or any other law, or any determination made by any court or government agency.

2.14. "**ERISA**" is short for the Employee Retirement Income Security Act of 1974, as amended.

2.15. "**Full-Time Employee**" is an Employee regularly scheduled to work thirty six (36) or more hours per week.

2.16. "**Group Health Programs**" include the Medical, Dental, Vision and Health FSA Welfare Programs.

2.17. "**Health Flexible Spending Account**" **or** "**Health FSA**" is an account maintained by the Company that allows you to use pre-tax dollars to pay for certain medical, dental and vision expenses not reimbursed under other programs. It is described in more detail in Section 7 of this SPD.

2.18. "**HIPAA**" is short for the Health Insurance Portability and Accountability Act of 1996, as amended.

2.19. "**Medical Programs**" are the Welfare Programs that provide medical care under the terms of the Medical Program documents.

2.20. "**Open Enrollment Period**" is the period before each Plan Year during which each eligible Employee may enroll in the Plan or elect or change coverage options under one or more of the Welfare Programs. If you are enrolled in the Plan, the Plan Administrator may automatically carry over your election from the prior Plan Year in the event you do not make an affirmative election. You will be given notice during Open Enrollment if this is applicable.

2.21. "**Part-Time Employee**" is an Employee regularly scheduled to work between twenty (20) and thirty five (35) hours per week.

2.22. "**Participant**" refers to an eligible enrolled Employee and/or eligible covered Dependents participating in the Plan.

2.23. "**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

2.24. "**Plan**" means the Renown Health Welfare Benefits Plan.

2.25. "**Plan Administrator**" is the Renown Health Employee Benefits Review Committee appointed by the Company (the "**Committee**"). In certain instances, the Committee has delegated its administrative duties to other persons or entities, including the Claims Administrators.

2.26. "**Program Documents**" are the documents and insurance policies describing the specific benefits and eligibility rules for each component Welfare Program under the Plan.

2.27. "**USERRA**" is short for the Uniformed Services Employment and Reemployment Rights Act of 1994.

2.28. "**Welfare Program" or "Welfare Plan**" means the individual plans, programs and policies that provide the specific benefits under this Plan.

3. GENERAL PLAN INFORMATION

Type of Plan:	Welfare Benefit Plan, which includes the following Welfare Programs: Medical, Dental, Vision, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, Critical Illness, Hospital Indemnity, Accident, Group Term Life Insurance, Group Accidental Death & Dismemberment (AD&D), Voluntary Life Insurance, Long-Term Disability (LTD), Short-Term Disability (STD), Employee Assistance Program, Legal Assistance, Commuter Benefits, Identity Theft Protection
Funding:	Fully-insured contracts and self-funded arrangements
Plan Name:	Renown Health Welfare Benefits Plan
Plan Number:	501
Plan Year:	The twelve month period beginning each January 1st and ending each December 31st
Plan Sponsor:	Renown Health 1155 Mill Street, Mail Stop Z-3 Reno, NV 89502
Plan Sponsor EIN:	94-2972845
Plan Administrator:	Renown Health Welfare Benefits Committee 1155 Mill Street, Mail Stop Z-3 Reno, NV 89502 (775-982-6477)
Agent for Service of Legal Process:	Renown Health Atten: Legal 1155 Mill Street, Mail Stop Z-3 Reno, NV 89502
Plan Administration:	Fully-insured Welfare Programs are administered by providers/insurers from which services or benefits are purchased. Self-insured Welfare Programs are administered by the Committee. Self-insured or unfunded benefits, are paid from the Employer's general assets.

4. ELIGIBILITY AND ENROLLMENT

You and your eligible Dependents, if applicable, are eligible to participate in the Plan, only if you are eligible for benefits under a particular Welfare Program and you make all required contributions for the coverage you elect. You will be provided the amount of the contributions for each type of coverage during the Open Enrollment Period prior to the beginning of each Plan Year.

(1) General Eligibility

You are generally eligible for benefits under the Plan if you are a full-time or part-time active Employee of the Company scheduled to work twenty (20) or more hours per week as set forth on Appendix B.

Different eligibility and participation requirements may be imposed by the component Welfare Programs. You must satisfy the eligibility requirements under a particular component Welfare Program in order to receive benefits under that program.

To determine whether you and your Dependents are eligible to participate in a Welfare Program, please see the eligibility information on Appendix B and described in the Attachment(s) for the applicable Welfare Programs.

(2) Excluded Employees

You are not eligible for any benefits under the Plan if you are:

(1) working for the Employer, but your employer of record is a temporary or staffing firm, payroll agency, or leasing organization;

(2) a contract employee,

(3) a non-resident, non-U.S. citizen employee with no U.S. sourced income, or an undocumented resident employee not legally eligible to work in the U.S.

(4) an employee covered under a collective bargaining agreement (unless the CBA includes coverage under the Plan),

(5) not on the Employer's payroll, as determined by the Employer, without regard to any court or agency decision determining common-law employment status, or

(6) otherwise eligible, but you or your Dependents committed fraud or misrepresentation with respect to the Plan and any of the Welfare Programs.

C. Enrollment and Time Limits

The Plan Administrator will provide you with information regarding how to enroll in each Welfare Program, the time frames within which you have to enroll, and any other enrollment requirements prior to the date your enrollment is due.

(3) Newly Eligible Employees

Newly Eligible Employees must enroll within certain time-periods after their date of hire or after first becoming eligible as described in the Welfare Program documents. Most enrollment periods require you to enroll no later than thirty (30) days following your date of hire or eligibility date.

If you do not make your Welfare Program elections within the required time periods, you will automatically be enrolled in the lowest cost "Employee Only" Medical Program option under the Plan and you will not be enrolled in any other Welfare Program under the Plan, meaning you will have waived coverage in all Welfare Programs other than the Medical Program for the rest of Plan Year.

*You won't be able to change your Welfare Program elections until the next Open Enrollment Period except in certain limited circumstances. (See "Changing Coverage During the Year" below for further details.)

(2) Open Enrollment

The Company will hold an annual Open Enrollment Period prior to each new Plan Year during which you may change your Welfare 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.

Before the Open Enrollment Period begins, you will be provided with information to help you with your Welfare Program elections. This may be provided through a website or electronic communication and you may also request written copies from the Plan Administrator free of charge. The enrollment information describes the enrollment process, the coverage options available for the upcoming Plan Year, your cost for each Welfare Program option, the maximum contributions under the Health FSA and Dependent Care FSA and any changes to the available coverages since the last Open Enrollment Period.

Your enrollment materials contain important tips on how to enroll. Be sure to read the information carefully.

During Open Enrollment you have the opportunity to:

- With respect to health care coverage, 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 calendar year.
- With respect to the Health FSA and Dependent Care Flexible Spending Account, enroll for coverage and authorize the amount you want to deduct from your pay on a pre-tax basis, subject to the Plan maximums.
- With respect to disability, life and AD&D coverage, you may enroll for coverage, or increase or decrease the level of life insurance coverage for you or your Dependents, subject to certain conditions. Prior to enrolling, you may also be required to show evidence of insurability.

- The Administrator will provide additional information regarding the enrollment options for the other component Welfare Programs under the Plan.

(3) Failure to Elect Benefits during Open Enrollment.

If you fail to make an election within the required time-period for Open Enrollment, you may automatically be enrolled in the lowest cost "Employee Only" Medical Program option under the Plan, however, you will not be enrolled in any other Welfare Program under the Plan, meaning you will have waived coverage in all Welfare Programs other than the Medical Program for the Plan Year, except that certain prior year Welfare Program elections may continue or "rollover" to the next Plan Year even if you do not actively enroll or make changes during Open Enrollment. The Administrator will provide you with information regarding "rollover elections" during Open Enrollment.

*It is important that you read the enrollment materials carefully and make your elections prior to the last day of the Open Enrollment Period because you won't be able to change your Plan elections until the next Open Enrollment Period except in certain limited circumstances (see "Changing Coverage During the Year" below for further details), *even if your enrollment carried over from the prior Plan Year*.

(4) Enrollment and Start of Coverage during a Leave of Absence.

If you are on an approved Leave of Absence when your newly elected disability, life, and/or AD&D coverages would otherwise start, the effective date of those coverages will be delayed, and you will not be covered until the day you are Actively at Work (as defined in the Plan).

Note that if you are on an approved vacation, you will still be considered Actively at Work.

If you are on an unpaid Leave of Absence and you dropped your coverage under any of the Welfare Programs for the duration of the unpaid Leave of Absence, you may make new elections during Open Enrollment, but the effective date of all your newly elected coverages will be delayed until you return to work as an Eligible Employee. (See "Changing Coverage During the Year" below for further details)

D. Pre-Tax Premium Payments

If you elect to pay for your benefits on a pre-tax basis, you will be required make that election during the applicable enrollment periods (prior to the effective date of your coverage if you are newly eligible, or before the end of the Open Enrollment Period before the first day of the applicable Plan Year). Because of this favorable tax-treatment, there are certain restrictions as to when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual Open Enrollment Period.

You will not be permitted to change your pre-tax contribution amounts during the Plan Year, unless you experience one of the events described in Section E below. Please make your elections carefully.

E. Special Enrollment Rights

(1) Changing Coverage During the Year

When you pay the amounts due for your Welfare Program benefits on a pre-tax basis, Federal rules and regulations restrict your ability to change your elections once they become effective.

However, there are several exceptions to those rules if you experience certain events. If you experience an event permitting a mid-year change, you may make changes to any of your elections (whether paid on a pre-tax or after-tax basis), subject to the limitations explained below if the changes are consistent with the event. These are the general categories of events that will allow you to make changes:

- Change In Status – You experience a "change in status" – as described in this section – that affects your or your Dependents' eligibility for Group Health coverage either under this Plan or another group health plan such as a Plan sponsored by your Spouse's or Domestic Partner's employer;

- HIPAA Special Enrollment – You qualify for a special enrollment during the Plan Year under HIPAA (they are listed in detail below).

- State Children's Health Insurance Plans – You can enroll a Dependent or drop Dependent coverage mid-year if your Dependent loses eligibility under a State Child Health Plan or becomes eligible for state premium assistance under Medicaid or through a State Child Health Plan.

- QMCSO – If the Plan Administrator receives a court order called a Qualified Medical Child Support Order (QMCSO) or National Medical Child Support Order requiring you to enroll a Dependent child for health care coverage;

- Medicare or Medicaid Entitlement – You or your Dependent enroll in or lose coverage under Medicare or Medicaid;

- Reduction in Hours Below 30 Hours per Week – You experience an employment status change that reduces your average weekly hours of service below thirty (30) hours per week;

- Marketplace Enrollment – You or your Dependent may drop medical coverage under the Plan so that you can enroll in coverage obtained through the Marketplace; or

- Significant Cost or Coverage Changes - The cost of the health and welfare coverages significantly increases or decreases, or coverage is significantly improved, or curtailed or lost.

Each of these events is explained in more detail below. Please note that these events permit you to change your elections after the elections take effect during a Plan Year.

(2) Consistency Rule

For change in status elections under a Group Health Program, any election change you make must affect eligibility under that program. In addition, regardless of the event you experience, any election change you make must be because of, and consistent with the event. The Plan Administrator, in its sole discretion, shall determine whether an event permits an election change and, if so, whether the election change is consistent with the event, in accordance with rules established by the IRS.

(3) Election Period for Changing Coverages and Effective Date of Coverage.

If you experience an event permitting you to change any of your Welfare Program elections, you must notify your local HR representative and make your election changes within thirty (30) days from the event. If timely made, the election changes made due to a mid-year event are generally effective prospectively from the date you notify your local HR representative. Three exceptions are:

- For enrollment of a child pursuant to a QMCSO or NMSN, coverage will be effective the first of the month after the Plan Administrator determines the QMCSO is valid,

- For HIPAA special enrollment of a child as a result of birth, adoption or placement for adoption, coverage will be effective as of the date on which you acquired the child, and

- For benefits that require you or your Dependent, as applicable, to satisfy Evidence of Insurability, coverage will be effective on the later of the first day of the month following a timely election change or the day on which the insurance company approves your Evidence of Insurability.

If you do not make a timely election, you will not be able to make a mid-year election and will have to wait until the next Open Enrollment Period to make any changes to your current elections.

Example. Assume you have "Employee Only" coverage in effect under the Medical Program. On July 12th, you get married and want to add your Spouse to the Plan. You must make your election change no later than August 11th. If you timely make your election, your Spouse will be covered under the Medical Program beginning as soon as administratively feasible after the date of notification. If you do not make a timely election (e.g., you submit your election on or after August 12th), your spouse will not have medical coverage through the Plan. In this case, you will have to wait until the next Open Enrollment Period to enroll your Spouse.

In addition, you may be required to provide proof of your change in status or other event, if requested by the Plan Administrator. If proof is requested and you do not provide proof, you cannot change your coverage until the next Open Enrollment Period, unless you once again meet one of the events for a mid-year change. The Plan Administrator reserves the right to require, at any time, appropriate documentation of your change in status or other event.

In certain circumstances, the Federal government has allowed or required the time periods within which you are allowed to make changes to your Welfare Program elections to be extended beyond

the thirty (30) day period normally permitted. The Plan Administrator will provide you with information regarding the extended deadlines, if applicable.

Change in Status

You can change your Welfare Program elections during the Plan Year if a change in status occurs that affects eligibility for coverage under the Plan or under another employer's group health plan (such as the plan of a Dependent's employer). A change in status is any of the following:

- You get married, divorced, legally separated or you have your marriage annulled;
- Your Spouse or other Tax Dependent dies;
- Your Dependent becomes eligible for coverage or ineligible for coverage (e.g., they reach the eligibility age limit);
- You acquire an eligible Dependent child;
- You change your place of residence outside of a network service area;
- You, your Spouse, or other Dependent, experiences a change in employment status. Changes in employment status include any of the following:
    - Start or end of employment (See "Special Circumstances: Reemployment" above for unique rules in the case of reemployment);
    - Change in work sites and your previous coverage is no longer available;
    - Change in hours of employment to become eligible or vice versa; or
    - Any other change in employment that leads to a loss of or gain in eligibility for coverage.

If you timely request to make changes to your Welfare Plan elections because you have acquired a newly Dependent child (such as adding Life Insurance coverage, or electing to contribute to a Health FSA) the changes to your Welfare Plan elections will be effective as of the first of the month following the date on which you acquired the child. The election to add your newly acquired Dependent child under the Medical Program will be effective as of the date of the birth, adoption or placement for adoption.

For changes in status resulting in either you or a Dependent becoming ineligible, coverage automatically ends as of the end of the month during which the event resulting in your or your Dependent's ineligibility occurs. A timely-made mid-year election change will stop the premium deduction that relates to the cost of coverage.

If you become divorced or legally separated or a Dependent child is no longer eligible for coverage, your former Spouse or child, as the case may be, will lose Medical Program coverage under the Plan. The individual losing health care coverage will have the right to continue coverage under

COBRA. To exercise these COBRA rights, the individual (or you, on the individual's behalf) must notify the Company within sixty (60) days of the loss of coverage. Please see Section 4.F below for more information on COBRA.

HIPAA Special Enrollment

Under HIPAA, you have the right to enroll yourself and your Dependents for medical coverage, even if you were not previously enrolled, within thirty (30) days after the following special enrollment events:

- You declined medical coverage because you or your Dependent had other coverage and the other coverage ends because:
    - You or your Dependent are no longer eligible for such coverage (whether such coverage was provided through another employer, private insurance or otherwise);
    - You or your Dependents exhaust COBRA coverage under another employer's group health plan (other than due to a failure to pay contributions or cause); or
    - Employer contributions toward the other group health plan coverage terminate.
- If you timely enroll, coverage will take effect on the first day of the month following timely enrollment.
- You acquire a Dependent as a result of a marriage, birth, adoption or placement for adoption. In the case of birth, adoption or placement for adoption, if you timely enroll, coverage will take effect on the date you acquired the new Dependent. In the case of marriage, if you timely enroll, coverage will take effect on the event date.

If you do not request the change within thirty (30) days of your special enrollment event, you will lose special enrollment rights for that event.

Please note these special enrollment rights apply only to changes in the Medical Program and permit you to enroll only yourself and your affected Dependents. They do not apply to any other changes in benefit coverage, such as Dental or Vision Program coverage. However, you may be able to change your elections under those programs if you experience one of the other change events described in this section.

Enrollment Pursuant to State Child Health Plan

If your Dependent loses coverage under a state children's health insurance program or becomes eligible for a state premium subsidy from a plan offered under Medicaid or through a State Child Health Plan and you notify the Plan Administrator within sixty (60) days, you can add or drop coverage for that individual.

Reduction in Hours Below thirty (30) Hours per Week

You may also revoke your elections under the Medical Program if you experience a change in your employment status that causes you to work, on average, less than thirty (30) hours per week. The cancellation of your coverage under the Plan must correspond to your intended enrollment in other coverage – such as Marketplace policies or another employer's plan.

Enrollment in Marketplace Coverage

Depending on where you live, a state or federal Marketplace (or "Exchange") is available to help you shop for individual health insurance policies for you and your family. If you qualify for open enrollment or a "Special Enrollment Period" for Marketplace coverage, you may also revoke your medical, dental, and vision elections under this Plan to enroll in corresponding Marketplace coverage.

Enrollment Pursuant to a QMCSO

You, a custodial parent or a state agency may enroll your Dependent child in the Plan, pursuant to the terms of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, which is determined to be a Qualified Medical Child Support Order (QMCSO). Alternatively, coverage for a Dependent child may be revoked if the QMCSO requires the spouse, former spouse or another individual to provide coverage for the child. Only the child who is eligible for coverage pursuant to a QMCSO may be enrolled for or dropped from coverage.

A Dependent child can be enrolled for health care coverage pursuant to a QMCSO only if any required contributions are made. This means that any required contribution for your Dependent child's coverage will be withheld from your paycheck unless a state agency pays the required contribution. Coverage will be effective immediately following the Plan Administrator's determination that the order is valid.

Medicare or Medicaid Entitlement

If you, your spouse, or other Dependent becomes entitled to Medicare or Medicaid coverage, you can drop Company coverage for yourself or that individual, as the case may be. In contrast, if you, your spouse, or other Dependent lose Medicare or Medicaid coverage, you may enroll for Company coverage for yourself or that individual, as the case may be.

Significant Cost or Coverage Changes

A number of events come under this category and are described below.

- The cost of coverage for a Welfare Program option significantly increases or significantly decreases during the Plan Year (including if the significant cost change occurs under your spouse's employer plan)

The Plan Administrator, in its discretion, makes a determination whether an increase or decrease is significant triggering a right to make mid-year election changes. Any insignificant increases or

decreases, as determined by the Plan Administrator, in the cost of coverage will be made automatically.

If cost for a coverage option in which you do not participate significantly decreases, you can make an election to participate in that coverage option. In contrast, if the cost for your elected coverage option significantly increases, you can select another coverage option providing similar coverage. If no option provides similar coverage, then you can drop coverage.

Keep in mind that if you participate in the Dependent Care Flexible Spending Account, a change can be made only as a result of this event if the cost change is imposed by a Dependent care provider who is not your relative.

- An event occurs that significantly curtails coverage or causes you to lose coverage under your current coverage option

A significant curtailment of coverage can include such things as a significant increase in the deductible, the copay or coinsurance amounts, and results in an overall reduction in coverage. In addition, the Plan Administrator may, in its discretion, treat a substantial decrease in participating physicians from a medical network as a significant curtailment of coverage. However, if you choose to participate in a Medical Program and your doctor leaves the network, your coverage is not considered significantly curtailed for purposes of this event. An event that may cause you to lose coverage can include such things as elimination of a coverage option.

These events allow you to change your coverage option to another coverage option providing similar coverage. If no similar coverage is available, then you may revoke coverage.

- A coverage option is added or significantly improved during the Plan Year for which you are eligible

In this event, even if you did not enroll for coverage, you can elect coverage under the new or significantly improved option.

- You or your Dependent lose coverage under any group health coverage sponsored by a governmental or educational institution

This event allows you or your Dependent to enroll for coverage. Note that if you gain eligibility for group health coverage sponsored by a governmental or educational institution, you may not drop your Company coverage. The change corresponds with a change made by you or your Dependent under another employer plan in the following circumstances:

    - If the annual enrollment period under the other employer plan occurs at a different time of year than Company's annual enrollment and the other employer plan has a period of coverage that is different than the calendar year period of coverage provided under the Company programs.

For example, you elected medical coverage during the Company's annual enrollment held in June. Your spouse's employer conducts annual enrollment in the following November for a twelve (12)

month Plan Year that begins January 1. In this case, you can drop your Company medical coverage if your spouse wants to enroll you as Dependent in her employer's health plan; or

- If the other employer plan allows you or your Dependent to change elections due to the reasons described above (change in status, special enrollment, QMCSO, Medicare or Medicaid entitlement and significant cost or coverage changes).

(4) Special Circumstances: Reemployment.

If you leave the Company and subsequently return to the Company, depending on the time that elapses between your termination date and the date on which you are rehired, you may or may not be eligible to make new elections.

- If you are rehired within thirty one (31) days of your termination, the coverages in effect immediately before your termination will be reinstated and you will not be eligible to make new elections.

- If you are rehired thirty one (31) or more days but less than thirteen (13) weeks after your termination, you have a choice as to whether or not to resume your same coverage or you may make new coverage elections.

- If you are rehired more than thirteen (13) weeks following the date of your termination, you will be treated as a new hire and you must re-enroll in the Plan.

F. Continuation Coverage: COBRA, USERRA, And Other Opportunities

In the event your Plan coverage under a group health Welfare Program terminates, you or your family member(s) may be eligible to continue the coverage for a period of time after the termination. There are several types of continuation coverage that may apply to particular Welfare Program, as summarized below. More detail is provided in the Attachments.

COBRA Continuation Coverage

If coverage for you or your Dependents under a Group Health Program ceases because of certain "qualifying events" specified in a Federal law called "COBRA" (for example, termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of Dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time.

If you have any questions about your COBRA rights, please read the general COBRA notice attached as Exhibit C.

The medical, dental, vision, and Health FSA Welfare Programs will be treated as separate plans for purposes of COBRA. This means that you can elect to continue some or all of these Welfare Programs separately.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about coverage available pursuant to USERRA is included in the Attachments.

Note that state law may also provide continuation and/or conversion coverage requirements for certain insured Welfare Programs.

H. ACA Offer of Minimum Essential Coverage

Notwithstanding the definition of Eligible Employee under the terms of this Plan, the ACA requires that all Employees working an average of at least thirty (30) hours per week be offered Medical Program coverage that meets the ACA "minimum value" and "affordability" requirements.[1] If you are a Per Diem Employee, the Employer will determine whether you worked an average of thirty (30) hours per week =as follows:

(1) New Hires. If at the time of you are hired, you are classified as a Per Diem Employee you are a Per Diem Employee and the Employer cannot determine whether you will work an average of at least thirty (30) hours or more per week, the Company will calculate the hours you work during the twelve (12) month period month beginning on your date of hire (or the first of the month following your date of hire) to determine if you work thirty (30) or more hours per week.

(2) On-going Per Diem Employees. The Employer will determine if you are working thirty (30) hours per week by calculating your average hours worked over the calendar year.

(3) Breaks in Service. If you stop working for the Company for a period of at least thirteen (13) consecutive weeks, and then you resume services for the Company, you may be treated as a new Employee for purposes of Medical Program eligibility. If you take a shorter break in service, upon your resumption of services the Company will treat you as a continuing Employee, with the same status you had before your break in service. In this event, you will be offered Medical Program coverage no later than the first day of the calendar month following resumption of services.

Determination of Per Diem Employee eligibility will be made by the Plan Administrator, in its sole and absolute discretion in accordance with the terms of the Plan and in compliance with the applicable Employer Shared Responsibility Provisions ("ESRP") of the ACA and its accompanying regulations.

[1] At least one of the Company's Medical Programs available to all Eligible Employees (other than Hospital Indemnity and Critical Care Coverage) provides coverage that meets the ACA minimum value and affordability requirements.

I. QMCSOs and National Medical Child Support Orders (NMCSO)

A QMCSO or NMCSO is a court order or a ruling by a state or Federal agency that requires a Group Health Plan to provide coverage to a child or children of an Employee. The Plan Administrator must comply with the terms of any QMCSO/NMCSO it receives, and it will:

(a) Promptly notify the Employee and the child (or child's guardian) that it received the medical child support order, and provide the Group Health Plan's established procedures for determining if the order meets the legal requirements; and

(b) Determine whether such order meets those requirements and notify the Employee and the child of such determination.

J. State Medicaid Programs

Eligibility for coverage or enrollment in a State Medicaid Program will not impact your eligibility or a Spouse's or Dependent's in this Plan. Payment of benefits shall be in accordance with any assignment of rights as required by any State Medicaid Program. If a Welfare Program available under this Plan contains provisions regarding coordination of benefits with State Medicaid Programs, the language in the written materials for such Welfare Program will govern unless the language fails to comply with applicable laws and regulations.

5. BENEFITS AND PARTICIPATION

The Welfare Programs offered under this Plan are listed on Append A. A summary of each Welfare Program describing the benefits provided under the program are attached and considered part of this SPD.

A. Cost of Coverage

The cost of the benefits provided through the Welfare Programs is funded in part by Employer contributions and in part by Employee contributions. Federal tax law governs your ability to pay for benefits on a pre-tax basis, so you may not be permitted to pay for all benefits on a pre-tax basis.

The Employer will determine and periodically communicate your share of the cost of the benefits provided through each Welfare Program, and it may change that determination at any time. The Employer will make its contributions in an amount that (in the Employer's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions and as required by applicable law. With respect to the insured Welfare Programs, the Employer will pay its contributions and forward your contributions to the insurer. With respect to benefits that are self-funded, the Employer will use your contributions to pay benefits directly to (or on behalf of) you or your eligible Dependents from the Employer's general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

Under ERISA, the Plan Administrator of the Group Health Programs may have fiduciary responsibilities regarding distribution of dividends, demutualization and use of the Medical Loss Ratio rebates from the Group Health Program insurers or Claims Administrators. Some or all of any rebate may be an asset of the Plan, which must be used for the benefit of the Participants covered by the policy or Welfare Program. You should contact the Plan Administrator directly for information on how the rebates, if any will be used.

B. When Participation Begins

Coverage under the Plan begins once you, as an eligible Employee, have completed the necessary enrollment paperwork or when you become eligible for a benefit that does not require enrollment, if earlier. Requirements may vary depending on the terms of each Welfare Program. For information about when coverage begins, please read the eligibility and participation information contained in the Attachments.

C. When Participation Ends

Coverage under a particular Welfare Program stops according to the terms and conditions reflected in the Welfare Program documents. Note that termination of coverage under a particular Welfare Program does not necessarily mean all Plan coverage terminates. You (or your covered Dependents) may still have coverage under another Welfare Program.

In general, your coverage under this Plan (including all Welfare Programs) terminates on the last day of the month during which your employment with the Employer is terminated. Coverage under the Plan or a particular Welfare Program may terminate earlier if you fail to pay your share of the premiums, your coverage expires during an approved Leave of Absence, if your active work hours drop below any required eligibility threshold, if you submit false claims, and for certain other reasons described in the Welfare Program documents.

If you are a Per Diem Employee who was determined to have worked thirty (30) or more hours per week during a measurement period, your coverage under the Medical Program will end on the earliest of: (i) the last day of the stability period, if during the coinciding measurement period, you did not average thirty (30) or more hours per week, (ii) the date you fail to pay your share of the premiums when due, or (iii) the last day of the month during which your employment with the Employer terminates.

Coverage for your covered Dependents stops when your coverage stops. Coverage for a Dependent will also stop if that Dependent becomes ineligible (for example, due to divorce or a Dependent's attaining the age limit specified for the Welfare Program) or for other reasons specified in the Attachments (such as nonpayment of applicable premiums). It is your responsibility to provide accurate information and to make accurate and truthful statements regarding family status, age, relationships, etc., and to update previously provided information and statements. ***Failure to do so may be considered an intentional misrepresentation of material fact and may result in termination of coverage and such termination of coverage may be retroactive***.

Coverage also ceases for all Participants upon termination of the Plan by the Company.

D. Participation During an Approved Leave of Absence (including FMLA and applicable state required leaves)

While you are on an approved Leave of Absence, your Group Health Program coverage under the Plan (medical, dental, vision, health FSA) and any other Welfare Program benefits that extend coverage during a protected leave may continue.

If all or a portion of your approved Leave of Absence is paid, payment of your monthly premiums will continue to be deducted in the normal course.

Unpaid Leaves of Absence

If your approved Leave of Absence is unpaid and you elect to continue your coverage under the Group Health Plans (or any other Welfare Programs that permit continued coverage during a Leave of Absence) you will still be required to pay your share of the premiums for such coverage.

The Company will advise you as to the options available to make your monthly premium payments. If the Company pays the amount of your share of the premiums, you will be obligated to repay the amount of the premiums the Company paid on your behalf upon your return to work. If you fail to return to work following your Leave of Absence, you will also be required to repay your share of the premiums paid on your behalf in accordance with the Company's Leave of Absence policies.

If any coverage that is continued has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on an approved Leave of Absence. Coverage under this Plan while you are on an approved Leave of Absence will end on the earliest of the following:

- The date you are required to make any premium contribution and you fail to do so in a timely manner.

- The date the Company determines your approved Leave Absence has ended or is terminated.

- The date coverage discontinues as to your eligible class.

- The date the coverage ends pursuant to the terms of the Welfare Program documents.

If your Group Health Coverage terminates because your approved Leave of Absence ends, you may be eligible to continue your coverage under federal law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If you acquire a new Dependent while your coverage is continued during an approved Leave of Absence, the Dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved Leave of Absence.

If you are on a protected Leave of Absence under FMLA, USERRA or other applicable state law, and you elect to suspend your coverage under this Plan during your approved protected Leave of

Absence and you return work at the end of your protected Leave of Absence, your coverage will be reinstated at the same levels of coverage in effect on the day before your protected Leave of Absence began.

E. Discrimination Based On Health-Related Factors Prohibited

HIPAA prohibits health plans from discriminating against any participant or Dependent in terms of eligibility to participate in the Plan based on a health-related factor. Accordingly, benefits provided under your Plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The Plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

6. CLAIMS PROCEDURES FOR THE PLAN

A. Fully Insured Benefits

Claims for benefits under the Welfare Programs that are provided through insurance contracts will be determined by the respective insurer. The insurer is the named fiduciary, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract. To obtain benefits from the insurer of a component Welfare Program, you must follow that insurer's claims procedures. See the Attachments for more information and Exhibit A for a list of the insured Welfare Programs and the relevant insurance provider contact information.

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

If your claim is denied, you may appeal to the insurer for a review of the denied claim. If you do not appeal on time, you may lose your right to file suit in a state or Federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

Under certain Welfare Programs you may also have the right to obtain an external review (that is, a review of your claim by someone outside of the Plan). See the Attachments for more information about the claims process for insured benefits.

B. Self-Funded Benefits

Benefits provided under the Welfare Programs that are funded by the Company and not through an insurance contract will be determined by the applicable Claims Administrator with which the Plan has contracted to administer those benefits. For example, a claim for benefits under the Dental

Program will be paid directly by the Company, but the Dental Program Claims Administrator will determine the amount of, and entitlement to, the dental benefits under the terms of the Dental Program. The Plan Administrator is the named fiduciary for the fully-insured benefits with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement, but has contracted with the Claims Administrator to determine the initial claims and resolve the appeals of a claim denial.

The claims administration and appeals procedures for the Health Flexible Spending Account, and Dependent Care Flexible Spending Account are set forth in Sections 7 and 8 respectively.

For other self-funded Group Health Plan benefits the following procedures apply:

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.

(1) Initial Claims.

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

(b) *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.

(c) *A Claim Involving Urgent Care* will be decided within seventy two (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 twenty four (24) hours after receipt of your claim. You will have at least forty eight (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 twenty four (24) hours following the failure. The Plan Administrator will contact you of the Plan's decision within forty eight (48) hours of receiving a completed claims application or forty eight (48) hours after the end of the time period you were given to complete your application.

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

A Pre-service Claim will be decided within fifteen (15) days after receipt of your claim by the Plan. The Claims Administrator may extend the initial period by up to fifteen (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 fifteen (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 (5) 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 forty five (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.

A Post-service Claim will be decided within thirty (30) days after receipt of your claim by the Plan. The Claims Administrator may extend that period by up to fifteen (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 thirty (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 forty five (45) days from the receipt of such notice to provide the information to the Claims Administrator.

(f) *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.

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 twenty four (24) hours after receipt of the claim, provided the claim was submitted to the Plan at least twenty four (24) hours before the expiration of the original period of time or number of treatments.

(2) 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;

(f) 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 three (3) days; and

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

(3) 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 one hundred and eighty (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 seventy two (72) hours after receipt of your request for review by the Plan.

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

iii. A Post-service Claim will be decided within sixty (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 (4) months after the date you receive notice of a final internal benefit denial.

Standard External Review

Within five (5) 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 ten (10) days.)

Within one (1) 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 (4) month filing period or within the forty-eight (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 (1) 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 forty five (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) 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

(b) 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 seventy two (72) hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, then within forty eight (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.

C. Claims Deadline

Unless specifically provided otherwise in a component Welfare Program or pursuant to applicable law, **a claim for benefits under this Plan (including the component Welfare Programs) must be made within one (1) year after the date the expense was incurred that gives rise to the claim.** It is the responsibility of the Participant to make sure this requirement is met.

D. Disability Claims Procedures.

In the event a Welfare Program that provides disability benefits does not include claims procedures within the policy documents, the benefits will be determined according to the following procedures:

(1) Time Limits for Initial Claims. If you believe that you are entitled to receive a Disability benefit under the Plan, including one greater than that initially determined by the Administrator, you may file a claim in writing with the Administrator. The Administrator (or their

designee) will, within forty five (45) days of the receipt of a claim, either grant or deny the claim in writing. An extension of thirty (30) days will be allowed for processing the claim if necessary due to matters beyond the Disability Program's control. If that is the case, you will receive notice of such extension before the expiration of the initial forty five (45) day period. The notice will state the special circumstances involved and the date a decision is expected. If, before the end of the first thirty (30) day extension period, the Administrator determines that, due to matters beyond the control of the Disability Program, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, and you will receive an additional notice before the expiration of the first thirty (30) day extension period of the circumstances requiring the additional extension and the date as of which the Disability Program expects to render a decision. In the case of any extension, the notice of extension will specifically explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, You will then be afforded at least forty five (45) days within which to provide the additional information. If additional information is requested to resolve the issues, the time period allowed for making the benefits determination is tolled from the date the notice is sent to you until the date you respond to the notice.

(2) Notice of Initial Denial. The Administrator's denial of a claim will be written in a manner calculated to be understood by you and will include:

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

(b) references to specific Disability Program provisions on which the benefit determination is based;

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

(d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim;

(e) an explanation of the appeal procedure;

(f) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(g) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the

determination, applying the Disability Program's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and

(h) a statement that you have the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

(3) Your Right to Appeal. If your claim is denied in whole or in part by the Administrator you or your authorized representative may, within one hundred eighty (180) days after receipt of denial of the claim or, if no notice of denial was received, within one hundred eighty (180) days of the date the notice should have been provided:

(a) submit a written request for review by the Administrator;

(i) receive reasonable access to, copies (free of charge) of all documents, records and other information relevant (within the meaning of Department of Labor Regulation Section 2560.503-1(m)(8)) to your claim; and

(j) submit written comments, documents, records and other information relating to the claim for benefits.

(4) Independent Review. The review of the initial decision concerning your claim must be performed by someone who is neither the original decision maker nor the subordinate of the original decision maker. In reviewing the initial decision, the decision maker must not give any deference to the initial decision and will consider all information relevant to the claim, not just information relied upon (or available) when the original decision was made. The decision maker will also consider any information submitted by you.

If the benefit determination is based in whole or in part on a medical judgment, the decision maker reviewing the claim will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment issue; provided that such health care professional will be an individual who is neither an individual who was consulted in the connection with the initial claim denial that is the subject of the appeal nor the subordinate of any such individual. The Disability Program will disclose to you the identity of medical or vocational experts whose advice was obtained by the Disability Program in connection with the review, even if the advice was not relied upon in making the final decision.

(5) Time Limits for Decision on Appeal. The Administrator will furnish you with a written decision providing the final determination of the claim. The decision will be issued as soon as reasonable after the date the request for appeal was submitted, and usually within forty five (45) days of the date in which the written appeal was submitted. The Administrator may take an additional forty five (45) days to make this decision if special circumstances are present. The Administrator will give you notice if this extension is necessary before expiration of the initial forty five (45) day period. In no event will such extension exceed a period of forty five (45) days from the end of the initial forty five (45) day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Disability Program expects to render the determination on review.

(6) Notice of Decision on Appeal. The decision concerning an appeal of a claim will be written in a manner calculated to be understood by you and will include:

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

(b) references to specific Disability Program provisions on which the benefit determination is based;

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

(d) an explanation of any voluntary appeal procedures offered by the Disability Program, if any;

(e) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(f) if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Disability Program's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and

(g) a statement that you have the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

Notwithstanding the foregoing, you may not seek benefits under the Disability Program in judicial or administrative proceedings without first complying with and fully exhausting these procedures. In addition, you must bring civil action under ERISA Section 502(a) within two (2) years after your initial claim or within six (6) months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the Disability Benefit Program. The decisions made pursuant to these procedures are final and binding on you and any other party.

E. Limitations Period For Filing Suit

Unless specifically provided otherwise under a Welfare Program or pursuant to applicable law, a suit for benefits under this Plan must be brought within one (1) year after the date of a final decision on the claim in accordance with the applicable claims procedures.

7. HEALTH FLEXIBLE SPENDING ACCOUNT

A. Health Flexible Spending Account

If you elect to participate in the Health Flexible Spending Account, you will determine the total amount you want deferred into your Health FSA Account up to the maximum amount allowed by the IRS each Plan Year. The total amount you elect will be divided by the twenty four (24) pay periods during the Plan Year and that amount will be deducted from your take home cash pay each such pay period on a pre-tax basis. These amounts are your "Salary Reduction Contributions" attributable to your Health FSA.

At any time during the Plan Year, you may submit claims for the reimbursement of eligible "Medical Care Expenses" from your Account for up to the full amount you elect to defer.

If you have a Health Savings Account, you may only be reimbursed for eligible Medical Care Expenses covered by the group health program once you have met your annual deductible under the medical Welfare Program. However, eligible Medical Care Expenses incurred pursuant to the Dental and Vision Welfare Programs may be reimbursed prior to meeting your annual Medical Welfare Program deductible.

If your employment is terminated or you otherwise become ineligible for benefits for any reason prior to the full reimbursement of the amount in your Health Flexible Spending Account, you will forfeit the amount left. Therefore, it is important that you carefully estimate your eligible Medical Care Expenses.

B. Eligible Medical Care Expenses

Eligible Medical Care Expenses are the expenses you pay out of your pocket for medical care that is provided to you, your spouse, and eligible Dependents during the Plan Year.

Generally, IRS rules state that medical care includes items and services that are meant to diagnose, cure, mitigate, treat, or prevent illness or disease. Transportation that is primarily for medical care is also included.

The Internal Revenue Service publishes a list of Eligible Medical Care Expenses each year in IRS Publication 502. This can be found on-line at:

https://www.irs.gov/publications/p502/ar02.html#en_US_2015_publink1000178851

A few examples of eligible Medical Care Expenses are:

- Your health plan deductible (the amount you pay before your plan starts paying a share of your costs, unless you have a Health Savings Account)
- Your share of the cost for doctor's office visits and prescription drugs (if you have a Health Savings Account, only after you have met your annual health plan deductible)
- Your share of the cost for eligible dental care, including exams, X-rays, and cleanings

- Your share of the cost for eligible vision care, including exams, eyeglasses, contact lenses, and laser eye surgery
- Laboratory fees
- X-rays and radiology
- Insulin whether or not you have a prescription
- Over the counter medicines
- Menstrual supplies

Eligible Medical Care Expenses do not include such things as:

- Premium payments for coverage under any health insurance plan
- Cosmetic surgery and procedures, including teeth whitening
- Expenses for comfort or vitality such as massages or vacations
- Herbs, vitamins, and supplements used for general health
- Personal use items such as toothpaste, shaving cream, and makeup
- Prescription drugs imported from another country

These are not complete lists of eligible Medical Care Expenses and exclusions. Please refer to IRS Publication 502 if you have any questions.

The IRS prohibits "double dipping", meaning expenses reimbursed under your Health Flexible Spending Account cannot be reimbursed under any other plan or program. Only your out-of-pocket eligible Medical Care Expenses are eligible for reimbursement and Medical Care Expenses reimbursed under this Plan may not be deducted when you file your tax return.

C. Forfeitures

(1) Generally. Any amounts left in your Health Flexible Spending Account after the processing of all your claims for eligible Medical Care Expenses will be forfeited at the end of each Plan Year. However, if a balance remains in your Account at the end of the time period for submitting claims for the Plan Year, up to $550 of such balance will be carried forward into the succeeding Plan Year. In addition, there may be additional certain circumstances permitted by the IRS and determined by the Company, allowing you to rollover remaining amounts to the next Plan Year. The Plan Administrator will provide you with information regarding these special circumstances if they are applicable.

(2) Special Rule for Unused Benefits of Individual Called to Active Duty.

Pursuant to the Heroes Earnings Assistance and Relief Tax Act of 2008 ("**HEART Act**") if you are a member of a reserve component of the US military and you are ordered or called to active duty for a period in excess of one hundred seventy nine days or for an indefinite period, you may request a distribution of all or a portion of the balance in your Health Flexible Spending Account, provided such distribution is made during the period beginning on the date of your order or call to

active duty and ending no later than ninety (90) days after the end of the Plan Year in which such order or call commenced.

D. Limitation of Allocations

Each year the IRS sets the maximum amount you may elect to contribute to your Health FSA. This Plan will allow you to elect up to the IRS maximum amount each Plan Year. The Company will let you know the maximum amount each year during Open Enrollment. You may always elect to contribute less than the maximum amount.

E. Health Flexible Spending Account Claims

(1) Eligibility for Reimbursement

You may only submit claims for reimbursement of eligible Medical Care Expenses that you incur while you are covered by this Plan and that you incur only during the current Plan Year. However, you may submit a claim for advance payment for certain orthodontia and durable medical equipment.

(2) Claims

The Company has hired a Claims Administrator to process your Health Flexible Spending Account claims. You must submit your eligible claims to the Claims Administrator pursuant to its procedures within a reasonable time after you incur the expense. You will have ninety (90) days following the end of the Plan Year to submit your claims before the amounts in your Account will be forfeited.

The written application for reimbursement must include a written statement that the eligible Medical Care Expense has been incurred by you and the amount of such expense. For example, you may submit a doctor's bill or an explanation of benefits from your insurance company. If you fail to submit a claim by the ninety (90^{th}) day immediately following the end of the Plan Year your claim will not be considered for reimbursement.

The Claims Administrator will inform you if your claim has been denied within a reasonable time but no later than thirty (30) days after it receives your claim. The Claims Administrator may extend that time up to an additional fifteen (15) days for circumstances that arise that are out of the Claims Administrator's control.

If an extension is necessary, you will be notified before the end of the initial thirty (30) day timeframe of the reasons for the delay and when the Claims Administrator expects to make a decision. Further, if an extension is necessary because certain information was not submitted with the claim, the notice will describe the required information that is missing, and you will be given an additional period of at least forty five (45) days after receiving the notice to furnish the information. The Claims Administrator will then notify you of its decision within fifteen (15) days after your response is received.

(3) Appeals

If you disagree with the decision on a claim, you (or your authorized representative) may file a written appeal with the Claims Administrator within one hundred eighty (180) days after receipt of the notice of adverse decision. The notice of adverse decision will include the appeal procedures. If you do not appeal on time, you may lose the right to file suit in a state or federal court, as you will not have exhausted internal administrative appeal rights (which is generally a requirement before suing in state or federal court).

You should include the reason you believe the claim was improperly denied, and all additional facts and documents you consider relevant in support of the appeal. The decision on your appeal will consider all comments, documents, records, and other information submitted, even if they were not submitted or considered during the initial claim decision.

A new decision maker will review the denied claim on appeal. The new decision maker will not give deference to the original decision on your claim. That is, the reviewer will give the claim a "fresh look" and make an independent decision about the claim.

You will receive a notice of decision on the appeal no later than sixty (60) days from the date the Plan receives all the information relevant to your appeal. If the Plan needs more time to issue its decision on appeal due to special circumstances, it must notify you before the end of the sixty (60) day period and it may only extend the time for an additional sixty (60) days. You will receive a notice of decision on appeal whether or not the Plan makes an adverse decision on the appeal. The timeframes for providing a notice of decision on appeal generally start when a written appeal is received by the Plan. Notice of decision on appeal may be provided in writing through in-hand, mail, or electronic delivery.

Upon request and free of charge, you have a right to reasonable access to and copies of all documents, records, and other information relevant to the Plan's denial of a claim.

(4) Debit Cards

If you are an active Employee, you may use a debit card to pay for eligible Medical Care Expenses, subject to the following terms:

(a) By accepting and using the debit card, you certify that such card will only be used for eligible Medical Care Expenses, that any Medical Care Expense paid with the card has not already been reimbursed by any other plan covering health benefits, and that you will not seek reimbursement from any other plan covering health benefits.

(b) The card will be issued on your effective date of coverage and reissued for each Plan Year that you elect to allocate Salary Reduction Contributions to this Health Flexible Spending Account. The card will be automatically canceled upon your death or termination of employment, or if you have a change in status that results in your withdrawal from the Health Flexible Spending Account.

(c) The dollar amount of coverage available on the card will be the amount you elected for the Plan Year up to the IRS maximum allowed amount each Plan Year.

(d) The cards will only be accepted by such merchants and service providers approved by the Administrator.

(e) The cards may only be used for Medical Care Expense purchases. Following are a few examples of Medical Care Expenses you may use your Debit Card for:

- Copayments for doctor and other medical care
- Co-insurance amounts
- Purchase of drugs
- Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) You must substantiate the purchases by providing receipts from your service providers detailing the service, the amount and the date.

(g) If your purchase is later determined by the Administrator to not qualify as an eligible Medical Care Expense, one of the following correction methods will be used to make the Plan whole and until the amount is repaid, the Administrator may deny you access to the card:

- Your repayment of the improper amount;
- Withholding the improper payment from your wages or other compensation to the extent consistent with applicable federal or state law; and
- Claims substitution or offset of future claims until the amount is repaid; and if the above fail to recover the amount, the Company may treat the amount as any other business indebtedness.

8. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account is designed to help you pay for childcare services for your child who is under the age of thirteen (13) or care services for a disabled spouse or Dependent when those services make it possible for you or your spouse to work. Any type of Dependent care that you could legally claim as a deduction from your federal income tax is eligible for reimbursement under the Dependent Care Flexible Spending Account.

If you elect to participate in the Dependent Care Flexible Spending Account, you will determine the total amount you want deferred into your Account up to the maximum amount allowed by the IRS each Plan Year. That amount will be divided by twenty four (24) pay periods during the Plan Year and deducted from each such pay each pay period on a pre-tax basis. These amounts will be

your "Salary Reduction Contributions" attributable to your Dependent Care Flexible Spending Account.

B. Eligibility

To be eligible for this benefit, you (and your spouse, if you are married and your spouse is not disabled or a full-time student) must be at work during the time your eligible Dependent(s) is receiving care.

You qualify for this benefit if any of the following:

- You are a single parent
- You have a working spouse, or your spouse is a full-time student for at least five (5) months during the year while you are working
- Your spouse is disabled and unable to provide for his or her own care

C. Allowable Expenses

(1) Eligible Providers

You may submit eligible Dependent care expenses for child or Dependent care that is provided by:

- Anyone other than your spouse, someone who is your Dependent for income tax purposes, or one of your children under age nineteen (19)
- A day care center or camp (if the center cares for more than six children, it must comply with all applicable state and local regulations)
- A housekeeper whose services include, in part, providing care for an eligible Dependent

(2) Eligible expenses include:

- The total cost of sending your child to school if your child is in a grade level below first grade and the amount paid for schooling is not separated from the cost of care
- Cost of daycare (excluding tuition) if your child is in first grade or higher
- Dependent care centers, providing daycare not residential care, for Dependent adults
- Cost of household services related to the care of a Dependent
- Social Security taxes or other taxes paid on behalf of a provider of Dependent care.

(3) Ineligible Expenses

Expenses which may not be reimbursed under the Dependent Care Flexible Spending Account are:

- The cost of transportation between your home and your Dependent care provider

- Any amount paid for services outside your home at a camp where your child or disabled spouse or Dependent stays overnight

- Amounts paid to provide food, clothing or education

If both you and your spouse work and both participate in Dependent Care Flexible Spending Accounts, your combined contributions must fall within the maximum IRS limits. And, if you are filing your taxes separately, your Salary Reduction Contributions can be no more than half of your total allowable maximum contribution.

If during a calendar year, your Dependent care expenses exceed the applicable dollar limit, amounts reimbursed above the limit will be taxable.

D. Tax Credit Alternative

Payments to you under the Dependent Care Flexible Spending Account for qualifying Dependent care expenses will not be taxable income to you. However, in some cases it may be more beneficial to claim the Dependent care credit on your income tax return than for you to have expenses reimbursed through this Plan. The Plan and the Company do not provide tax advice and they strongly recommend that you contact your personal tax advisor for guidance.

E. Termination of Coverage

When you are no longer eligible to participate in this Plan, your participation in the Dependent Care Flexible Spending Account will immediately end. However, you are entitled to receive reimbursement for any eligible Dependent care expenses you incurred up to the date you became ineligible, not exceeding the actual amount of Salary Reduction Contributions attributable to your Dependent Care Flexible Spending Account as of your last day of eligibility.

F. Forfeitures

Any amounts left in your Dependent Care Flexible Spending Account after the processing of all your claims for eligible Dependent care expenses for the Plan Year shall be forfeited.

G. Limitation of Allocations

Each year the IRS sets the maximum amount you may elect to contribute to your Health Care Flexible Spending Account. This Plan will allow you to elect up to the IRS maximum amount each Plan Year.

H. Claims

The Company has hired a Claims Administrator to process your claims for reimbursement under the Dependent Care Flexible Spending Account. You will have ninety days after the end of the Plan Year to submit your eligible claims for reimbursement in a form acceptable to the claims administrator. You must also provide substantiation of the eligible Dependent care expenses you incur such as a receipt or invoice.

9. INCORPORATED DOCUMENTS

All documents relating to the Plan, including the Insurance Policies, Certificates of Coverage and Welfare Program documents, a listing of Network Providers, premium contribution rates, the Plan's General COBRA Notice, Medicare Creditable Coverage Notice, and any other relevant Plan documents or notices, are available to Participants via the Employer's internal benefits website. Plan Participants may receive a paper copy of any of the above documents free of charge by contacting the Plan Administrator.

Please refer to the Welfare Program documents for specific details, including a description of benefits, cost-sharing provisions, requirements for use of network providers, and circumstances by which benefits may be denied.

10. ADMINISTRATION & FIDUCIARY POWERS

This SPD, the official Welfare Plan document and the component Welfare Programs' documents and summaries provide the terms for the various benefits provided, whether each benefit is insured or self-funded, and claims administration and other services for the Welfare Programs. The Plan Administrator, at its discretion, may elect to use a third party claims administrator (TPA) to administer a Welfare Program and adjudicate claims. The Plan Administrator may serve as a point of contact for questions regarding any of the Welfare Programs. For the self-funded Welfare Programs, the Plan Administrator has ultimate fiduciary responsibility for benefit determinations. The TPA will have limited fiduciary responsibility for claims determinations. For fully-insured Welfare Programs, the insurance company is deemed the fiduciary and will review benefits claims and appeals.

A. Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Plan Administrator has discretionary power to administer the Plan and make decisions regarding benefits to the fullest extent under applicable law. The Plan Administrator has full discretionary authority to, among other things, interpret the Plan, to establish Plan rules and procedures, to determine eligibility for and the amount of benefits under the Plan, to make all factual determinations relevant to Plan operations and benefits, to authorize benefit payments and to gather information necessary for administering the Plan.

B. Power and Authority of Insurer or Third Party Administrator

Certain benefits offered under the Plan are fully-insured while other benefits may be self-funded and paid from the Company's general assets. The Insurers are responsible for (1) determining eligibility for and the amount of any benefits payable under the respective Insurance Policies, and (2) prescribing claims procedures to be followed and the claims forms to be used by Participants. The Plan Administrator has delegated certain responsibilities with respect to benefit determinations and eligibility to the Claims Administrators for self-insured Welfare Programs.

Insurance premiums for you and your eligible Dependents are paid in part by the Company out of its general assets and in part by your contributions. The Plan Administrator provides a schedule of the applicable Welfare Program premiums during your initial Plan enrollment, subsequent Open Enrollment Periods and upon your request.

C. Exclusive Benefit

No part of the Plan or its assets shall be used for purposes other than for the exclusive benefit of eligible Employees, Dependents, and their designated beneficiaries, in accordance with the provisions of the Plan, other than paying of reasonable expenses associated with administering the Plan.

11. POSSIBLE LIMITS ON OR LOSS OF BENEFITS

A. Denial or Loss of Benefits

Your benefits under the Plan will cease when your participation in the Plan terminates, such as when you cease to meet the eligibility requirements under the Plan, or your employment terminates, and you do not elect to continue coverage under COBRA. Your benefits will also cease if or when the Plan is terminated by the Company. Other circumstances can result in termination, reduction or denial of benefits such as failure to pay your share of the premiums or if you commit fraud in applying for or receiving benefits. Refer to the Welfare Plan documents for additional details regarding when a Welfare Plan may terminate.

B. Coordination of Benefits

If you and your covered family members do not maintain coverage under another health and welfare plan that is not sponsored by the Company, the Plan will be the primary payer for all eligible claims and benefits as defined in the underlying Welfare Plans documents. If you and your covered family members are covered by another medical or insurance plan, the two (2) plans will coordinate together eliminating duplication of payments as explained in the Welfare Plan documents. The Insurer has primary responsibility to coordinate benefits for eligible expenses for other employer plans, government plans, Medicare or other coverage such as motor vehicle insurance.

C. Subrogation of Benefits

This Plan will not cover any illness, injury or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. However, the Plan will provide you with benefits for claims incurred due to the acts of a third party. Once you have accepted such benefits, you and your covered family members automatically agree to refrain from any act that would result in prejudicing the Plan's right to subrogation. Subrogation means that if you or your covered family members accept any payment under this Plan, the Plan will then have the right to "step into your shoes" and sue a third party whom you or your covered family members could have sued.

Also, if you have already received a payment from the Plan, and you receive an additional payment for the same expense, you must reimburse the Plan for all the payments you have already received. The additional payment includes the following: (a) payment from a third party due to any settlement arrangement or agreement, and (b) payment as a result of a court decision or arbitration. In such a situation, the reimbursement must be made to the Plan regardless of whether the additional payment is made to you due to a settlement or judgment. However, the reimbursement to the Plan will not exceed the amount received by you for such medical expenses from the third party or the amount the Plan paid for such expense.

If you decide to sue a third party for expenses that are covered under this Plan, the Plan shall not be responsible for any fees or costs you incur without first obtaining the Plan's consent. In addition, you must provide the Plan Administrator with written notice of any and all demand letters, complaints and or other claims you make against a third party for recovery of expenses that are covered under this Plan within ten days of the date such act is made. As part of the written notice, you will be required to provide the Plan Administrator with a copy of the demand letter, complaint or other claim made against the third party.

The Plan has first priority from any recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries. You and your legal representative must do whatever is necessary to enable the Plan to exercise its rights and must do nothing to prejudice those rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan. The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan. To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, your attorney fees, other expenses or costs.

The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

If it is unclear whether third party liability exists with respect to a condition or occurrence which causes you or your covered family member to incur medical expenses, the Plan Administrator may, in its sole and absolute discretion, decide to not seek reimbursement from you without waiving its right to seek reimbursement for any other claims under that may be subject to the Plan's subrogation rights.

12. REQUIRED NOTICES AND ADDITIONAL INFORMATION

A. HIPAA Privacy And Security Provisions

Title II of HIPAA requires group health plans to protect the confidentiality of your private health information. This Plan will not use or disclose information that is protected by HIPAA ("Protected Health Information") except as necessary for treatment, payment, health care operations, and plan administration functions or as otherwise permitted or required by law (such as by the Company for enrollment, participation, and in summary form, for obtaining insurance premium bids or modifying or terminating the Plan), without your written authorization. The Company has required all of its employees that have access to the Plan's Protected Health Information ("PHI") to comply with the HIPAA privacy and security rules.

Before this Plan may disclose, or permit one of its agents or contractors to disclose, PHI to the Company, the Plan will require the Company to:

- Certify that the information is necessary in connection with plan administration functions or other permitted functions performed or to be performed by the Company;
- Amend the Plan documents and provide certification of amendment to give assurances that the Company will use and disclose the information solely in connection with such plan administration or other permitted functions; and
- Not use or further disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company without your authorization.

Under HIPAA, you have certain rights with respect to your PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information and, under certain circumstances, to amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights under HIPAA have been violated.

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

B. Summary of Notice of Privacy Practices

The Plan's Notice of Privacy Practices for Protected Health Information (the "**Notice**") contains important information about your privacy rights. It is attached as Appendix D. The Plan Administrator recognizes that the Notice is lengthy and detailed. You still should read the entire Notice carefully.

This summary highlights some of the important points in the Notice. However, this summary is not a substitute for the Notice.

- The Notice applies to information about your health care and payment for your health care created or received by, or on behalf of, Renown's group health, pharmacy benefit and dental plans. The Notice does not apply to health information in employment records.
- The Notice explains how the Plan Administrator will use and disclose your health information without your written permission.
- The Notice explains how you can exercise certain rights. These rights include the right to access your health information, the right to amend your health information, and the right to receive an accounting of when and why the Plan Administrator has disclosed your health information to others.
- The Notice explains how you can file a complaint, either with the Plan Administrator or with the federal government, if you believe the Plan Administrator has violated the policies and procedures stated in the Notice.
- The Notice provides contact information for the person who can answer your questions or respond to your complaints about the Plan Administrator's use and disclosure of your health information.

C. ERISA RIGHTS AND NOTICES

With respect to the group health care Welfare Plans, the Plan 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. Please see the official Plan document and the Welfare Program documents for more information regarding these laws.

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 forty eight (48) hours following a vaginal delivery, or less than ninety six (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 forty eight (48) hours (or ninety six (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 forty eight (48) hours (or ninety six (96) hours).

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.

HIPAA Portability 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 thirty (30) days of the qualifying event or as required by state or federal law (sixty (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.

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.

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 twenty six (26) weeks of leave in a single twelve (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 twelve (12) month period during which you are entitled to a combined total of twenty six (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).

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.

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.

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.

Participant's Responsibilities

You and your covered Dependents are responsible for providing the Plan Administrator, Claims Administrators, Welfare Program insurers, and third-party administrators as applicable 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.

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.

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".

13. 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 one hundred (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 thirty (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 one hundred and ten dollars ($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 ninety (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.

14. TERMINATION OF BENEFITS

Some Welfare Program benefits may terminate as of the last day of the month in which your employment ends and other Welfare Program benefits may terminate as of your last day of employment. Participation in the Plan may also be terminated due to disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, etc. Refer to the corresponding Welfare Program documents for detailed information.

Some Welfare Programs may contain conversion privileges; while, some Welfare Programs may offer continuation options for such benefits as Medical/Prescription Drug, Vision and Dental under COBRA as previously explain in this SPD. Check with the Plan Administrator for possible conversion options or questions on possible continuation rights. See each Welfare Program document for specific termination provisions.

15. PLAN AMENDMENT AND TERMINATION

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 sixty (60) days' written notice.

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.

COVID-19 Outbreak Period Deadline Extension

Due to the COVID-19 public health emergency, the federal government has issued guidance extending some of the regular deadlines under ERISA and the Tax Code.

You now have extra time to:

- File a claim for benefits or an appeal of a denial of benefits under the Group Health Welfare Programs;
- Elect COBRA continuation coverage;
- Pay your initial, or monthly, COBRA premiums;
- Notify the Company of a COBRA qualifying event or of a qualified beneficiary's determination of disability by the Social Security Administration;
- Enroll yourself, your Spouse or your Child in the Medical Welfare Program due to a HIPAA Special Enrollment right such as the birth, adoption, or placement for adoption of your child, your marriage or loss of other coverage; and
- File a request under the Medical Welfare Program for, and to provide information needed to obtain, an independent external review with respect to certain claim denials.

For additional information about the extended deadlines please refer to the Joint Notice and final regulations issued by the Internal Revenue Service and the U.S. Department of Labor, which can be found on the U.S. Department of Labor's website at dol.gov. You can also refer to COVID-19 FAQs issued by the U.S. Department of Labor, which is available on their website.

These extensions apply to the deadlines described throughout this document and any applicable Incorporated Documents, even if standard deadlines are referenced in this document or the Incorporated Documents. In addition, some future standard communications may contain "boilerplate" information that includes the usual deadlines (which are now temporarily subject to an Extension). Consequently, you are responsible for understanding whether an Extension applies to your particular situation and determining when the Extension ends.

ATTACHMENTS

Welfare Plan Documents and Summaries

APPENDIX A

COMPONENT WELFARE PROGRAMS AND ADMINISTRATORS

Self-Insured plans denoted by (SI)

*Not Subject to ERISA

Use the address and phone number provided on your ID Card if different.

Welfare Program	Policy or Contact #	Contact Information
Medical (SI)– Hometown Health Insurance	Group # 9990115	1-775-982-5883 or 1-800-336-1703 1-844-373-0970 pharmacy services P.O. Box 981703 El Paso, TX 79998-1703 www.hometownhealth.com
Dental - MetLife	Group #317876	1-866-832-5756 P.O. Box 981282 El Paso, TX 79998-1282 www.mwtlife.com/mybenefits
Vision – Vision Service Plan (VSP)	Group #12081061	1-800-877-7195 www.vsp.com
Health FSA – WEX Health Inc.	Group #36521	1-866-451-3399 customerservice@wexhealth.com email benefitslogin.wexhealth.com
Dependent Care FSA - WEX Health Inc.	Group #36521	1-866-451-3399 customerservice@wexhealth.com email benefitslogin.wexhealth.com
Life/AD&D – The Standard	Policy #758424-A	1-833-240-6583 general information 1-800-368-2859 customer service www.standard.com
Long Term Disability – The Standard	Policy #758424-B	1-833-240-6583 general information 1-800-368-2859 customer service www.standard.com
Short Term Disability - Aflac	Policy #27267	1-800-433-3036 groupclaimfiling@aflac.com email aflacgroupinsurance.com
Provider Short Term Disability (SI) – The	Policy #758425-A	1-833-240-6583 general information

Standard		1-800-368-2859 customer service www.standard.com
EAP – Health Advocate	The Standard EAP 3 Visits	1-888-293-6948 TDD 1-800-327-1833 Healthadvocate.com/standard3
Accident Insurance – The Standard	Policy #758424-C	1-833-240-6583 general information 1-800-368-2859 customer service www.standard.com
Critical Illness – The Standard	Policy #758424-D	1-833-240-6583 general information 1-800-368-2859 customer service www.standard.com
Hospital Indemnity – The Standard	Policy #758424-E	1-833-240-6583 general information 1-800-368-2859 customer service www.standard.com
Universal Life - Transamerica	Policy #EL00071304	1-888-763-7474 TEBcustresp@transamerica.com Transamericaemployeebenefits.com
Identity Theft* - Allstate	Policy #4491	1-888-537-9068 https://privacyarmor.infoarmor.com
Legal Services*- MetLife Legal	Plan #9903507 &9903509	1-800-821-6400 https://members.legalplans.com
Commuter Benefits - Regional Transportation Commission (RTC)		1-775-348-POOL http://www.rtcwashoe.com/

APPENDIX B- Eligibility

Eligibility

Unless otherwise stated by the Insurance Certificate, Employees are eligible for the Benefit Program(s) shown in Appendix A if you meet the criteria indicated in the "Benefits Offered" Table below. The Table denotes our Employee Classes, the work hours requirements for eligibility (eligibility hours), and the date upon which coverage begins for our various Benefit Programs. If you have any questions about this Table or what Employee Class applies to you, please reach out to the Company or the Human Resources/Benefits Team to confirm your benefits eligibility.

Employee Class	Working Hours Requirement	Benefits Offered	Effective Date of Eligibility
Full-time	30	All benefits on Appendix A	First of the month following thirty (30) days of employment
Part-time	20	All benefits on Appendix A	First of the month following thirty (30) days of employment
Variable Hour	30+ hours per week determined over 12 month measurement period		

APPENDIX C

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice 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.

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."

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.

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 twenty nine (29) months. The disability would have to have started at some time before the sixtieth (60^{th}) day of COBRA continuation coverage and must last at least until the end of the eighteen (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 eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty six (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.

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**.

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[2] 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

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

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.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

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:
PO Box 226101
Dallas, TX 75222

APPENDIX D

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed by the Plan and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run the Plan
- Pay for your health services
- Administer the Plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within sixty (60) days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll

provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the Plan's Privacy Officer at **markneu@renown.org**, or

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:
  200 Independence Avenue, S.W., Washington, D.C. 20201,
  calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care

- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your employer for plan administration purposes such as participation statistics to explain the cost of premiums and cost sharing options.

Example: We provide your employer with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

Premium Assistance Under Medicaid & Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health- plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health - insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**

Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840

IOWA-Medicaid and CHIP (Hawki)	MINNESOTA-Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**

Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493

NEW YORK-Medicaid	UTAH-Medicaid and CHIP
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565