Welfare Benefits Plan
Summary Plan Description
as of January 1, 2014
Updated May 2021

- Medical
- Prescription
- Vision
- Dental
- Life
- Accidental Death & Dismemberment
- Employee Assistance Program
- Long Term Disability
- Short Term Disability
- Accident
- Critical Illness
- Hospital Indmenity
- Universal Life
- Legal Plan
- Identity Theft Protection

This document contains important information about your rights and responsibilities under the Renown Health Welfare Benefits Plan.

Renown Health Welfare Benefits Plan Overview

About the Plan

Renown Health sponsors the Renown Health Welfare Benefits Plan (the "Plan") which provides several types of benefits, each called a "component" in this Summary. The components include:

- Medical (including prescription and vision benefits)
- Dental
- Basic Life Insurance
- Accidental Death & Dismemberment (AD&D)
- Supplemental Life
- Employee Assistance Program
- Long-term Disability
- Short Term Disability
- Accident Insurance
- Critical Illness
- Hospital Indemnity
- Universal life
- Legal Plan
- Identity Theft Protection

These programs are summarized in this Summary Plan Description and in the evidence of coverage booklets and other governing documents attached as Appendix A, called the "Component Plan Material."

Summary Plan Description

This summary ("*Summary*") was prepared for the Plan (the "*Plan*") as it existed on January 1, 2014. However, Renown Health has the power to amend the Plan, and any Component Plan Material, from time to time. You will receive updates if and when any changes are made to the Plan that affect the information contained in this Summary. You should keep any such updates with this Summary.

Because this is only a Summary of the official governing Plan document, it cannot cover all the details of the Plan or how the rules will apply to every person in every situation. In the event there is any conflict between this Summary and the Plan document, the official Plan document will always be followed in the actual determination of your benefits or rights. This Summary and the Component Plan Material together constitute the Summary Plan Description for your health and welfare benefits under the Plan, which is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 ("*ERISA*").

This Summary provides the official ERISA disclosures for the Plan, along with the identity of the applicable Plan Sponsor, Plan Administrator, insurers and claims administrators (if any) and other important information specific to the benefits under the Plan.

Please note that the Component Plan Material may contain information on topics such as benefit coverage, definitions, coordination of benefits, waiting periods, exclusions and limitations. *Although the body of this Summary is intended to be accurate, any differences between it and the Component Plan Material will be resolved in favor of the Component Plan Material.*

Questions If you have any questions about the Plan, or if you would like a copy of the plan document, you may contact Human Resources or refer to the plan documents located on Inside Renown under Benefits.

Eligibility for Plan Participation

Employee Eligibility

Generally, as an eligible employee, your benefits are effective the first of the month coincident with or next following the date you meet the following requirements (the "Benefits Effective Date"):

- you are a common law employee of Renown Health and receive compensation through Renown Health's payroll,
- you are regularly scheduled to work at least 20 hours per week,
- you complete at least 30 consecutive calendar days of employment with Renown Health,
- you meet the eligibility requirements that apply to the specific program offered by the Plan in which you wish to enroll, as described in the Summary Program Descriptions listed in Appendix A and other governing documents. Such eligibility programs may include, but are not limited to, evidence of insurability, medical underwriting requirements, and preexisting conditions limitations, and
- you are not otherwise excluded below.

You are not eligible to participate in the Plan if you are a per diem employee, leased employee, independent contractor, consultant or agency worker, temporary employee, intern, casual employee, reclassified employee, non-resident alien with no U.S. earned income, or party to an agreement that does not allow you to participate in the Plan.

Family Member Eligibility

You may enroll certain family members in the same program(s) in which you enroll. Eligible family members include your:

- your legally married spouse. (NOTE: For medical coverage only: your spouse must not be eligible to participate in any other group medical plan offered by his or her employer. Group medical is defined as having a portion of the cost contributed by the employer. Limited benefit and high deductible (individual deductibles greater than or equal to $5,000) medical plans are excluded from the definition of group coverage. An Affidavit for Spouse Coverage is required annually.)
- You and/or your spouse's child (natural child, stepchild, legally adopted child, court-appointed child) under age 26,
- dependent children of any age, who became disabled before age 19, are mentally or physically incapable of self-support, and depend on you for a majority of their financial support.

- non-custodial children as required by any qualified medical child support order (QMCSO)

***Note*: Additional eligibility criteria for the benefit programs apply and are described in the documents listed in Appendix A.**

Child Defined

Your "child" means your natural child; the natural child of your spouse; a child that has been placed with you by a court for adoption; a child for whom a court has awarded legal guardianship to you, who resides with you in a parent-child relationship and is primarily dependent on you for support; and a child who is the subject of a qualified medical child support order (QMCSO).

Dual Coverage

If you and your spouse are both employed by Renown Health, you must each elect your own coverage as an eligible employee for the Medical, Dental, Vision, Prescription, Supplemental Life Insurance and Accidental Death & Dismemberment (AD&D) programs. Eligible children (or other eligible dependents) may be carried as dependents under either (but not both) eligible employee's coverage for the Medical, Dental, Vision, Prescription, Supplemental Life Insurance and Accidental Death & Dismemberment (AD&D) programs.

Termination of Coverage

You and your family members' coverage will end if and when the first of any one of the following events occurs:

- the Plan or the applicable benefit program is terminated,
- you cease to meet any of the eligibility requirements,
- you die,
- you fail to timely make required contributions, or
- you (or a family member) submit a false claim or engage in other fraudulent or illegal activity.

Other reasons for why you and your family members' coverage may end are described in the applicable Component Plan Materials. If your employment with Renown Health terminates, unpaid employee contributions will be deducted from your final paycheck and coverage will continue until the end of the month in which your employment terminates.

Enrolling In Medical and Dental Components

Enrollment Proce dures

As a newly eligible employee (that is, as a new hire or, if later, when you are first eligible to participate in the Plan) and during each Open Enrollment thereafter, you, as an eligible employee, will have the opportunity to select your benefits for the current or upcoming year, as applicable. To select benefits, you must properly complete, and timely submit your elections through the online enrollment systems.You will also be required to submit supporting documentation and applicable affidavits within 30 days.

Important! Enrollment Deadline. For new hires and rehires, elections must be made within 30 days from your hire/rehire date. For open enrollment, elections (including supporting documentation and applicable affidavits) must be received by the end of Open Enrollment, announced and coordinated by Human Resources.

Each Open Enrollment will either be a “positive” enrollment or a “passive” enrollment. During a positive enrollment, if your enrollment is incomplete, not submitted or not timely received, you will be enrolled in a medical plan for employee-only coverage, and applicable payroll deductions will be taken from your pay, during the applicable period. You will not be enrolled in any other component plans and none of your dependents will be enrolled in any component plan. During a passive enrollment, if your enrollment and/or applications are incomplete, not submitted, or not submitted timely, you will be deemed to have elected to continue the same benefits and coverages then in effect, including coverages for your dependent child(ren). If you are covering a spouse you are required to complete the Spouse Coverage Affidavit each year otherwise your spouse coverage will dropped. You will not be able to make or change your elections after these deadlines, unless you qualify for a mid-year change in election.

A benefit eligible employee who elects to waive medical coverage under the Plan must complete annually a Waiver of Coverage Affidavit for him- or herself and all eligible dependents. Contact Human Resources for more details.

Elections may be confirmed by following the directions set forth in the enrollment materials. If you are a new hire and you are unable to confirm your elections, your intended elections do not appear, or your intended elections are incorrect, contact Human Resources *before your Benefits Effective Date.* For open enrollment, confirmation statements will be mailed to each eligible employee’s attention at the employee’s home mailing address. If your intended elections do not appear or are incorrect on your confirmation statement you must notify Human Resources within 10 calendar days, or if you do not receive a confirmation statement within 3 weeks of your effective date, inform Human Resources immediately. *If you do not contact Human Resources within this timeframe, the selections noted will be final.*

Mid-year Election Changes

Normally, your elections when you first enroll will apply for the remainder of that year, and the elections that you make during Open Enrollment will apply to the following plan year. However, you may make a change to your elections during the year if you experience one of the following mid-year changes in election events, as determined by Renown Health:

- **Change in your legal marital status.** This includes marriage, death of spouse, divorce, legal separation, or annulment.

- **Change in the number of your eligible family members.** This includes birth of a child, adoption, placement for adoption, death, and gain/loss of legal custody.

- **Change in your or a family member's employment status.** This includes beginning or ending employment, a reduction or increase of hours. The change in employment status must affect your or your family member's eligibility to participate in the Plan or another employer's plan to qualify for a mid-year election change.

- **Change in ability to meet eligibility requirements.** If your family member no longer meets eligibility requirements, such as due to reaching a certain age you must change your election to remove that family member from the Plan or underlying benefit program.

- **Loss of other coverage.** If you chose not to elect coverage in the medical, pharmacy, dental, or vision program because you had other coverage, and if that other coverage ends, you may be able to enroll yourself and your family members in such program(s) under this Plan during the year. In addition, if you lose coverage from a governmental or educational institution, you may elect coverage mid-year. If the other coverage was COBRA Continuation Coverage, you may elect coverage only after the exhaustion of the COBRA Continuation coverage.

- **Judgments, decrees, and court orders.** If the Plan receives a valid court order, such as a "qualified medical child support order," that requires it to change your coverage during the year, the Plan will follow the court's order.

- **Change in family circumstances.** You may start, cancel or change coverage due to a change in enrollment (such as at open enrollment) or eligibility under your spouse's plan or a change in residence that affects your or your family member's ability to receive benefits from the Plan.

- **Significant change in cost of coverage.** You may cancel or change your coverage due to a significant change in the cost of your coverage. For example, if you change your dependent care provider, or if your dependent care provider significantly increases its fees, then you may be able to change your dependent care spending account election.

- **Termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage.** You may start or change your coverage as a result of loss of eligibility for Medicare or CHIP coverage.

- **You or your Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.** You may start, cancel or change your coverage due to eligibility for Medicaid or CHIP.

- **Legal compliance**. Other changes may be recognized by the Plan Administrator, as it deems appropriate or necessary to keep the Plan in compliance with legal requirements.

> ***Note:*** *All changes you make must be both "on account of" and "consistent with" the change in status event. Human Resources can provide further information to you on permissible mid-year election changes.*

Except as provided in the next sentence, once you experience a mid-year change in election event described above, you must make your new election within 30 days of the date the event occurred. You must also provide supporting documentation of the qualifying life event within 30 days. For termination of Medicaid or CHIP coverage, or eligibility for premium assistance under Medicaid or CHIP, you must make your new election within 60 days of the date the event occurred. If you do not change your election within this time period, you will not be permitted to make the change.

Benefits During Leaves of Absence

If Your Leave Is FMLA Leave

If you take a paid FMLA leave, your coverage will continue during your FMLA leave and you will continue to make contributions for your coverage during your FMLA leave.

If you take an unpaid FMLA leave, your coverage will continue if you agree to pay your share of the contributions either during or after your FMLA leave, as determined by the Plan Administrator. Your coverage will stop when your leave ceases to qualify as FMLA leave, unless you elect COBRA coverage (see the section in this Summary Plan Description regarding COBRA continuation coverage).

If you take an unpaid FMLA leave, you may also elect to stop your coverage during your FMLA leave. If your coverage stops during your FMLA leave, your benefits will be reinstated the first of the month following your return to active employment. Please contact Human Resources for more information.

If Your Leave Is USERRA Leave

If you take USERRA leave, you may continue your health coverage (that is, medical, pharmacy, vision, dental, and health flexible spending account coverage) for a certain period of time. If your coverage stops during your USERRA leave, you may re-enroll upon your return to active employment. Please contact Human Resources for more information.

If Your Leave Is Not USERRA And Not FMLA

If you take an unpaid leave that is not USERRA and not FMLA, your coverage will continue until the end of month following 90 days of your leave if you agree to pay your share of the cost of the coverage either during or after your leave, as determined by the Plan Administrator. Your coverage will stop the first of the month following 90 days of your leave, unless you elect COBRA coverage (see the section in this Summary Plan Description regarding COBRA continuation coverage). Please contact Human Resources for more information.

> ***Note:*** *If you are required to pay for your coverage, you and your family members will be covered only for the period of time for which payment is timely received. If your contributions are not timely received, your coverage will be canceled and will not be reinstated until the first of the month following your return to work. Any claims incurred during the time period for which you did not pay for your coverage will not be processed and will be your responsibility.*

Benefits for Rehires

If your employment with Renown Health ends and you are rehired in the month after your termination date or later, you will be treated as a new hire. Therefore, you may make new benefit elections after you satisfy eligibility and waiting period requirements.

If your employment with Renown Health ends and you are rehired in the same month as your termination date and you made employee contributions for that month prior to your termination, you will be reinstated in the same elections that you had elected prior to your break in service.

`

Enrolling In Life, AD&D, and Long Term Disability Insurance Programs

Enrolling in Life, AD&D, and Long-term Disability Insurance Benefits

Eligible employees may elect supplemental life, accidental death and dismemberment (AD&D), and long-term disability insurance coverage at any time, subject to the terms of the particular program. Eligible employees may also change their elections for these benefits at any time during the year, subject to the terms of the particular program.

Your election for such Plan benefits and any mid-year changes that you make to your election for such benefits will be effective as soon as administratively possible after your completed online election for such programs is received and approved.

> ***Note:*** *Eligible employees will be enrolled automatically in employer-paid basic life insurance.*

Benefits During Leave of Absence

If Your Leave Is FMLA Leave

If you take a paid FMLA leave, your coverage will continue during your leave and you will continue to make contributions for your coverage during your FMLA leave.

If you take an unpaid FMLA leave (or if your pay during your FMLA is insufficient to cover your share of the contributions for your coverage), your coverage will continue if you agree to pay your share of the contributions either during or after your leave, as determined by the Plan Administrator.

If you take an unpaid FMLA leave, you may also elect to stop your coverage during your FMLA leave. If your coverage stops during your FMLA leave, you may re-enroll upon your return to active employment. Please contact Human Resources for more information.

If Your Leave Is USERRA Leave

If your coverage stops during your USERRA leave, you may re-enroll upon your return to active employment. Please contact Human Resources for more information.

Enrolling In Life, AD&D, and Long Term Disability Insurance Programs, continued

If Your Leave Is Not USERRA And Not FMLA

If you take an unpaid leave that is not USERRA and not FMLA, your coverage will continue for the first 90 days of your leave if you agree to pay your share of the contributions either during or after your leave, as determined by the Plan Administrator. Your coverage will stop after the first 90 days of your leave, unless you elect conversion coverage that may be available directly through the applicable insurance company(ies). Please contact Human Resources for more information.

> ***Note:*** *If you are required to pay for your coverage, you and your family members will be covered only for the period of time for which payment is timely received. If your contributions are not timely received, your coverage will be canceled. Any claims incurred during the time period for which you did not pay for your coverage will not be processed and will be your responsibility.*

Benefits for Rehires

For purposes of the life, AD&D, and long-term disability insurance benefits programs, if your employment with Renown Health ends and you are rehired, you will be treated as a new hire. Therefore, you may make new benefit elections after you satisfy eligibility and waiting period requirements.

Component Plan Provisions

Medical Plan (medical, prescription and vision benefits)

Medical, prescription and vision benefits are offered through the Medical Plan component. Materials describing the levels of coverage, deductibles, co-pays, maximum benefits and other provisions of the Medical Plan are attached as Appendix A to this Summary Plan Description.

Dental Plan

Renown Health offers eligible employees a choice between two dental programs: the dental plan and dental plus plan. The programs generally offer different levels of coverage, deductibles, and co-pays. Both programs offer a choice of dentists who have contracted with MetLife Dental.

The dental program is administered by MetLife Dental. For more information, see the employee benefits website or the applicable document listed in Appendix A. You may also contact MetLife Customer Service at 800-METLIFE(638-5433), visit www.metlife.com/insruance/dental-insurance

Component Plan Provisions

Basic Life Insurance

Eligible employees are automatically enrolled in employer paid basic life insurance. Coverage amounts are:

Hourly (non-exempt) employees	$15,000 life benefit
Salaried (exempt) employees	1 times annual earnings to a maximum of $200,000
Management employees	2 times annual earnings to a maximum of $300,000

The Standard Insurance Company (The Standard) will provide benefits under this policy. For more information, see the employee benefits website or the applicable document listed in Appendix A. You may contact The Standard at 833-240-6583 or visitwww.standard.com. You are encouraged to contact Human Resources at 982-4156 to make or change a beneficiary designation.

Supplemental Life Insurance

As an eligible employee, you may purchase supplemental life insurance for yourself and your eligible family members. To purchase supplemental life insurance for eligible family members, you must purchase supplemental life insurance for yourself. Coverage amounts are:

Participant Increments of $10,000 to a maximum of $500,000 or 5 times annual salary whichever is less. Coverage amounts for participants age 65 and older will be reduced

Spouse Increments of $5,000 to a maximum of the participant's benefit amount or $250,000 whichever is less

Children Increments of $2,500 to a maximum of the participant's benefit amount or $20,000, whichever is less

The supplemental life insurance program is administered by The Standard. For more information, see the employee benefits website or the applicable document listed in Appendix A. You may also contact The Standard at 833-240-6583or visit www.standard.com.

Component Plan Provisions

Accidental Death and Dismemberment (AD&D)

As an eligible employee, you may purchase accidental death and dismemberment insurance for yourself and your eligible family members. To purchase accidental death and dismemberment insurance for eligible family

---

members, you must purchase accidental death and dismemberment insurance for yourself. Coverage amounts are:

Participant	Increments of $10,000 to a maximum of $500,000 or 10 times annual salary whichever is less. Coverage amounts for participants age 65 and older will be reduced
Spouse	Increments of $10,000 to a maximum of the participant's benefit amount or $250,000 whichever is less
Children	Increments of $2,500 to a maximum of the participant's benefit amount or $25,000, whichever is less

The AD&D insurance program is administered by The Standard. For more information, see the employee benefits website or the applicable document listed in Appendix A. You may also contact The Standard at 833-240-6583 or visit www.standard.com.

Long-Term Disability

The long-term disability insurance program replaces a portion of your income if lost due to a covered sickness or covered injury.

You are disabled when the LTD carrier determines that:

Employees -

are limited from performing the material and substantial duties of your regular occupation due to sickness or injury; after 24 months you are considered disabled when due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

Physicians -

are limited from performing the material and substantial duties of your regular occupation due to sickness or injury.

After a 90 day elimination period, benefits are 60 percent of covered monthly earnings to a maximum of $10,000 and a maximum of $15,000 for physicians. Benefit duration payable until age 65 if the disability occurs before the age of 60.

The long-term disability program is administered by The Standard. For more information, see the employee benefits website or the applicable document listed in Appendix A. You may also contact The Standard at 833-240-6583 or visit www.standard.com.

Component Plan Provisions

Short-Term Disability

The short-term disability insurance program replaces a portion of your income if lost due to a covered sickness or covered injury.

After a 14 elimination period, benefits are up to 60% of your covered monthly earnings from $300 to a maximum of $6000.

The short-term disability program is administered by Aflac. For more information, see the employee benefits website or the applicable document listed in Appendix A. You may also contact Alfac at 800-433-3036 or visit www.aflacgroupinsurance.com.

Employee Assistance Program

The Employee Assistance Program is designed to provide clear and reasonable solutions to help put life back in balance. This program is available to employees and their family members as of the first day of active employment. The Employee Assistance Program is available 24 hours a day, seven days a week, 365 days a year. The program is administered by The Standard.

Telephone consultations	To speak candidly and confidentially with a consultant to help clarify your issues and identify your options, call 888-293-6948.
Face-to-face consultations	Up to three in-person sessions with a provider may be available to you for short-term problems.
Online computer resources	Explore a wealth of information online at www.workhealthlife.com including videos, guides, articles, webinars, resources, self-assessments and calculators. Download the My EAP app for access to these resources as well.

For more information, see the employee benefits website or the applicable document listed in Appendix A.

COBRA

About COBRA

Renown Health offers certain individuals ("qualified beneficiaries") the opportunity to purchase continued coverage under the Medical Plan, as well as dental benefits (each called a "COBRA Component" in this part of the Summary Plan Description), if their coverage under the COBRA Component ends due to certain "qualifying events." This extended coverage is called "COBRA" coverage.

Health Insurance Marketplace

There may be other coverage options for you and your family other than COBRA coverage. In the health insurance marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the marketplace.

Qualified Beneficiary defined

A "qualified beneficiary" is:

- an eligible employee or eligible family member, who is also
- enrolled in the COBRA Component on the day before a qualifying event.

Qualifying Event defined

A "qualifying event" is any of the following circumstances, which causes a qualified beneficiary to lose coverage under the COBRA Component:

- termination of the covered employee's employment (other than for gross misconduct) or reduction of work hours that results in ineligibility for coverage,
- death of the covered employee,
- divorce or legal separation of the covered employee from his or her spouse,
- covered employee becoming entitled to Medicare, or
- a dependent child ceasing to meet the eligibility requirements of the COBRA Component.

COBRA, continued

Cost of COBRA Coverage

You are required to pay 102% of the cost of the total premium for your COBRA coverage. If your coverage is extended because of disability, you will be required to pay 150% of the premium for the remainder of the COBRA continuation period.

The first payment will be due 45 days from the date you elect COBRA coverage. All payments after that will be due on the first day of each month with a 30-day grace period.

> ***Important****! Claims for benefits will not be paid until you have paid for your COBRA coverage. Until that time, you must pay for your benefits yourself and submit a claim form for reimbursement.*

Important deadlines!

Deadline – Electing COBRA

If you are a qualified beneficiary, you must elect COBRA coverage within 60 days of the later of the following or your coverage will end:

- the date coverage would end due to the qualifying event, or
- the date that you are notified of your right to elect COBRA continuation coverage.

Deadline – Divorce, Separation, Dependent child ineligibility

If you divorce or legally separate or if your dependent child ceases to meet the Plan's eligibility requirements, you must provide written notice to Human Resources within 60 days of the later of:

- the date of the qualifying event, or
- the date coverage for the affected qualifying beneficiary(ies) would end due to the qualifying event.

> ***Note****: If the qualifying event is the employee's termination of employment, a reduction in the employee's work hours, the employee's death, or the employee's entitlement to Medicare, you are not required to provide notification of the qualifying event.*

Deadline - Social Security Disability

If the Social Security Administration determines that you are disabled, you must provide written notice to Human Resources within 60 days of the latest of:

- the date of disability determination by the Social Security Administration,
- the date on which a qualifying event occurs, or
- the date coverage would end due to a qualifying event.

In no event may notice be given after the end of the first 18 months of COBRA coverage to be eligible for additional months of COBRA coverage.

You must provide written notice to Human Resources within 30 days of a determination by Social Security Administration that the qualified beneficiary is no longer disabled.

Deadline - Second Qualifying Events

If you have a second qualifying event during the initial 18 month coverage period that would entitle you to up to 36 months of COBRA coverage, you must provide written notice to Human Resources within 60 days of the second qualifying event to be eligible for additional months of COBRA coverage.

Termination of COBRA Coverage

Your COBRA coverage will end:

- if the Plan is terminated or any applicable component under the Plan is terminated and then only for that component,
- if you do not make required payments for your COBRA coverage on a timely basis,
- if you become covered under another group health program which does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary,
- if you become entitled to Medicare,
- if your COBRA coverage was extended due to disability, and the Social Security Administration determines that you are no longer disabled, or
- for cause, such as if you submit false claims or engage in an activity which Renown Health believes is illegal.

COBRA, continued

Duration of COBRA Coverage

Generally, the maximum time period for COBRA coverage is 18 months. However, the maximum time period for COBRA coverage is extended up to 36 months for the following qualified beneficiaries:

- a covered employee's spouse who loses coverage under the Plan due to divorce or legal separation,
- a child who ceases to meet the eligibility requirements of the Plan,
- a family member who loses coverage due to the covered employee's death,
- a family member who loses coverage due to the covered employee's entitlement to Medicare.

The maximum time period for COBRA coverage is extended up to 29 months, if the Social Security Administration determines that a qualified beneficiary is disabled before or within the first 60 days of COBRA coverage.

If a covered employee was entitled to Medicare prior to termination of employment or reduction in hours, the maximum time period for COBRA coverage is extended to the later of (i) 36 months from the date the covered employee first became entitled to Medicare, or (ii) 18 months from the date of the covered employee's termination or reduction in hours.

Qualified Beneficiary Notice Procedures

As described in the "Important Deadlines" section above, you have the responsibility to provide notice to Human Resources upon the occurrence of (1) divorce or legal separation of the covered employee from his or her spouse, (2) if your dependent child no longer meets the Plan's definition of dependent, or (3) if you become disabled as determined by the Social Security Administration. This notice may be given by either the covered employee, the qualified beneficiary who is affected by the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary. This notice must include:

- the date and type of qualifying event,
- the name(s) of the affected beneficiary(ies), and
- current mailing address(es) for the affected beneficiary(ies).

The Plan Administrator reserves the right to require supporting documentation prior to authorizing COBRA coverage.

For more Information

If you have any questions about COBRA and how it affects your coverage under the Plan, please read the COBRA Initial Notice, a copy of which has been provided to you. Call Human Resources if you need another copy. You may also contact Infinisource COBRA Compliance Systems, Inc. at 800-300-3838.

Claims Procedure

Answers to Your Questions

You may call Human Resources if you have any questions about the Plan. In addition, you may file a "claim" in accordance with the following procedure.

Filing a Claim for Eligibility and Contributions

If your claim relates to eligibility for the Plan or the amount that Renown Health will contribute to the Plan for your coverage, you must submit your claim in writing (not email) to the Plan Administrator at the following address:

Renown Health Welfare Benefits Plan
Administrator, c/o Human Resources
Renown Health
1155 Mill Street, Mail Stop Z-3
Reno, NV 89502

You will receive a decision on your claim within 90 days after the claim is received, unless special circumstances require an extension of time, in which case a decision will be given within 180 days after the claim is received (you will be notified within the first 90 days if the Plan Administrator requires an extension).

Written notice of the denial

If your claim is denied in whole or in part, then you will be provided with written notice of the denial of your claim. Such notice will:

- describe the specific reason(s) for the denial,
- refer to the specific provision(s) of the Plan on which the denial is based,
- describe any additional material or information necessary for you to perfect your claim, and an explanation of why such material or information is necessary, and
- indicate the Plan's review procedures, including a statement of your right to initiate civil action in federal court under ERISA Section 502(a) only after this process has been timely and properly completed.

Filing an appeal of a claim denial

If your claim is denied, you have the opportunity to submit an "appeal" of the decision. Your appeal must be submitted in writing (not email) to the Plan Administrator, at the address listed above, within 60 days of notice of the denial of your claim. You then will have the right to review documents (other than those which are legally-privileged) relevant to your claim and to submit issues and comments in writing to the Plan Administrator. Your request for review should set forth the grounds upon which it is based, all facts in support of your request, and any other matters that you deem pertinent. In addition, the Plan Administrator may require you to submit such additional facts, documents or other material, as it may deem necessary or appropriate in making its decision.

The Plan Administrator will provide written notice of its decision within 60 days after receiving your appeal, unless special circumstances require an extension of time, in which case you will receive a decision within 120 days of receipt of your claim (you will be notified within the first 60 days if the Plan Administrator requires an extension).

Written notice of denial of appeal

If the Plan Administrator affirms the denial of your claim on appeal, then you will be provided written notice of the denial. Such notice will:

- describe the specific reason(s) for the denial,
- refer to the specific provision(s) of the Plan on which the denial is based,
- include a statement that you are entitled to access copies of documents, records and other information that is relevant to your claim (other than those which are legally-privileged) upon request and free of charge,
- provide a description of the review procedures and the time limits applicable to such procedures, and
- provide a statement of your right to initiate civil action in federal district court under ERISA Section 502(a) only after this process has been timely and properly completed.

Filing a claim for benefits

If your claim relates to the benefits that you believe that you are entitled to receive under a particular benefit program (other than your eligibility for the Plan and the amount that Renown Health will contribute for your coverage), then you may follow the procedures outlined in the applicable Component Plan Material. The Plan Administrator has delegated to each insurance carrier, administrator, HMO provider and third party administrator, the authority and responsibilities of the Plan Administrator with respect to benefits claims administration.

You and the outside benefits claims administrator are both subject to specific time deadlines to file and respond to claims inquiries. Those time periods

and other important information are specified in the procedures regarding notices for those responses are set forth in the applicable program document or evidence of coverage booklet.

Notice of denial of claim for benefits

If the applicable program document does not prescribe how a decision on an initial claim will be communicated to you, then the claims administrator will respond to you within the time provided for the type of claim you have. See schedule beginning on page 25. The following information will be included in the notice of a decision on an initial claim:

- the specific reason(s) for the denial,
- reference to the specific provision(s) of the Plan or applicable document on which the denial is based,
- any additional material or information necessary for you to perfect your claim, and an explanation of why such material or information is necessary,
- the Plan's review (appeal) procedures, the time limits applicable to such procedures, and a description of any voluntary review procedures available to you if your claim is denied on appeal, and your right to obtain copies of such procedures;
- a statement that if you appeal the denial of your claim under the Plan's review procedures and your claim is denied on appeal, there is no further administrative review under the Plan, and a statement of your right to bring a civil action under ERISA Section 502(a) following timely and proper completion of the claims procedure,
- if the denial is based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request; or if the denial is not based on an internal rule, guideline, protocol or similar criterion, an affirmative statement to that effect,
- if the denial is based on medical necessity or experimental treatment, then either an explanation of the scientific or clinical judgment for the determination, or a statement that a copy of such explanation will be provided free of charge upon request,
- if the denial is for a disability claim, a discussion of the Plan's decision, including an explanation for disagreeing with or not following the views you presented of health care professionals who treated you and vocational professionals who evaluated you; the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse decision of your claim, whether or not they were relied on in

making the decison; and any disability determinations made by the Social Security Administration, and

- if the denial is for an urgent care claim, then a description of theexpedited review process applicable to such claims.

  An initial denial of an urgent care claim may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification.

Filing an appeal

If your claim is denied in whole or in part, then you may submit an appeal in accordance with the procedures described in the applicable program document and within the time provided in the schedule starting on page 25. If you appeal, you have the right to review pertinent documents (other than legally privileged documents) and to submit issues and comments to the Claims Administrator in writing. Your request for review should set forth all of the grounds upon which it is based, all facts in support of your request, and any other matters that you deem pertinent. In addition, the Claims Administrator may require you to submit such additional facts, documents or other material, as it may deem necessary or appropriate in making its decision.

If your claim involves urgent care, then a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the Claims Administrator and you by telephone, fax, or other similar method.

Review of your claim on appeal

Your appeal will be given a full and fair review. The review will take into account all comments, documents, records and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

If your appeal is for a medical or disability claim, the following additional review procedures will apply:

- Your claim will be reviewed by a reviewer who is neither the individual who made the original adverse determination of your claim or the subordinate of such individual, and the review will not afford deference to the original adverse determination,

- If the original adverse determiation was based on a medical judgment, the reviewer will consult with an appropriate health care professional who was not consulted on the original adverse determination, is not the subordinate of such person, and who has appropriate training and experience in the field of medicine involved in the medical judgment; and you will either be provided with a list of any experts whose advice was obtained in connection with the original adverse determination or notified that you may request in writing a list of such experts, and

- If the reviewer anticipates denying your appeal based on any new or additional evidence, or a new or additional rationale, you will be provided with such new or additional evidence, or new or

additional rationale, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on appeal is required to allow you time to respond.

Notice of denial of a claim on appeal

If the applicable program document does not prescribe how a decision denying your claim on appeal will be communicated to you, then the following information will be included in the notice of a decision on an appeal:

- the specific reason(s) for the denial with reference to the specific provision(s) of the Plan on which the denial is based,
- if the denial on appeal is based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or other similer criterion relied on in making the adverse determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request, or if the denial is not based on an internal rule, guideline, protocol or similar criterion, an affirmative statement to that effect,
- if the denial on appeal is based on medical necessity or experimental treatment, then either an explanation of the scientific or clinical judgment for the determination, or a statement that a copy of such explanation shall be provided free of charge upon request,·
- if the denial on appeal is for a disability claim, a discussion of the Plan's decision, including an explanation for disagreeing with or not following the views you presented of health care professionals who treated you and vocational professionals who evaluated you; the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse decision of your claim, whether or not they were relied on in making the decison; and any disability determinations made by the Social Security Administration,
- a statement that you are entitled to receive, upon request and free of charge, copies of documents, records, or other information (other than legally privileged documents) relevant to your claim for benefits,·
- a statement of your right to bring a civil action under ERISA Section 502(a), following the timely and proper completion of this procedure,·
- a statement that "You or 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."

Authorized Representative

Any actions that you may take under the Plan's claims procedure, such as filing the claim and submitting an appeal, may be taken by a representative that you have authorized in writing to act on your behalf. If you authorize a

representative to act on your behalf, then the Plan Administrator and/or Claims Administrator will communicate with your authorized representative.

Finality of decision and limits on legal action

If you do not file your claim in accordance with the Plan's claims procedure, you may lose benefits. No legal action with respect to this Plan may be brought until you have exhausted the claims procedures described above. The decision on appeal by the Plan Administrator (or Claims Administrator) shall be final, conclusive and binding on all parties.

No legal action may be brought more than one (1) year after notice of an adverse decision on appeal has been provided. Notwithstanding the foregoing, no legal action may be brought more than four (4) years after the facts or allegations giving rise to the claim occurred.

Time limits where no limit is included in benefit program descriptions

If no time limit is described in the applicable Component Plan Material or other governing document, then the time limits on the following schedule will apply. These time limits vary with the type of claim.

URGENT HEALTH CARE CLAIM		
Claims for conditions that could jeopardize your life, health, or ability to regain maximum function, or, in the opinion of a physician, would subject you to severe pain that cannot be adequately managed.	**YOUR INITIAL CLAIM**	
	Step 1:	The Claims Administrator has **72 hours** after receiving your initial claim to approve or deny the claim.
	IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Claims Administrator has **24 hours** after receiving your initial claim to notify you of additional information needed to complete or correct your claim.
	Step 2:	You have **48 hours** after receiving notice from the Claims Administrator to provide the requested information.
	Step 3:	The Claims Administrator will notify you if your claim is approved or denied within the earlier of: (a) **48 hours** after the Claims Administrator received the additional requested information, or (b) **96 hours** after you received notice that additional information is requested, whichever occurs earlier.
	APPEAL OF A DENIED CLAIM	
	Step 1:	If denied, you have **180 days** after receiving the claim denial to appeal the Claims Administrator's decision.
	Step 2:	The Claims Administrator has **72 hours** after receiving your appeal to notify you of its appeal decision.
PRE-SERVICE HEALTH CLAIM		
A claim for health benefits that requires advanced approval.	**YOUR INITIAL CLAIM**	
	Step 1:	The Claims Administrator has **15 days** after receiving your initial claim to notify you if your claim is approved or denied.
	IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Claims Administrator has **5 days** after receiving your initial claim to notify you if additional information is needed to correct or complete your claim.
	Step 2:	You have **45 days** after receiving the notice from the Claims Administrator to provide the requested information. (The period for making the determination will be delayed from the date of the notification of extension until you provide the requested information.)

	Step 3:	If the Claims Administrator determines that an extension is necessary due to circumstances beyond control of the Plan, and provides an extension notice during the initial 15-day period, the Claims Administrator has **30 days** after receiving the claim to notify you of its decision.
	APPEAL OF A DENIED CLAIM	
	Step 1:	If your claim is denied, you have **180 days** after receiving the claim denial to appeal the Claims Administrator's decision.
	Step 2:	The Claims Administrator has **30 days** after receiving your appeal to notify you of the appeal decision.

POST-SERVICE HEALTH CLAIM		
A claim for health benefits that does not require advanced approval (including Health Care Spending Account program benefits).	**YOUR INITIAL CLAIM**	
	Step 1:	The Claims Administrator has **30 days** after receiving your initial claim to notify you if your claim is denied.
	IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION	
	Step 1:	You have **45 days** after receiving notice from the Claims Administrator to provide requested information. (The period for making the determination will be delayed from the date of the notification of extension until you provide the requested information.)
	Step 2:	If the Claims Administrator determines that an extension is necessary due to circumstances beyond the control of the Plan, and provides an extension notice during the initial 30-day period, the Claims Administrator has **45 days** after receiving the claim to notify you if your claim is denied.
	APPEAL OF A DENIED CLAIM	
	Step 1:	If your claim is denied, you have **180 days** after receiving the claim denial to appeal the Claims Administrator's decision.
	Step 2:	The Claims Administrator has **60 days** after receiving your appeal to notify you of the appeal decision.
CONCURRENT HEALTH CARE CLAIM		
A claim where a course of health care treatment is reduced or terminated before the end of the period of time or number of	**YOUR INITIAL CLAIM**	
	The Claims Administrator will notify you sufficiently in advance of the reduction or termination to allow you to appeal the decision and have the appeal decided before the benefit is reduced or terminated.	
	If your claim is an urgent care claim, and you request an extension of the treatment beyond the approved period of time or number of treatments, then the Claims Administrator will notify you of its decision on the claim within **24 hours** after receipt of the claim, provided that the claim is made at least 24	

treatments previously approved.	hours before the expiration of the prescribed period of time or number of treatments.	
	APPEAL OF A DENIED CLAIM	
	Step 1:	If your claim is denied, you have **180 days** after receiving the claim denial to appeal the Claims Administrator's decision.
	Step 2:	The Claims Administrator has **60 days** after receiving your appeal to notify you of the appeal decision.

DISABILITY BENEFITS CLAIM
YOUR INITIAL CLAIM
The Claims Administrator has **45 days** after receiving your initial claim to notify you if your claim is denied.
IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION
The Claims Administrator determines that an extension is necessary due to circumstances beyond the control of the Plan, and provides an extension notice during the initial 45-day period, the Claims Administrator has **75 days** after receiving the claim to notify you if your claim is denied.
If the Claims Administrator determines that an additional extension is necessary due to circumstances beyond the control of the Plan, and provides an extension notice during the initial 75-day period, the Claims Administrator has **105 days** after receiving the claim to notify you if your claim is denied.
You will have **45 days** after receiving the notice from the Claims Administrator to provide requested information. (The period for making the determination will be delayed from the date of the notification of extension until you provide the requested information.)
APPEAL OF A DENIED CLAIM
If your claim is denied, then you have **180 days** after receiving the claim denial to appeal the Claims Administrator's decision.
The Claims Administrator has **45 days** after receiving your appeal to notify you of the appeal decision.
If the Claims Administrator determines that an extension is necessary due to circumstances beyond the control of the Plan, and provides an extension notice during the initial 45-day period, the Claims Administrator has **90 days** after receiving the claim to notify you if your claim is denied.

Other Important Plan Information

Plan name	Renown Health Welfare Benefits Plan
Plan type	Welfare plan providing medical, pharmacy, vision, dental, group term life, accidental death and dismemberment, supplemental life, supplemental accidental death and dismemberment, long term disability insurance, short-term disability insurance, and employee assistance benefits. . As described below, certain Plan components are insured and others are self-funded. The cost of coverage for eligible employees and their eligible family members is paid in part by the Company out of its general assets and in part by payroll deductions. The Plan Administrator provides a schedule of the applicable premiums for each Plan component during the initial and subsequent open enrollment periods and on request.
Plan year	January 1 to December 31
Plan number	501

Funding medium and type of plan administration

Medical Plan	Self-funded group health plan Third party administrator: *Hometown Health Insurance Provider Inc.
Dental Plan	Self-funded group health plan Third party administrator: *MetLife
Accidental Death & Dismemberment	The Standard – fully insured
Group Term Life	The Standard – fully insured
Long Term Disability	The Standard – fully insured
Short Term Disability	The Standard – fully insured
Employee Assistance Program	The Standard – fully insured
Wellness Program	MOBE

Other Important Plan Information, continued

Plan Sponsor

Renown Health
c/o Plan Sponsor of the Renown Health Welfare Benefits Plan
Renown Health
1155 Mill Street, Mail Stop Z-3
Reno, NV 89502

Plan Sponsor's Employer Identification Number

94-2972845

Plan Administrator

The Welfare Benefit Plan document designates the Committee as the Plan Administrator of the Plan. The Committee consists of the Chief Executive Officer, Chief Financial Officer and Vice President of Human Resources, or such other officers of Renown Health that may be named by Renown Health.

The address for the Plan Administrator is:

Plan Administrator Committee for the
Renown Health Welfare Benefits Plan
Renown Health
1155 Mill Street, Mail Stop Z-3
Reno, NV 89502
775-982-4156

The Plan Administrator has the sole and absolute discretion to determine eligibility for participation and benefits, and to interpret and/or construe the terms of the Plan. The Plan Administrator's determinations and interpretations shall be final and binding. The Plan Administrator may delegate its duties and discretionary authority among one or more persons or entities.

Agent for Service of Legal Process

Renown Health
c/o Plan Administrator of the Renown Health Welfare Benefits Plan
Renown Health
1155 Mill Street, Mail Stop Z-3
Reno, NV 89502

Amendment and Termination of the Plan

Renown Health has the right to amend or terminate the Plan or any of the Plan's benefit programs or components at any time and for any reason. Benefit programs may be added, eliminated, or changed at any time. This can occur without the consent of any employee or participant in the Plan.

Other Important Plan Information, continued

Special Rights on Childbirth

Group health programs under this Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. In addition, the Plan may not require that a provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours. However the Plan may pay for a shorter stay if the attending provider, after consulting with the mother, discharges the mother or newborn earlier. The Plan may not (1) give monetary incentives to encourage mothers to accept less than these minimal protections; or (2) penalize or otherwise reduce or limit the reimbursement of an attending provider for minimum hospital stays, or provide incentives to induce the provider to provide care that is inconsistent with these protections.

Women's Health and Cancer Rights

To the extent required by the Women's Health and Cancer Rights Act, this Plan provides mastectomy-related services including (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) reconstruction and surgery of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications resulting from mastectomy (including lymphedema). The Plan may not penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives to induce the provider to provide care that is inconsistent with the Women's Health and Cancer Rights Act.

Patient Protection Disclosure

Many of our medical plan options require the designation of a primary care provider.You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Hometown Health designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers,contact Hometown Health at 982-3232 or at www.hometownhealth.com. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Hometown Health or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Hometown Health at 982-3232 or at www.hometownhealth.com

Other Important Plan Information, continued

Qualified Medical Child Support Orders

The Plan will provide benefits as required by any qualified medical child support order (QMCSO) under the benefit programs offered under the Plan that are group health programs. The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from Human Resources.

Conversion Rights

Some of the insured components of the Plan may offer "conversion" coverage that would provide coverage to you if you are no longer eligible for coverage under that component. For more information, contact the applicable provider or insurance company

Coordination of Benefits

Unless otherwise described in Component Plan Materials, the Plan includes a coordination of benefits provision. As a condition of receiving benefits under the Plan, the participant agrees to be subject to these provisions. If a person is covered under this Plan and is also covered under another plan or by an insurer, this Plan's coordination of benefits provisions determine whether this Plan pays benefits first on a claim (is primary) or whether the Plan pays second (secondary). When the Plan is secondary, total payments from both plans will never be more than the amount that would be payable under this Plan had it been primary.

Subrogation Rights

Unless otherwise described in Component Plan Materials, the Plan includes a subrogation and reimbursement provision. As a condition of receiving benefits under the Plan, the participant agrees to be subject to these provisions.

You or your dependent may incur medical or dental charges due to an injury or illness caused by the act or omission of a third party. A "third party" is any individual or entity that may be liable or legally responsible to pay expenses, compensation and/or damages in relation to such illness or injury. The term "third party" includes, without limitation: (1) the party or parties who caused the illness or injury; (2) the insurer or other indemnifier of the party or parties who caused the illness or injury; (3) a guarantor of the party or parties who caused the illness or injury; (4) your own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage); (5) a workers' compensation insurer; and (6) any other person, entity, policy or plan that is liable or legally responsible in relation to the illness or injury.

Subrogation Rights, cont.

If you or your dependent have a claim against a third party for payment of such medical or dental charges and you accept benefits under this Plan, the Plan is automatically assigned any rights that you or your dependent may have to recover payments from a third party. Thus, you or your dependent must repay to the Plan any benefits it pays on behalf of you or your dependent out of the amount you or your dependent may recover from a third party. The term "recover," "recovered," "recovery" or "recoveries" means all monies paid to you or your dependent by way of judgment, settlement, or otherwise to compensate for all losses caused by an injury or illness, whether said losses reflect medical or dental charges covered by the Plan or otherwise. "Recoveries" also include, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation.

This subrogation right allows the Plan to pursue any claim which you or your dependent has against a third party, whether you or your dependent chooses to pursue that claim. The Plan may make a claim directly against the third party, but in any event, the Plan has a lien on any amount recovered by you or your dependent whether such recovery is designated as payment for medical expenses or other. This lien shall remain in effect until the Plan is repaid in full.

This right of subrogation and refund also applies when you or your dependent recovers under an uninsured or underinsured motorist plan (which will be treated as third party coverage when subrogation or refund is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

In consideration of the benefits received under the Plan, you and your dependents agree to recognize the Plan's right to full subrogation and refund of any and all amounts paid by the Plan, for or on behalf of you or your dependents. These rights provide the Plan with a 100%, first dollar priority over any and all recoveries and funds paid by any third party. Thus, you or your dependent will be responsible for all expenses of recovery paid by a third party, including but not limited to, attorneys' fees, claims for non-medical or dental charges or other costs and expenses, which fees and expenses shall NOT reduce the amount of refund to the Plan.

Additionally, the Plan's right to subrogation and refund provide the Plan with a 100%, first dollar priority to any full or partial recovery even if the recovery received by you or your dependent is less than the claimed damage, and, as a result, you or your dependent are not made whole.

Other Important Plan Information, continued

Subrogation Rights, cont.

Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan shall be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical or dental expenses from you or your dependent.

The Plan has no obligation whatsoever to pay medical or dental benefits to your or your dependent if you or your dependent refuse to cooperate with the Plan's subrogation and refund rights or refuse to execute and deliver such papers as the Plan may require in furtherance of its subrogation and refund rights.

In the event your dependent is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of an injury or illness caused by a third party until after you, or your dependent's authorized legal representative, obtains valid court recognition and approval of the Plan's 100%, first dollar subrogation and refund rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof.

Certificate of Credible Coverage

Upon termination of group health coverage under the Plan, you (and your participating family members) will be provided with a certificate of coverage. A certificate of coverage will also be provided to you upon request, if you make the request within 24 months after you (or your participating family members) lose coverage under the Plan.

Genetic Information and Non-Discrimination Act

GINA (Genetic Information and Non-Discrimination Act, effective 01-01-2010) prohibits group health plans from collecting genetic information and discriminating in enrollment and cost of coverage based on an individual's genetic information – which includes family medical information.

Affordable Care Act Non-Discrimination Compliance

The Affordable Care Act (ACA) prohibits the Plan and its component plans from discriminating against any otherwise eligible individual based on the individual's race, color, national origin, sex, age or disability with respect to the provision of health benefits or eligibility or participation in health coverage. The ACA also requires that we make appropriate arrangements to ensure that eligibile individuals with disabilities or with limited English profiicency are provided assistance and services if needed to access health benefits under the Plan. If you believe that you have been discriminated against in violation of the ACA's nondiscrimination requirements, you may file a complaint in writing with the Plan Administrator. The Plan Administrator will conduct a prompt investigation of your complaint. If you need assistance in accessing health benefits due to a disability or limited English proficiency, please contact the Plan Administrator.

Other Important Plan Information, continued

General Information

This Plan and the benefit programs offered under the Plan are not intended to be and cannot be construed as constituting a contract between you and Renown Health nor shall they be construed to guarantee employment for any period of time.

In the event of a conflict between the terms of this document and the plan document, the plan document will control.

Neither the Company nor the Plan Administrator assumes responsibility or liability with respect to any care or benefits received under the Plan. Although the Company and the Plan Administrator endeavors to provide its eligible employees with quality care at a reasonable cost, the selection of a provider is strictly a personal choice by the eligible employee.

Your ERISA Rights

As a participant in the Renown Health Welfare Benefits Plan (the "Plan"), you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

Receive Information About Your Plan and Benefits

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

- obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Your ERISA Rights, cont.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $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 that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Appendix A:
Component Plan Material

Appendix B: Additional Information For Retirees

Eligibility For Retiree Health Coverage

This Appendix B summarizes Renown Health's health plan for retired employees. To be eligible for retiree health coverage, an individual must qualify as a Category I, Category II, or Category III Retiree (as described below).

Renown Health reserves the right to discontinue or modify retiree health benefits at any time.

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

> ***Employees hired on or after January 1, 1990 are not eligible for retiree health coverage.*** *Such employees may be eligible to continue health coverage under COBRA for a limited period following retirement (or other qualifying event. See the section on COBRA, above.*

Details of coverage available to retirees is included in the Component Plan Material for the Medical Plan.

Table of Contents

Table of Contents

SUMMARY OF MATERIAL MODIFICATION TO THE SUMMARY PLAN DESCRIPTION OF THE RENOWN HEALTH WELFARE BENEFITS PLAN

The purpose of this Summary of Material Modification to the Summary Plan Description of the Renown Health Welfare Benefits Plan is to summarize for you an important change in the administration and operation of the Plan.

Effective July 1, 2021, any employee who was employed by the University of Nevada School of Medicine on June 30, 2021 and who became employed by Renown Health on July 1, 2021 can begin participating in the Plan on July 1, 2021. Therefore, the Employee Eligibility section at the beginning of the "Eligibility for Plan Participation" section of your Summary Plan Description is modified by adding the following at the end of that section:

> "Effective July 1, 2021, if you were employed by the University of Nevada, Reno School of Medicine on June 30, 2021 and you became employed by Renown Health on July 1, 2021, your Benefits Effective Date is July 1, 2021."

Please read your Summary Plan Description, including the section referenced above, for additional details concerning eligibility under the Plan.