RENOWN HEALTH

WELFARE BENEFITS PLAN

AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2019

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ARTICLE 1.
INTRODUCTION AND PURPOSE OF PLAN

1.1 INTRODUCTION

Renown Health (the "Company") hereby amends and restates the Renown Health Welfare Benefits Plan ("Plan" or "Welfare Benefits Plan") as of January 1, 2019.

The Welfare Benefit Plan consists of two basic parts: this "core" document and the Component Plans which together constitute a single plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") for purposes of satisfying the reporting requirements of ERISA Title I. The core document provides general terms that apply to all benefits except as explicitly otherwise provided under the Component Plans. Each Component Plan, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. The Component Plans describe each particular benefit provided under the Welfare Benefit Plan. Each Component Plan contains particular rules that apply only to the benefit described in that Component Plan. If the terms of this Welfare Benefit Plan and any Component Plan conflict, the terms of the Component Plan will control. Any terms exclusively applicable to a Component Plan will be set forth in the applicable Component Plan Material.

1.2 PURPOSE

The Plan is intended to constitute an employee welfare benefit plan as defined in ERISA Section 3(1), and, as such, to provide the Company's eligible employees and their eligible dependents with the benefits described in the Component Plans. However, to the extent provided in any Component Plan, the Plan may also provide benefits not described as welfare benefits in ERISA Section 3(l). The Plan will be administered for the exclusive benefit of eligible employees and their eligible dependents solely to provide such benefits in accordance with the provisions of the Plan.

ARTICLE 2.
DEFINITIONS

The following terms, when capitalized, have the meanings specified below, except to the extent otherwise defined in a Component Plan.

2.1 *Affiliate*

Affiliate means any corporation, limited liability company or other business entity that is: (a) under common control with the Company (as determined under Code Section 414(b) or (c)); (b) a member of an affiliated service group with the Company (as determined under Code Section 414(m); (c) required to be aggregated with the Company pursuant to Code Section 414(o); or (d) related closely enough to the Company that such corporation or entity's participation in this Plan would not be considered a "multiple employer welfare arrangement" under Section 3 of ERISA.

2.2 *Affordable Care Act*

Affordable Care Act means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and the applicable regulations

thereunder.

2.3 ***CLAIMS Administrator***

Claims Administrator means any person or persons appointed by the Company to provide claims administration services to the Plan for a particular Component Plan.

2.4 ***COBRA***

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and the regulations issued thereunder.

2.5 ***Code***

Code means the Internal Revenue Code of 1986, as amended and the regulations issued thereunder.

2.6 ***Committee***

Committee means the committee comprised of the Chief Human Resources Officer or such other officers of the Company as may be designated by the Chief Executive Officer, that will perform the duties and responsibilities as detailed in this Plan document and, if applicable, the documents of a Component Plan. .

2.7 ***Company***

Company means Renown Health and any successor of Renown Health that adopts the Plan by action of its governing body or that contractually assumes the obligations of the Company under the Plan.

2.8 ***Component Plan***

Component Plan means an employee welfare benefit program or arrangement which is sponsored by the Company and that forms part of the Plan. The Component Plans offered through the Plan are listed in Exhibit A. The Company, in its discretion, may adopt, modify, replace or terminate Component Plans from time to time.

2.9 ***Component Plan Material***

Component Plan Material means the materials (such as insurance contracts, administrative service agreements, summary of benefits documents, or provider network contracts) attached as Exhibit B that constitute the plan documents of the Component Plans.

2.10 ***Dependent***

Dependent has the meaning specified below, except as otherwise provided in the Component Plan Material, and subject to the other terms and conditions of this Plan (including Section 3.2) and the Component Plans.

(a) "Dependent" means:

(1) a Participant's legal spouse, provided that:

(A) such spouse is not otherwise eligible for other group health coverage other than (x) a plan with a deductible of $5,000 or more; (y) a limited medical plan; or (z) a plan for which the participant is responsible for 100% of the premiums; and

(B) such spouse is not separated from the Employee pursuant to a legal separation decree;

(2) each child (regardless of marital status) of a Participant until the end of month in which he turns age 26; and

(3) each child of a Participant who is age 26 or older who is claimed as a dependent on the Participant's tax return and who is physically or mentally handicapped or incapacitated, provided the terms and conditions of subsection (d) are satisfied.

(b) For purposes of this Section 2.10, "child" includes:

(1) the Participant's natural child and legally adopted child;

(2) a stepchild or a child committed by a court of law to the custody of the Participant or his spouse where health coverage is not available through the child's natural parents or through a state or federal agency;

(3) a stepchild for whom the Participant's spouse is required to provide medical coverage even though such spouse does not have custody of the child; and

(4) a child under the age of 18 for whom the Participant is a legally appointed guardian, provided that the child resides with the Participant in a parent-child relationship and is primarily dependent on the Participant (or the Participant's spouse) for maintenance or support.

(c) Notwithstanding any of the previous limitations or definitions, "Dependent" also includes any child required to be enrolled in the Plan pursuant to a qualified medical child support order (QMCSO) to the extent required by law. A Participant's Spouse is not eligible for coverage under a QMCSO.

(1) A QMCSO can be issued by a court of law or by a state or local child welfare agency. In order for the medical child support order to be qualified, the order must specify the following: (1) the Employee's name and last known mailing address (if any) and the name and mailing address of each alternate recipient covered by the order; (2) a reasonable description of the type of coverage to be provided, or the manner in which the coverage will be determined; and (3) the period to which the order applies.

(2) A National Medical Support Notice (NMSN) is a QMCSO issued by a state or local child welfare agency to withhold from an Employee's income any

contributions required by the Plan to provide health insurance coverage for a child.

(3) The Employee and the child must be eligible for coverage under the Plan, unless specifically required otherwise by applicable law. The Employee and the child will be enrolled without regard to annual open enrollment restrictions.

(4) The effective date of coverage under a QMCSO will be the later of:

(A) the start date indicated in the order;

(B) the date any applicable waiting period is satisfied; or

(C) the date the Plan receives the order.

(5) Court-ordered coverage for the child will be provided to the age specified in the order, but no later than age 26 (for a Component Plan providing group health coverage) or age 18 (for other Component Plans).

(d) A child's status as a Dependent will be extended past the age of 26 if, while the child's coverage under the Plan as a Dependent is in force and the child otherwise qualifies as a Dependent, such child:

(1) is incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap or other incapacity;

(2) became so incapable prior to attainment of age 19; and

(3) is claimed as a dependent on the Participant's tax return.

However, to continue such coverage the Participant must have submitted to the Committee, within 31 days before such Dependent's attainment of age 26, written proof of incapacity acceptable to the Committee and must continue to timely make any required contributions for such coverage. The coverage of any such Dependent may be terminated pursuant to the other termination provisions of this Plan.

The Committee, upon receipt of proof of such incapacity, has the right and opportunity to have a physician it designates examine such Dependent when and so often as it may reasonably require, but not more often than once each Plan Year after such incapacity has continued uninterruptedly for at least 24 months beyond the date the initial written proof is received by the Committee.

All Dependent coverage under the Plan extended under this subsection (d) will automatically and immediately cease on the last day of the month following the earliest of:

(1) the date the Dependent's incapacity no longer exists;

(2) the date the Dependent fails to submit to any required medical examination; or

(3) the date the Participant fails to submit any required proof of the uninterrupted existence of the Dependent's incapacity.

2.11 ***Eligible Employee***

Eligible Employee means, except as otherwise provided in the Component Plan Material, (a) a full-time or part-time Employee regularly scheduled to work at least 20 hours per week who has been employed by the Employer for 30 consecutive calendar days and (b) solely for purposes of the Medical Plan Component, a member of the Board of Directors of Renown Health who is not eligible for group medical insurance coverage through his or her employer.

2.12 ***Employee***

Employee means a common law employee of an Employer. However, the term Employee excludes:

(a) leased employees (including but not limited to those individuals who must be treated as employees for limited purposes under the leased employee provisions of Code Section 414(n));

(b) any individual classified by the Employer as a per diem employee, leased employee, contract worker, independent contractor, temporary employee, consultant, intern, or casual employee for the period of time during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS, a court or any other entity to be a common-law employee of the Employer, unless a Component Plan specifically provides coverage for such individual;

(c) any individual who performs services for the Employer but who is paid by a temporary agency or other such staffing agency for the period of time during which such individual is paid by such agency, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer;

(d) a nonresident alien with no U.S. source income; and

(e) any individual who is subject to an agreement that by its terms excludes such individual from participation in the Plan.

2.13 ***Employer***

Employer means the Company and any Affiliate which adopts this Plan with the Company's approval.

2.14 ***ERISA***

ERISA means the Employee Retirement Income Security Act of 1974, as amended, and the regulations issued thereunder.

2.15 ***HIPAA***

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and the applicable regulations issued and effective thereunder.

2.16 ***Participant***

Participant means an Eligible Employee or Dependent who is covered under the Plan pursuant to ARTICLE 3 and who has properly enrolled in, and who participates in, a Component Plan in accordance with the terms and conditions established for that benefit plan, and who has not for any reason become ineligible to participate in the Plan.

2.17 ***Plan***

Plan means this Renown Health Welfare Benefits Plan, as amended from time to time.

2.18 ***Plan Administrator***

Plan Administrator means the Committee.

2.19 ***Plan Year***

Plan Year means the calendar year.

2.20 ***Special Enrollment Event***

Special Enrollment Event means the events described in Code Section 9801(f), which are generally described below:

(a) loss of coverage under another employer's group health plan or other health insurance due to loss of eligibility for non-COBRA continuation coverage, the termination of employer contributions toward non-COBRA coverage or the exhaustion of COBRA continuation coverage by an Eligible Employee or Dependents;

(b) an Eligible Employee's acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption;

(c) an Eligible Employee or his Dependent losing eligibility for their Medicaid or state children's health insurance program ("SCHIP") coverage; or

(d) an Eligible Employee or his Dependent becoming eligible for a state premium assistance subsidy from Medicaid or SCHIP.

In addition, the term Special Enrollment Event includes any future change to the definition in Code Section 9801(f).

2.21 ***Summary Plan Description***

Summary Plan Description means the summary plan description for the Plan, as it may be amended from time to time by the Committee.

ARTICLE 3.
PARTICIPATION

3.1 PARTICIPATION

(a) ***Generally***. The terms and conditions for the enrollment procedures in any Component Plan will be provided in the Summary Plan Description or in other information from the Committee. Participation in the Plan commences when an Eligible Employee or Dependent first becomes covered under any Component Plan.

(b) ***Special Enrollment***. In addition to annual enrollment procedures described in the Summary Plan Description or in other information from the Committee, an Eligible Employee or the Dependent(s) of an Eligible Employee will be permitted to enroll in the Component Plans pursuant to and as required by HIPAA if they have a Special Enrollment Event. For any Special Enrollment Event, the enrollment is effective:

(1) in the case of marriage, not later than the first day of the first calendar month beginning after the marriage if the completed request for enrollment is received by the Committee or its designee within 30 days of the marriage;

(2) in the case of a Dependent's birth, on the date of such birth if the completed request for enrollment is received by the Committee or its designee within 30 days of the birth and if required documentation of the birth is received by the Committee or its designee within 90 days of the birth;

(3) in the case of a Dependent's adoption or placement for adoption, on the date of such adoption or placement for adoption if the completed request for enrollment is received by the Committee or its designee within 30 days of the adoption;

(4) in the case of loss of eligibility for other coverage, on the first day of the first calendar month beginning after the loss of coverage, if the completed request for enrollment is received by the Committee or its designee within 30 days after the loss of other coverage;

(5) in the case of an Eligible Employee's or Dependent's loss of coverage or loss of eligibility for a subsidy under Medicaid or a state children's insurance program, on the first day of the first calendar month beginning after the date such coverage or eligibility was lost if the completed request for enrollment is received by the Committee or its designee within 60 days of such loss.

(c) ***Other Permissible Enrollment Events***. An Eligible Employee may make changes in enrollment if the Eligible Employee has a Change in Status and if the new election is consistent with the Change in Status. A "Change in Status" for purposes of this paragraph means an event that would permit an employee to revoke an election during a period of coverage and make a new election under the Employer's premium conversion plan, consistent with Treasury Regulation Section 1.125-4.

3.2 DUAL COVERAGE PROHIBITED

No person may be covered under this Plan as both an Eligible Employee and a Dependent at the same time. No Dependent may be enrolled as a Dependent of two Employees.

ARTICLE 4.
LENGTH OF COVERAGE

4.1 TERMINATION OF PARTICIPATION

A Participant's participation in the Plan will terminate: (a) on the last day of the month in which he is no longer eligible to participate in every Component Plan, (b) as of the last date for which he pays the required contributions for coverage, or (c) on the date the Employer no longer participates in the Plan. Upon termination of participation in the Plan, no Participant will be entitled to further benefits or coverage under the Plan except to the extent described in the Plan or a Component Plan or as required by law (such as COBRA continuation coverage).

4.2 DEPENDENTS

Plan coverage with respect to all Dependents of a Participant will cease on the earlier of: (a) the date such Participant's coverage under the Plan or Component Plan terminates, (b) the end of the month in which the Participant ceases to cover such person as a Dependent, or (c) the end of the month in which the person ceases to satisfy the definition of Dependent.

4.3 REINSTATEMENT AFTER LAY OFF OR TERMINATION

If an Eligible Employee's Plan coverage terminates because of a lay-off or termination of employment, the Eligible Employee will be treated as a new employee for purposes of enrollment and eligibility if the Participant is later rehired by the Employer.

4.4 CONTINUATION COVERAGE (COBRA)

As mandated by federal law, the Plan offers optional continuation coverage (also referred to as COBRA coverage) to Participants and their Dependents if such coverage would otherwise end due to one of certain specified qualifying events.

(a) ***In General.*** The terms and conditions of COBRA continuation coverage are described in the Summary Plan Description:

(b) ***Cost of Continuation Coverage.*** The cost of continuation coverage is determined by the Committee and paid by the qualifying individual. Contribution rates may change at the discretion of the Committee due to Plan modifications.

If the qualifying individual is not disabled, the applicable contribution cannot exceed 102% of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the Plan's cost of coverage.

(c) ***When Continuation Coverage Ends.*** Continuation coverage ends on the earliest of:

(1) the date the maximum continuation coverage period expires;

(2) the date the Employer no longer offers a group health plan to any of its employees;

(3) the first day for which timely payment is not made to the Plan;

(4) the date the qualifying individual becomes covered by another group health plan. However, if the new plan contains an exclusion or limitation for a pre-existing condition of the qualifying individual, continuation coverage will end as of the date the exclusion or limitation no longer applies;

(5) the date the qualifying individual becomes entitled to coverage under Medicare; and

(6) the first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he is no longer disabled.

4.5 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

As mandated by federal law, the Plan provides certain rights to Employees who take a leave for service in the uniformed services. Such rights are described in the official policies of the Employer.

4.6 FAMILY AND MEDICAL LEAVE (FMLA)

As mandated by federal law, the Plan provides certain rights to Employees who take leave under the Family and Medical Leave Act (FMLA). Such rights are described in the official policies of the Employer.

ARTICLE 5.
FUNDING AND CONTRIBUTIONS

5.1 ESTABLISHMENT OF FUNDING POLICY

The Company will establish and implement a funding policy and method with respect to each Component Plan consistent with the objectives of the Component Plans and the requirements of Title I of ERISA. The funding policy for any particular Component Plan may call for the Company to purchase and hold insurance contracts and policies to provide some or all of the benefits, for all or a part of the benefits provided to be paid from the general assets of the Company, or for all or part of the benefits provided to be funded by Participant contributions. The funding policy of any particular Component Plan may be amended by the Committee or the Company from time to time.

5.2 PARTICIPANT CONTRIBUTIONS

The amount of contributions, if any, required from Participants under the Component Plans will be determined from time to time by the Committee. Any Participant contributions must conform to any applicable rules established by the Committee regarding Participant contributions. Participants will be advised of any changes in the amount of Participant

contributions prior to the effective date of any such change. Participants and beneficiaries will not be entitled to any interest on any amounts contributed pursuant to the Plan.

5.3 EMPLOYER CONTRIBUTIONS

Each Employer will make such contributions in the time and manner the Company determines or as required by applicable law.

5.4 POLICY DIVIDENDS AND/OR REFUNDS

In accordance with the funding policy as provided in this ARTICLE 5, the Employer will be entitled to retain any demutualization payment, policy dividend, refund, or similar payment or portion thereof, received from any insurance company, service provider or any other organizations or individuals that exceeds the sum of the amount necessary to fund the benefits provided by any particular Component Plan and any Component Plan expenses, except to the extent that amounts received are attributable to Participant contributions, or otherwise prohibited by ERISA.

5.5 NO RIGHT TO ASSETS

No Participant or beneficiary has any right to, interests in or claim for any particular assets of any Employer, the Plan, any Component Plan or any underlying contract, trust or other vehicle for purposes of satisfying any benefits due such individual.

ARTICLE 6.
PLAN ADMINISTRATION

6.1 PLAN ADMINISTRATOR

The Committee is the Plan Administrator and a named fiduciary that has the absolute discretionary authority to control and manage the operation and administration of the Plan. The Committee has all powers and duties necessary to fulfill its responsibilities, including, but not limited to, the following powers and duties:

(a) to interpret and construe the Plan and the Component Plans as it, in its sole discretion, determines to be appropriate and, based on such interpretation, to determine and compute the amount of benefits payable to Participants to the extent permitted under the Component Plans and to remedy ambiguities, inconsistencies and omissions, of whatever kind to the extent allowed by law or as the Committee determines appropriate for the administration of the Plan except as provided in Section 6.2;

(b) to use, in a non-discriminatory manner, prudent business judgment which from time to time results in the administration of limited exceptions to the contractual provisions of the Plan (any such decisions will not, however, prevent administration of the Plan in strict accordance with its terms in other situations);

(c) to maintain all records necessary for the administration of the Plan and concerning its proceedings and acts in such form and detail as the Committee may decide;

(d) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(e) to file with the Secretary of Labor, the Secretary of the Treasury and all other appropriate government officials all reports and other information and required by applicable law;

(f) to make and publish rules for interpretation or application of the Plan;

(g) to administer the claims appeal procedures except to the extent any Claims Administrator has that responsibility;

(h) to retain consultants and to delegate any power or duty to any company or person in accordance with Section 6.2;

(i) to enforce the Plan and any Component Plan in accordance with its terms and with such applicable rules and regulations as may be adopted by the Committee;

(j) to give such directions to the trustee with respect to any trust fund as may be provided in the trust agreement;

(k) to resolve any factual disputes and render a final determination with respect to claims made under the Plan or any Component Plan by Participants and their legal representatives and beneficiaries; and

(l) to exercise all other powers or duties granted to the Committee by other provisions of the Plan.

The Committee will exercise all rights and powers granted to it under the Plan in accordance with the standards set forth in ERISA Section 404(a)(1).

6.2 DELEGATION OF ADMINISTRATIVE RESPONSIBILITY

(a) The Committee may delegate all or any portion of its administrative responsibilities with respect to the Plan or any particular Component Plan to any other person, including a Claims Administrator, pursuant to this Section 6.2.

(b) A delegation under this Section 6.2 will be accomplished by a written instrument executed by the Committee specifying the responsibilities delegated to such delegate. The allocation of such responsibilities will be effective on the date specified in the delegation, subject to acceptance by the delegate. Any delegate exercising the responsibilities and powers delegated under this Section 6.2 will report periodically to the Committee on its exercise of such powers and discharge of such responsibilities.

(c) A Claims Administrator appointed under this Section 6.2 may, at the sole discretion of the Committee, have the complete authority to administer, apply, and interpret any designated Component Plan provisions.

(d) Notwithstanding the provisions of subsection (a), any insurance company or third party administrator has sole discretion with respect to the matters for which it is made

responsible under such Component Plan Materials, and to the extent required by ERISA, will acknowledge in writing that it is a fiduciary with respect to those responsibilities.

(e) Each named fiduciary will be deemed to have properly exercised its authority unless it has abused its discretion hereunder by acting arbitrarily or capriciously.

6.3 CERTIFICATION

The certificate of the Committee that the Committee has taken or authorized any action will be conclusive in favor of any person relying on the certificate.

6.4 INFORMATION TO BE FURNISHED TO COMMITTEE

To receive benefits under the Plan, a Participant must furnish to the Committee such documents, evidence, data or other information as the Committee considers desirable to determine eligibility for such benefits.

6.5 COMMITTEE'S DECISION FINAL

To the extent permitted by law, any interpretation of the Plan and Component Plans and any decision on any matter within the discretion of the Committee made by the Committee in good faith is binding on all persons. A misstatement or other mistake of fact must be corrected when it becomes known, and the Committee will make such adjustment on account thereof as it considers equitable and practicable.

6.6 INDEMNIFICATION

To the extent permitted by law, any employees or officers of each Employer and the Committee will be indemnified by each Employer against any and all liabilities, losses, damages, costs, and expenses (including legal fees claims, and expenses) which may be imposed on, incurred by, or asserted against each Employer by reason of the acts or omissions relating to the Plan, except for any willful violation of law or willful breach of duty to the Plan.

6.7 BONDING AND INSURANCE

To the extent required by law, with respect to benefits subject to ERISA, every fiduciary of the Plan and every person handling Plan funds must be bonded. The Committee will take such steps as are necessary to assure compliance with applicable bonding requirements. The Committee may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility at the Plan's expense and insuring each fiduciary against liability to the extent permissible by law at the Company's expense.

6.8 REMUNERATION AND EXPENSES

No remuneration will be paid to the Committee. However, the Committee's expenses (including fees of persons retained by it in accordance with Section 6.1(h)) incurred in the performance of an administrative function will be reimbursed by each Employer.

6.9 INTERESTED PARTY

No person may decide or determine any matter or question concerning his own benefits under the Plan unless such decision could be made by him under the Plan if he were not a member of the Committee.

6.10 ALLOCATION OF FIDUCIARY RESPONSIBILITY

Except to the extent provided in ERISA Section 405, no fiduciary will have any liability for a breach of fiduciary responsibility of another fiduciary with respect to the Plan.

ARTICLE 7.
BENEFITS AND CLAIMS

7.1 BENEFITS

Exhibit A and the underlying Component Plans may be revised from time to time by the Committee or the Company without amendment to this Welfare Benefit Plan and constitutes a part of this Plan. The benefits payable under a Component Plan and the conditions for receipt of such benefits (including exclusions, limitations and exceptions) are specified in the Component Plan. Except to the extent specifically provided in the Component Plan, no Participant, Dependent or beneficiary is vested in any coverage or benefits under a Component Plan.

7.2 CLAIMS INFORMATION

(a) All information, procedures and provisions relating to claims and appeals for benefits under the Plan are described in the Summary Plan Description.

(b) Each Participant must provide to the Claims Administrator such pertinent information concerning himself, the expenses for which a claim has been filed, benefits payable under other plans and such other information as the Claims Administrator may specify or as required by a Component Plan, and no Participant or other person has any rights or is entitled to any benefits under any Component Plan or this Plan unless such information is filed by or with respect to him. Such information must be provided to the Claims Administrator within the time periods and other guidelines provided in the Summary Plan Description.

7.3 PAYMENT OF BENEFITS TO OTHERS

(a) If the Committee or the Claims Administrator determines in its sole discretion that any person to whom any amount is payable under the Plan is unable to care for his affairs because of sickness or injury or is a minor or has died, then any payment due him or his estate (unless a prior claim therefore has been made by a duly appointed legal representative) may be paid to his spouse, a dependent child, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Committee or the Claims Administrator to be a proper recipient on behalf of such person otherwise entitled to payment in accordance with the terms of such Component Plan. Any such payment will be a complete discharge of the liability of the Plan, the Employer and the Committee for such benefits.

(b) Benefits under this Plan are payable to, or on behalf of, the Participant whose injury or sickness, or whose Dependents' injury or sickness, is the basis of the claim. The Committee or Claims Administrator may make arrangements for benefits under this Plan to be paid directly to providers who have a contractual relationship with the Plan.

7.4 BENEFITS OF UNLOCATED PERSONS

If the Claims Administrator cannot ascertain the whereabouts of any person to whom a payment is due under a Component Plan, and if, after three months from the date such payment is due, a notice of such payment due is mailed to the last known address of such person, as shown on the records of the Plan, and within three months after such mailing such person has not made written claim therefore, the Claims Administrator, if it so elects, may direct that such payment and all remaining payments otherwise due to such person be canceled, and upon such cancellation, the Plan and each Employer will have no further liability therefore until such person claims the benefit with appropriate documentation no later than the date the Plan terminates or the statute of limitations has elapsed, whichever is earlier.

7.5 MISREPRESENTATIONS

(a) Any representations or statements made to a Participant by the Committee, its representative or agent, about being covered for benefits under the Plan, if inconsistent with the provisions of the Plan, will not bind the Committee for benefits under the Plan.

(b) Any Participant who, with intent to defraud or knowing that he is facilitating a fraud against the Plan, submits an application, enrolls a person as a dependent, or files a claim containing a false, incomplete, or misleading statement, or misuses or permits the misuse of any Plan membership or coverage card, is guilty of fraud. The Committee reserves the right to take appropriate action in any instance where fraud is at issue, including but not limited to retroactive termination of coverage and legal action to recover the cost of benefits paid in error.

7.6 PLAN BENEFITS COVERED BY MEDICAID OR MEDICARE

(a) To the extent required by applicable law, the Component Plans and the Plan will not reduce or deny benefits for any Participant or beneficiary to reflect that such individual is eligible to receive medical assistance under a state Medicaid plan.

(b) To the extent required by applicable law, the Plan or a Component Plan will reimburse any state Medicaid plan for the cost of any services provided under the state plan that are covered by the Plan or a Component Plan, and the Plan and all Component Plans will honor any subrogation rights that a state has to recoup such mistaken payments.

(c) The Plan and any applicable Component Plans will comply with the Medicare as secondary payer requirements.

7.7 EFFECT OF FIDUCIARY ACTION

The Committee will interpret the Plan in accordance with the terms of the Plan and their intended meanings. However, the Committee has the sole discretion to make any findings of fact needed in the administration of the Plan, and has the sole discretion to interpret or construe

ambiguous, unclear or implied (but omitted) terms in any fashion it deems to be appropriate in its sole judgment. The validity of any such finding of fact, interpretation, construction, or decision will not be given de novo review if challenged in court or in any other forum, and will be upheld unless clearly arbitrary and capricious. To the extent the Committee has been granted sole discretionary authority under the Plan, the Committee's prior exercise of such authority will not obligate it to exercise its authority in a like fashion thereafter. If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent, the provision will be considered ambiguous and may be interpreted by the Committee in a fashion consistent with its intent, as determined by the Committee in its sole discretion. The Committee may amend the Plan retroactively to cure any such ambiguity. This Section may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretation by the Committee. All actions taken and all determinations made in good faith by the Committee are final and binding on all persons claiming any interest in or under the Plan.

ARTICLE 8.
PROTECTED HEALTH INFORMATION

8.1 PROTECTED HEALTH INFORMATION

HIPAA and its applicable regulations require group health plans to protect the privacy of individually identifiable health information that is transmitted or maintained by the Plan, regardless of its form ("Protected Health Information") with respect to each Participant. Protected Health Information includes, but is not limited to, information about a Participant's condition, about services provided to a Participant, or about payments made for the care of a Participant. The provisions of this Article shall apply only to the extent that this Plan constitutes a group health plan as defined in section 2791(a)(1) of the Public Health Service Act, as amended.

8.2 USE AND DISCLOSURE BY THE PLAN

(a) The Plan will not use or disclose Protected Health Information except for (i) payment activities and health care operations; (ii) as required by law; (iii) as authorized by a Participant; or (iv) to help business associates administer the Plan. Neither the Plan nor any business associate will disclose Protected Health Information to the Company (the "Plan Sponsor," for purposes of this ARTICLE 8) unless the Plan Sponsor requires the Protected Health Information to perform Plan administrative functions, the notice of privacy practices discloses the Plan Sponsor's use of Protected Health Information and the Plan receives a certification from the Plan Sponsor stating that the Plan has been amended to incorporate restrictions on Protected Health Information. Neither the Plan nor any business associate will disclose Protected Health Information to the Plan Sponsor for the purpose of employment related actions or decisions or in connection with any other benefit or employee plan of the Company. Any disclosure to the Plan Sponsor will be consistent with HIPAA and subject to the provisions of this amendment. The Plan Sponsor will take reasonable steps to ensure that any use or disclosure of Protected Health Information is the minimum necessary to accomplish the task.

(b) Payment activities means (i) actions by or on behalf of the Plan to obtain premiums or to determine or fulfill its responsibility for coverage under the Plan or (ii) actions by or on behalf of a healthcare provider obtaining reimbursement for the provision of healthcare. Payment activities include the determination of coverage or cost sharing amounts, adjudication or subrogation of claims, risk assessment, coordination of benefits, billing, claims management (including auditing payments, investigating and resolving payment disputes), responding to participant inquiries about payments, obtaining payment under a contract for reinsurance, medical data processing, review of medical necessity, eligibility, establishing employee contributions and utilization review.

(c) Health care operations include, but are not limited to (i) quality assessment; (ii) population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, and disease management; (iii) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs; (iv) underwriting; (v) resolution of internal grievances; (vi) premium rating; or (vii) customer services such as provision of data analyses for policyholders, plan sponsors or other customers.

(d) Plan administration includes, but is not limited to, (i) quality assurance; (ii) claims processing; (iii) activities relating to the creation, renewal or replacement of a contract of health insurance; (iv) business planning and development, including conducting cost-management and planning-related analyses related to managing and operating the Plan; (v) business management and general administration; and (vi) due diligence in connection with a sale or transfer of assets to a potential successor in interest if the potential successor in interest is a covered entity (as such term is defined in HIPAA) or will be a covered entity following the transfer or sale.

8.3 RESTRICTIONS ON PLAN SPONSOR'S USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to receive Protected Health Information from the Plan or a business associate, the Plan Sponsor agrees that it will:

(a) neither use nor further disclose Protected Health Information except as permitted or required by the Plan, as amended, or as required by law;

(b) ensure that any agent, including any subcontractor, to whom it provides Protected Health Information agrees to these restrictions and conditions of the Plan relating to Protected Health Information;

(c) not use or disclose Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee plan, unless authorized by the individual who is the subject of the Protected Health Information;

(d) report to the Plan any use or disclosure of Protected Health Information that is inconsistent with uses and disclosures permitted under this section promptly upon learning of such inconsistent use or disclosure;

(e) provide access to Protected Health Information to the individual who is the subject of the Protected Health Information in accordance with 45 C.F.R. Section 164.524;

(f) make the Protected Health Information available for amendment and incorporate any amendments, if necessary, in accordance with 45 C.F.R. Section 164.526;

(g) track disclosures of Protected Health Information so that the Plan Sponsor can make available the information required for the Plan to provide an accounting of disclosures for purposes other than treatment, payment or health care operations, in accordance with 45 C.F.R. Section 164.528;

(h) make internal practices, books and records, relating to the use and disclosure of Protected Health Information available to the Plan and to the Secretary of the U.S. Department of Health and Human Services to determine compliance with HIPAA;

(i) if feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor continues to maintain in any form, and retain no copies of such Protected Health Information when no longer needed for Plan administration functions or, if return or destruction is not feasible, limit further use or disclosure to those purposes that make the return or destruction infeasible in accordance with HIPAA;

(j) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality of Electronic Protected Health Information, as defined in 45 C.F.R. Section 160.103;

(k) ensure that the adequate separation between the Plan and the Company (*i.e.,* the firewall) required by 45 C.F.R. Section 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(l) ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information; and

(m) report to the Plan any security incident of which it becomes aware, as follows: The Company will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify or destroy Electronic Protected Health Information or to interfere with systems operations in an information system containing Electronic Protected Health Information; in addition, the Company will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification or destruction of Electronic Protected Health Information or interference with systems operations in an information system containing Electronic Protected Health Information.

8.4 ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR

(a) In accordance with HIPAA, only the following employees or classes of employees or other workforce members under the control of the Plan Sponsor may be given access to Protected Health Information received from the Plan or a business associate servicing the Plan:

(1) employees in the Company's human resources department and management employees who oversee such department;

(2) employees in the Company's finance and accounting departments;

(3) employees or independent contractors of the Company who work in the Company's benefits department;

(4) employees or independent contractors of the Company who work in the information technology department;

(5) employees or independent contractors of the Company who work in the payroll department;

(6) the Committee or its delegate (or individuals who may be members of the Committee);

(7) independent contractors or consultants that the Company may engage to assist with respect to the Plan;

(8) attorneys who advise the Company with respect to the legal aspects of the Plan; and

(9) any employee of the Employer or any other person who receives Protected Health Information relating to payment under, health care operations of or other matters pertaining to the Plan in the ordinary course of business.

(b) The employees, classes of employees and workforce members identified above will have access to Protected Health Information only to perform administration functions that the Plan Sponsor provides to the Plan.

(c) The employees, classes of employees and workforce members identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of Protected Health Information in breach of, violation of, or non-compliance with the Plan. The Plan Sponsor will promptly report any breach, violation, or act of non-compliance to the Plan and will cooperate with the Plan to correct the breach, violation, or act of non-compliance and will mitigate the effect of such act on the individual who is the subject of the Protected Health Information and whose privacy has been compromised by the breach, violation or act of non-compliance. Individuals who believe the privacy of their Protected Health Information and their rights under HIPAA have been compromised have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services.

ARTICLE 9.
NON-DUPLICATION PROVISIONS

9.1 **PURPOSE**

This Article sets out guidelines for coordination of coverage under this Plan with similar coverage provided under another health insurance policy or plan. These guidelines apply except to the extent a Component Plan provides otherwise.

9.2 DEFINITIONS

The following terms, when used in this Article only, have the meaning set forth below, unless a different meaning is plainly required by the context:

Allowable Expense means an expense of a Participant at least a portion of which is both a Covered Charge under one of the health care options of this Plan and is covered by another Plan under which the Participant or Dependent is entitled to benefits. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be an Allowable Expense.

Claim Determination Period means, for any individual, that portion of a Plan Year during which he would be eligible to receive benefits under this Plan in the absence of this ARTICLE 9.

Plan means each separate policy, contract, or other arrangement providing benefits or services for or by reason of medical, mental health, or dental care or treatment, which benefits or services are provided by:

(a) any group, franchise, hospital or medical service, prepayment or other coverage arranged through any employer, trustee, union, employee benefit or other association;

(b) any coverage required by statute and any governmental program including any Parts of Medicare; or

(c) any coverage sponsored by, or provided through, a school or other educational institution (except that "Plan" does not include student accident insurance covering elementary through high school students).

Plan also means each separate policy, contract, or other arrangement for benefits or services and each separate portion of any such policy, contract, or other arrangement that reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion that does not.

This Plan means those provisions of health care options offered under this Plan that provide the benefits that are subject to the provisions of this ARTICLE 9.

9.3 EFFECT ON BENEFITS

(a) ***Applicability***. These provisions apply in determining the benefits of a Participant under this Plan for any Claim Determination Period if such Participant has incurred an Allowable Expense during such period.

(b) ***This Plan's Benefits Secondary***. As to any Claim Determination Period with respect to which these provisions are applicable, the benefits payable under this Plan will be reduced by the benefits payable under any other Plan if the other Plan's benefits are

determined to be payable before this Plan's benefits. The benefits under this Plan will be reduced to an amount that, when combined with the benefits payable under the other Plan, will not exceed the benefits that would be payable under this Plan without regard to those payable under any other Plan. Benefits payable under another Plan include the benefits that would have been payable had claim been made for them.

(c) ***This Plan's Benefits Primary***. If another Plan that contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and the rules set forth in Section 9.4 would require this Plan to determine its benefits before those of such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits payable under this Plan.

(d) ***Proportionate Reduction***. When these provisions operate to reduce the total amount of benefits otherwise payable to a Participant during any Claim Determination Period, each benefit that would be payable in the absence of these provisions will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of this Plan.

9.4 ORDER OF PRIORITY

Except as provided under the Medicare Exception set out in Section 9.5, the benefits payable from a plan that does not have a coordination of benefits provision substantially similar to those described in this ARTICLE 9 will be determined before the benefits payable from a Plan that does have such a provision. In all other instances, the order of determination will be:

(a) ***Non-Dependent/Dependent***. The benefits of a Plan that covers the individual for whom benefits are claimed as an employee or subscriber (that is, other than as a dependent) are determined before the benefits of a Plan that covers the individual as a dependent.

(b) ***Dependent Child-Parents Not Separated or Divorced***. Except as stated in subsection (c), when this Plan and another Plan cover the same child as a dependent of different parents, who are not divorced or separated, the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time. However, if another Plan does not have the rule described in this subsection (b), but instead has a rule based on the gender of the parent, and if, as a result, the other Plan and this Plan do not agree on the order of the benefits, the rule in the other Plan will determine the order of benefits.

(c) ***Dependent Child-Separated or Divorced Parents***. If two or more Plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;

(2) then, the Plan of the spouse of the parent with custody of the child; and

(3) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any claim determination period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(d) ***Active/Inactive Employee.*** The benefits of a Plan that covers the individual for whom benefits are claimed as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before the benefits of a Plan that covers that individual as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

(e) ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan that covered the individual for whom benefits are claimed for a longer time are determined before those of the Plan that covered the individual for the shorter time.

9.5 MEDICARE

Benefits payable under this Plan for a Participant who is age 65 or older will be determined before the benefits payable under Medicare.

9.6 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of this Article or any provisions of similar purpose in any other Plan, the Committee may, without the consent of, or notice to, any individual, release to or obtain from any insurance company or other organization or individual any information regarding any individual that the Committee deems to be necessary for such purposes. Any individual claiming benefits under this Plan must furnish to the Committee such information as may be necessary to implement these provisions.

9.7 FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan in accordance with this ARTICLE 9 have been made under any other Plans, the Committee has the right, exercisable alone and in its sole discretion, to pay over to any organizations making such payments any amounts it determines to be warranted to satisfy the intent of these provisions, and amounts so paid will be deemed to be benefits paid under this Plan and, to the extent of such payments, the Employer will be fully discharged from liability under this Plan.

9.8 RIGHT OF RECOVERY

Whenever the total Plan payments that have been made exceed the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Committee has the right to recover such payments, to the extent of such excess, from among one or more of the

following, as the Committee may determine: any individuals to or for or with respect to whom such payments were made; any insurance companies; and any other organizations.

ARTICLE 10.
AMENDMENT AND TERMINATION

10.1 AMENDMENT

The Plan may be amended at any time in writing by Company's board of directors, by any officer of Company to whom the Company's board of directors delegates authority to amend the Plan, or by the Committee.

The Company, the Committee, or its delegate may amend in writing any part or all of the Plan, any Component Plan or any contract providing benefits (with, if applicable, the agreement of the relevant insurance company or third party administrator) at any time or from time to time. The Company, the Committee or its delegate may also remove or change any insurance company or third party administrator at any time and from time to time.

10.2 TERMINATION

The Company, the Committee or its delegate may terminate or partially terminate the Plan, any individual Component Plan, or discontinue Employer contributions to one or more Component Plans at any time.

ARTICLE 11.
MISCELLANEOUS

11.1 PROOF OF AGE, MARRIAGE AND DEPENDENT STATUS

Participants and their dependents may be required to furnish satisfactory proof of age, marital or dependent status as a condition to maintain coverage under the Plan.

11.2 WORKERS' COMPENSATION

The Plan is not in lieu of, and does not affect any requirement for coverage by, workers' compensation insurance.

11.3 NONDISCRIMINATION

The Committee will take all steps it considers necessary or desirable to conform the operation of the Plan to the nondiscrimination requirements of the Code, if applicable, or other applicable law, and may unilaterally change or revoke an election by a Participant for that purpose.

11.4 NOTICE

Any notice to be delivered under this Plan must be given in writing and delivered, personally or by certified mail, postage prepaid, addressed to the Company (or the insurance company or third party administrator, as applicable and as described in the Component Plan Materials), the Participant, or any beneficiaries, as the case may be, at their last known address. Participants are responsible for notifying the Plan of any change in address.

11.5 EVIDENCE

Evidence required of anyone under the Plan may be by certificate, affidavit, document or other information which the person acting on it considers pertinent and reliable, and signed, made or presented by the proper party or parties.

11.6 EMPLOYMENT NOT GUARANTEED

Nothing contained in the Plan, nor any action taken hereunder, may be construed as a contract of employment, or as giving any Employee any right to be retained as an Employee of any Employer. Each Employer reserves the right to terminate any Employee at any time in its sole discretion, with or without cause, except to the extent expressly provided otherwise in a written employment agreement between Employee and the Employer.

11.7 CAPTIONS

The captions of the sections of this Plan are for convenience only and do not control the meaning or construction of any of its provisions.

11.8 GENDER AND NUMBER

Where the context admits, words in any gender include any other gender, words in the singular include the plural and the plural include the singular.

11.9 NO VESTED INTEREST

Except as otherwise provided under the Plan with respect to benefits, no person has any right, title or interest in or to the assets of any Employer because of the Plan. A Participant has no vested right to a benefit unless and until the benefit is paid to the Participant. Prior to such time, the benefit will be forfeitable in accordance with rules in the Component Plans or rules established by the Committee.

11.10 WITHHOLDING OF TAXES

To the extent required by law, the Employer may withhold from payments made pursuant to this Plan or otherwise all federal, state, local, or other taxes as may be required with respect to any amounts paid or payable under this Plan or any Component Plan.

11.11 ASSIGNMENT OF BENEFITS

Except as may otherwise be required by law, or as otherwise specifically provided in the Plan, no amount payable at any time under the Plan may be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind, nor in any manner be subject to the debts or liabilities of any person. Any attempt to so alienate or subject any such amount, whether presently or thereafter payable, will be void. If any person attempts to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount payable under the Plan, or any part thereof, or if by reason of his bankruptcy or other event happening at any such time, such amount would be made subject to his debts or liabilities or would otherwise not be enjoyed by him, then the Committee may direct that such amount be withheld and that the same or any part thereof be

paid or applied to or for the benefit of such person, his spouse, dependent children or other dependents, or any of them, in such manner and proportion as the Committee may deem proper.

Notwithstanding the previous paragraph, any Participant may request and authorize the Committee to pay benefits directly to a hospital, physician, dentist or other person furnishing services or supplies covered under the Plan and any such payment, if made, will constitute a complete discharge of the liability of the Plan.

11.12 CORRECTION OF ERRORS

In the event an incorrect amount is paid to or on behalf of a Participant or beneficiary, any remaining payments may be adjusted to correct the error. The Committee may take such other action it deems necessary and equitable to correct any such error. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage that would otherwise be validly in force nor continue coverage that would otherwise be validly terminated.

11.13 SEVERABILITY OF PROVISIONS

If any provision of this Plan is held invalid or unenforceable, such invalidity or unenforceability will not affect any other provisions hereof, and this Plan will be construed and enforced as if such provisions had not been included.

11.14 GOVERNING LAW

This Plan will be construed and enforced in accordance with ERISA and the laws of the United States of America and, to the extent it is not preempted by ERISA or the laws of the United States of America, in accordance with the internal laws of the State of Nevada, without regard to any conflict of laws provisions.

11.15 NO WAIVER OF TERMS

No term, condition or provision of the Plan will be deemed to have been waived, and there will be no estoppel against the enforcement of any provision of the Plan, except by written agreement of the party charged with such waiver or estoppel. No such written waiver may be deemed a continuing waiver unless specifically stated therein, and each such wavier will operate only as to the specific term or condition waived and may not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

11.16 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Employer nor the Committee makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It will be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes and to notify the Committee if the Participant has reason to believe that any such payment is not so excludable.

11.17 RELATIONSHIP WITH PROVIDERS

The Plan and the Employer are not liable for any claim or demand that a Participant may have against a provider. The traditional relationship between a provider and a patient is unaffected by the Plan, and the Participant's medical providers retain full control of and authority of all medical decisions and recommendations regarding medical treatment. The Plan's determination that a particular course of medical treatment is not covered or is inconsistent with the Plan's criteria and protocols will not be considered a medical determination. The Participant's provider maintains full authority and responsibility for all medical determinations regardless of the availability of coverage by the Plan for any such medical treatment.

11.18 DATE OF CHARGES INCURRED

The date a charge for services or treatment is deemed to be incurred is the date that the service or treatment is performed, regardless of when the provider requests payment for such service or treatment.

11.19 TIME PERIOD FOR SUBMISSION OF CLAIMS

Except to the extent otherwise specifically provided in a Component Plan, benefits under the Plan will only be paid where a claim is properly submitted within one year from the date on which the covered expenses were first incurred.

11.20 RESCISSION

The Committee shall not rescind health coverage under this Plan except in the case when the Participant has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For purposes of this Section ___, a "rescission" means a cancellation or discontinuance of coverage that has a retroactive effect. A "rescission" does not include the cancellation or discontinuance of coverage retroactively to the extent it the cancellation or discontinuance of coverage is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage after required notice from the Committee. In the event the Committee seeks to rescind coverage, it must provide 30 days advance written notice to each Participant affected.

11.21 ACA NONDISCRIMINATION COMPLIANCE

The Plan (including any Component Plan) shall not discriminate in violation of Section 1557 of the Affordable Care Act or any other applicable law against any otherwise eligible Employee, Dependent or member of the Board of Directors on the basis of race, color, national origin, sex, age or disability with respect to the provision of health benefits or eligibility or participation in health benefits coverage. Appropriate arrangements will be made to ensure that eligible individuals with disabilities and eligible individuals with limited English proficiency are provided auxiliary aids and services or language assistance service if needed to obtain access to health benefits under the Plan. Any individual who believes that he or she has been discriminated against in violation of this Section 11.21 may file a grievance with the Plan Administrator. All information, procedures and provisions relating to such grievance procedure are set forth in the Summary Plan Description.

IN WITNESS WHEREOF, the Company has caused this Plan to be executed, effective as of January 1, 2019.

RENOWN HEALTH

By: _____

Title: CHRO

Date: 10/30/19

EXHIBIT A

Component Plans

Various Component Plans listed from time to time below are maintained as part of the Plan.

Medical Plan (including prescription benefits and including vision benefits for some levels of coverage)

Dental Plan

Accidental Death & Dismemberment

Group Life Insurance

Employee Assistance Program (EAP)

Long Term Disability Plan

Wellness Program

EXHIBIT B

Component Plan Materials

[see attached]

ADDENDUM #1

Retiree Medical Benefits

1. In General

In addition to eligibility and benefits provisions stated in the Plan document, the Plan provides benefits to eligible retired employees in accordance with the terms of this Addendum #1.

Retiree health coverage under this Plan includes medical, pharmacy, vision, and dental programs only.

3. Procedure for "Category I" retirees

"Category I" retiree means any former employee of Renown Health System who retired from Renown Health service and is eligible to receive retiree medical benefits after meeting the following eligibility requirements:

(a) Eligibility

A retiree must have been an active full or regular part-time employee who retired from Renown Health service on or before December 31, 1993; and

The retiree may continue medical benefits for themselves, spouse and/or dependent(s) if retiree, spouse and/or dependent(s) were covered under Renown's plan on the date of the retiree's date of retirement. Retirement must be immediately subsequent to employment with Renown Health.

(b) Rates

Renown Health will continue to subsidize a "Category I" Retiree's health insurance rate equal to that amount paid by Renown Health on January 1, 1994 for similar coverage as for active employees. This subsidy is for that coverage the retiree has in effect upon their retirement.

Should an insurance rate change from a January 1, 1994 rate, Renown Health will subsidize a retiree at the January 1, 1994 rate or the new insurance rate whichever is less. The retiree will be responsible for any difference in rate between Renown Health subsidy and the prevailing rate.

(c) Open Enrollment

Retirees may change enrollment options during an open enrollment period (lasting 30 days) once each year. Dependents may not be added to coverage after the "Category I" Retiree's date of retirement. Changing from the Self-insured Health Plan to the HMO is allowed. Changing from the HMO to the Self-insured Health Plan is not allowed.

(d) Duration of Benefits

"Category I" retirees covered by Renown Health's medical plan on the day of retirement will be eligible for retiree medical benefits. When the "Category I" retiree is eligible for government sponsored or legislated medical coverage, Renown Health reserves the right to discontinue Renown Health provided retiree medical benefits.

4. Procedure for "Category II" retirees

"Category II" retiree means any Renown Health employee on active full-time or regular part-time status who retires from Renown Health after meeting the following eligibility requirements:

(a) Eligibility

The employee must have been hired before January 1, 1990 and be a participant in Renown Health's Retirement Income Plan (RIP), and

The employee must be enrolled in a Renown Health medical benefits plan. A spouse and/or eligible dependent(s) must be enrolled in one of the Renown Health's medical benefits plans at least two (2) years prior to the employee's date of retirement to be eligible for continuing benefits. Retirement must be immediately subsequent to employment with Renown Health.

(b) Rate

Renown Health will subsidize a "Category II" Retiree's health insurance rate equal to that amount paid by Renown Health on January 1, 1994 for similar coverage as for active employees as outlined below. This subsidy is for that coverage the retiree has in effect upon retirement.

A "Category II" retiree will receive 100% of Renown Health subsidy for retiree health benefits. This subsidy is equal to the January 1, 1994 rate which is equivalent to that amount paid by Renown Health on January 1, 1994 for similar coverage as for an active employee. To receive this subsidy, the employee must retire on or before December 31, 1995 in accordance with the rules governing retirement eligibility under Renown Health's Retirement Income Plan or has attained a minimum age of 55 but no more than 59 years of age with at minimum of 30 years of service on or after January 1, 1996.

If a "Category II" employee retires on or after January 1, 1996 and does not meet the eligibility requirements as set forth in the paragraph immediately above, the Renown Health subsidy will be 50% of the January 1, 1994 rate which is equivalent to that amount paid by the Renown Health on January 1, 1994 for similar coverage as for an active employee.

Should an insurance rate change from a January 1, 1994 rate, Renown Health will subsidize retirees at the January 1, 1994 rate or the new insurance rate whichever is less. The retiree will be responsible for any difference in amount between the Renown Health subsidy and the prevailing rate.

(c) Open Enrollment

Retirees may change enrollment options during an open enrollment period (lasting 30 days) once each year. Dependents may not be added to coverage after the "Category II" Retiree's date of retirement. Changing from the Self-insured Health Plan to the HMO is allowed. Changing from the HMO to the Self-insured Health Plan is not allowed.

(d) Duration of Benefits

Eligible "Category II" retirees will be covered by medical insurance offered by Renown Health on the day of retirement. When the "Category II" Retiree is eligible for government sponsored or legislated medical coverage, Renown Health reserves the right to discontinue Renown Health provided retiree medical benefits.

3. Procedure for Category III retirees

"Category III" retiree means any Renown Health employee on active full-time or regular part-time status who retires from Renown Health and is eligible for retiree medical benefits after meeting the following requirements:

(a) Eligibility

(1) The employee must have been hired before January 1, 1990 and;

(2) Have a minimum of ten (10) years of continuous service immediately prior to attaining age 60, or,

(3) Qualifies for early retirement under rules governing the CustomSave plan,

(4) Be enrolled in a Renown Health medical benefits plan on the date of retirement. A spouse and/or eligible dependent(s) must be enrolled in one of Renown Health's medical benefits plans at least two (2) years prior to the employee's date of retirement to be eligible for continuing benefits. Retirement must be immediately subsequent to employment with Renown Health.

(b) Rate

Renown Health will subsidize a "Category III" Retiree's health insurance rate as follows. This subsidy is for that coverage the retiree has in effect upon their retirement.

If an employee retires on or before December 31, 1995 under eligibility requirements specified in Paragraphs (1) and (2) above, Renown Health subsidy for retiree health benefits will be equal to the January 1, 1994 rate which is equivalent to that rate paid by Renown Health on January 1, 1994 for similar coverage as for an active employee.

If the employee retires on or after January 1, 1996, under eligibility requirements specified in Paragraph (1) above, (employees who take early retirement after January 1, 1996 under CustomSave rules are not eligible for retiree medical benefits), Renown Health subsidy will be 50% of the January 1, 1994 rate which is equivalent to that rate paid by Renown Health on January 1, 1994 for similar coverage as for an active employee.

Should insurance rates change from the January 1, 1994 rate, Renown Health will subsidize retirees at the January 1, 1994 rate or the new insurance rate whichever is less. The retirees will be responsible for any difference in amount between Renown Health subsidy and the prevailing rate.

(c) Open Enrollment

Retirees may change enrollment options during an open enrollment period (lasting 30 days) once each year. Dependents may not be added to coverage after the "Category III" Retiree's date of retirement. Changing from the Self-Insured Health Plan to the HMO is allowed. Changing from the HMO to the Self-Insured Health Plan is not allowed.

(d) Duration of Benefits

"Category III" Retirees covered by medical insurance offered by Renown Health on the day of retirement who retire on or before December 31, 1995 will be eligible for retiree medical benefits. When the Category III Retiree is eligible for government sponsored or legislated medical coverage, Renown Health reserves the right to discontinue Renown Health provided retiree medical benefits.

"Category III" Retirees covered by medical insurance offered by Renown Health on the day of retirement which is on or after January 1, 1996 will be eligible for retiree medical benefits. When the retiree is eligible for Medicare or other government sponsored or legislated medical coverage, Renown Health benefits will be discontinued.

4. Procedure for "Category IV" retirees

"Category IV" Retirees are those full-time and regular part-time employees hired after January 1, 1990. These employees are eligible for COBRA benefits as provided under Renown Health health insurance. They are not eligible for any other Renown Health provided retiree medical benefits.

5. Reservation of Rights

Renown Health reserves the right to amend, modify or terminate benefits for retirees under this Addendum #1 at any time without notice.

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CERTIFIED COPY OF RESOLUTIONS
OF THE
RENOWN HEALTH EMPLOYEE BENEFITS REVIEW COMMITTEE

[Adopt Restatement of Renown Health Welfare Benefits Plan]

The undersigned Chairman of the Employee Benefits Review Committee of Renown Health hereby certifies that the following resolutions were adopted at a meeting of the Committee properly conducted on ____October 19____, 2019.

WHEREAS, pursuant to Section 10.1 of the Renown Health Welfare Benefits Plan, as amended and restated effective January 1, 2012 and subsequently amended by the first, second, third and fourth amendments thereto (the "Plan"), the Committee or its delegate has the authority to amend in writing the Plan or any Component Plan thereof; and

WHEREAS, the Committee or its delegate wishes to amend and restate the Plan to incorporate prior amendments and to make other appropriate modifications;

WHEREAS, the attached Renown Health Welfare Benefits Plan, Amended and Restated Effective January 1, 2019 (the "Plan Restatement"), has been presented to the Committee for approval and adoption:

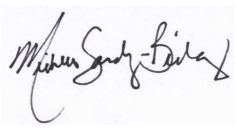
NOW, THEREFORE, BE IT RESOLVED, that the Committee hereby approves and adopts the Plan Restatement, to be effective January 1, 2019.

FURTHER RESOLVED, that the proper officers of the Committee be, and each of them hereby is, authorized and directed in the name and on behalf of the Committee to take any and all such actions as they in their discretion deem appropriate or as any such officers may, with the advice of counsel, deem necessary or desirable to comply with applicable law and regulations, and otherwise carry out the intent of the resolutions.

FURTHER RESOLVED, that any and all actions heretofore taken by the proper officers of the Committee within the terms of the foregoing resolutions are hereby ratified, confirmed and approved in all respects.

DATED: ____October 19_____, 2019.

RENOWN HEALTH



_____
Michelle Sanchez-Bickley
Vice President of Human Resources

CERITFIED COPY OF RESOLUTIONS
OF THE
RENOWN HEALTH EMPLOYEE BENEFITS REVIEW COMMITTEE

[Adopt First Amendment to Renown Health Welfare Benefits Plan]

The undersigned Chair of the Employee Benefits Review Committee of Renown Health (the "Committee") hereby certifies that the following resolutions were adopted at a meeting of the Committee duly convened and properly conducted on April 27, 2021.

WHEREAS, on July 1, 2021 employees of University of Nevada, Reno School Medicine shall become employees of Renown Health, and

WHEREAS the Committee wishes to amend the Renown Health Welfare Benefits to include coverage of such employees.

NOW, THEREFORE, BE IT RESOLVED, that the Committee hereby approves and adopts the First Amendment to the Renown Health Welfare Benefits Plan in the form attached hereto, effective July 1, 2021.

FURTHER RESOLVED, that the proper officers of Renown Health be, and each of then hereby is, authorized and directed in the name and on behalf of the Committee to take any and all such actions as they in their discretion deem appropriate or as any such officers may, with the advice of counsel, deem necessary or desirable to comply with applicable law and regulations and otherwise carry out the intent of the resolutions.

RENOWN HEALTH

DocuSigned by:

By: Michelle Sanchez-Bickley
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Title: Chief HR Officer

Date: 7/14/2021 | 15:14 PDT

FIRST AMENDMENT TO
RENOWN HEALTH WELFARE BENEFITS PLAN

The Renown Health Welfare Benefits Plan, as amended and restated effective as of January 1, 2019, is hereby amended in the following manner. This Amendment is effective as of the July 1, 2021.

1. Section **3.1 Participation** is amended by the addition of the following at the end of subparagraph (a):

> "Notwithstanding the previous sentence, any Employee who was employed by the University of Nevada, Reno School of Medicine on June 30, 2021, and who became employed by Company on July 1, 2021, shall be eligible to participate in the Plan on July 1, 2021."

IN WITNESS WHEREOF, Renown Health caused this Amendment to be executed by its duly authorized representative on the date set forth below.

RENOWN HEALTH

By: _____

Title: Chief HR Officer

Date: 7/14/21