Summary of Benefits – **Enhanced Plan**

The following is the Renown Health Enhanced Plan benefit summary for the Renown Health Welfare Benefit Plan (the "Plan"). This benefit summary is a part of the Plan's Summary Plan Description.

LIMITED CHOICE OF PROVIDERS

Each covered person shall select (or have selected on his or her behalf) a Primary Care Physician (PCP). Except in limited situations which are explained below, in order to receive Plan benefits all health care must be provided by or on referral from the covered person's Primary Care Physician. A Primary Care Physician must be participating in the Hometown Health Provider network. A covered person may change his/her Primary Care Physician by contacting Hometown Health Providers Insurance Company.

In addition to the PCP referral requirement, services of any provider other than the covered person's Primary Care Physician must be pre-certified. Where pre-certification is not possible in an emergency or urgent situation, certification must be obtained as soon as reasonably possible. See the **Referral and Certification/Pre-Certification Requirements** which follow the benefit schedule for more information.

OB/GYN office visits – A covered person may use a participating OB/GYN provider without a PCP referral.

Emergency or Urgent Services In-Area - Within the service area, emergency or urgent services may be covered without PCP referral but must be provided at a contracted facility unless the time requirement to reach a contracted provider would result in a significant risk of permanent health damage. Covered services furnished by a physician, oral surgeon, hospital or emergency facility personnel are covered during an emergency. Ambulance transport in an emergency is a covered service.

Emergency or Urgent Services Out-of-Area - Out-of-area coverage is limited to situations in which care is required immediately and unexpectedly. Elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from the service area are **not covered**. Covered charges for out-of-area services are based on usual and reasonable allowances.

Unanticipated complications of pregnancy or premature delivery are covered outside the service area if the covered person is in her first or second trimester of pregnancy. Childbirth outside the service area is **not covered** if the covered person has entered her third trimester of pregnancy.

No coverage is provided for any services rendered to a covered person who is outside the service area for a period exceeding ninety (90) consecutive days.

Follow-up Care - Coverage for continuing or follow-up treatment for an emergency or urgent care situation (in or out of the service area) is limited to care required before the covered person can, without medically harmful or injurious consequences, transfer to a participating provider.

DEFINITIONS

Coinsurance - The percentage of covered charges that is due and payable by the member to a provider upon receipt of certain covered services.

Copay – A payment that is due and payable by the covered person to a provider upon receipt of certain covered services. Copays do not apply toward the deductible requirements but do accumulate to the annual out-of-pocket maximums.

Deductible – An amount of covered charges that is due and payable by the covered person upon receipt of certain covered services. Where applicable, the deductible must be met before benefits are paid by the Plan.

Out-of-Pocket Maximum(s) – see the Schedule of Benefits, below

SCHEDULE OF BENEFITS

LIFETIME MAXIMUM BENEFIT	Unlimited
Total Plan benefits for each covered person are not limited. However, utilization limits may apply to all or certain periods of Plan coverage, or to certain conditions or types or levels of care. Such limits are included in this summary. NOTE: Any use of the term "lifetime" refers to all periods an individual is covered under the Plan. It does not mean a covered person's entire lifetime.	
OUT-OF-POCKET MAXIMUMS	
Individual Out-of-Pocket Maximum	$ 7,150
Family Out-of-Pocket Maximum	$14,300
Individual Out-of-Pocket Maximum – Except as noted, in any calendar year a covered person will not be required to pay more than his Individual Out-of-Pocket Maximum toward his copay obligations. Once he has paid his out-of-pocket maximum, his covered charges will be paid at 100% for the balance of the calendar year. Family Out-of-Pocket Maximum – Except as noted, a covered family (employee and his dependents) will not be required to pay more than the Family Out-of-Pocket Maximum in any calendar year toward their copay obligations. Once the family has paid their out-of-pocket maximum, their covered charges will be paid at 100% for the balance of the calendar year.	

COVERED CHARGES	Covered Person Pays	Plan Pays
Alcohol and Substance Abuse Care Inpatient Treatment, per admission: thereafter Outpatient Treatment, per visit	 $1000/Admit -0- $15 copay	 Balance 100% Balance
Benefits for inpatient alcohol and substance abuse care are subject to review for medical necessity and level of care determination.		
Alternative Medicine	(see "Homeopathic and Acupuncture Care")	
Ambulance (air/ground), per trip	$100 copay	Balance
Applied Behavioral Therapy for the Treatment of Autism	$30 copay	Balance
Limited to one hundred and fifty (150) visits not to exceed five hundred and fifteen (515) total hours of therapy per calendar year.		
Bariatric Surgery	(benefits are based on types of services provided)	
Limited to one medically necessary gastric restrictive surgery at a Bariatric Center for Excellence per lifetime. The designation of this is at the Plan Administrator's discretion. Limits include complications directly resulting from gastric restrictive services.		
Chemotherapy <u>in office</u>, per visit	$30 copay	Balance
Durable Medical Equipment	-0-	100%
Limited to one purchase of a specific item of DME, including repair and replacement every three (3) years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The rental of warning or monitoring devices for infants (defined as a child 24 months old or less) suffering from recurrent apnea is limited to 90 days.		
Food Products, Special as defined by Nevada Statute	-0-	100%
Special Food Products limited to a maximum benefit of four (4) thirty (30) days of therapeutic supplies per member per calendar year.		
Genetic Counseling/Testing if medically necessary as determined by the plan, per visit If mandated by PPACA for high risk BRCA testing and counseling.	$30 copay -0-	Balance
Home Health Care, per visit	$30 copay	Balance
Limited to fifty (50) visits per calendar year. Home health care requires prior authorization for in-network benefits.		
Home Hospice Services	-0-	100%
Limited to a 185-day period of patient care beginning on the first day of home hospice care services. Benefits for outpatient counseling services for the patient and his/her immediate family are limited to six (6) visits for all family members combined if they are not otherwise eligible for mental health benefits under another policy. Respite care providing nursing care is limited to a maximum of eight (8) inpatient respite care days per calendar year and thirty-seven (37) hours per calendar year for outpatient respite care services.		
Homeopathic, Alternative and Acupuncture Care, per visit	$30 copay	Balance
Limited to 20 visits per calendar year.		

COVERED CHARGES	Covered Person Pays	Plan Pays
Hospital Services		
Inpatient Hospital Services, per admission:	$1,000/Admit	Balance
thereafter	-0-	100%
Outpatient Surgery	$250 copay	Balance
Observation	$250 copay	Balance
Emergency Room Facility Services Use (see NOTE)	$200 copay	Balance
Inpatient short-term rehabilitative services are limited to 60 days per calendar year. NOTE: Routine or follow-up care in an emergency room facility is not covered. Follow-up care should be provided by the covered person's Primary Care Physician.		
Infertility Services	(benefits are based on types of services provided)	
Limited to medically necessary services to diagnose problems of infertility for a covered individual. One diagnostic evaluation for infertility every year up to three (3) per lifetime and up to six (6) artificial inseminations per lifetime. Exclusions apply and are detailed in the Medical Plan Component.		
Kidney Dialysis Services, per visit	$50 copay	Balance
Lab and Diagnostic Services		
CT Scan	$200 copay	Balance
MRI Scan	$200 copay	Balance
Pet Scan	$200 copay	Balance
All other x-ray services	$ 25 copay	Balance
Clinical Laboratory	-0-	Balance
Medical Pharmaceuticals		
Special Pharmaceuticals	$75 copay	Balance
Other Medical Pharmaceuticals	$15 copay	Balance
Mental Health Care		
Inpatient Treatment, per admission:	$1,000/Admit	Balance
thereafter	-0-	100%
Outpatient Treatment, per visit	$15 copay	Balance
Inpatient mental health and substance abuse services require prior authorization. Outpatient mental health, substance abuse and counseling visits for greater than 12 visits per calendar year require prior authorization for benefit coverage.		
Orthopedic and Prosthetic Devices	$25 copay	Balance
Limited to a single purchase of a specific type of prosthetic device including repair and replacement once every three (3) years.		
Ostomy Care Supplies	-0-	100%
Limited to thirty (30) days worth of therapeutic supplies per month.		
Outpatient Surgery Center	$250 copay	Balance

COVERED CHARGES	Covered Person Pays	Plan Pays
Physician Services		
Inpatient Visits	-0-	100%
OB/GYN visits, per visit	$15 copay	Balance
Other Office Visits:		
Primary Care Physician	$15 copay	Balance
Specialty Care Physician	$30 copay	Balance
Lipoma Surgery	$50 copay	Balance
In-Office Procedure:		
Primary Care Physician	$15 copay	Balance
Specialty Care Physician	$30 copay	Balance
Port Wine Stain Removal	$30 copay	Balance
Preventive Care		
In-Office Services, per visit	$0	$0
Other Covered Services	$0	$0

Preventive Care includes, but is not limited to:

- 1 physical exam each calendar year and immunizations in accordance with medical practice guidelines, including influenza immunizations;
- 1 routine GYN exam each calendar year including a Pap smear, pelvic exam, urinalysis and breast exam;
- mammograms screening;
- colorectal cancer screening;
- prostate screening (PSA);
- well-baby care during the first 2 years of life, including immunizations in accordance with the American Academy of Pediatrics and other federal agencies;
- hearing and vision screening for children through age 17 to determine the need for hearing or vision correction

Plan will cover the following services without any Member cost-sharing requirements if such services are provided by a Participating Provider:

- Evidence –based items or services that have in effect a rating of "A" or "B" in the current recommendation of the United States Preventive Services Task Force, provided that, with regard to breast cancer screening, mammography, and prevention, the current recommendations of the United States Preventive Services Task Force will be the most current other than those issued in or around November 2009;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention with respect to the individual involved

Rehabilitation Facility	$1,000 copay per admit	Balance
Thereafter	-0-	100%

Limited to 60 days per calendar year.

COVERED CHARGES	Covered Person Pays	Plan Pays
Short-Term Rehabilitative Therapy	$15 copay	Balance
Outpatient speech, occupational and physical therapy coverage is limited to 60 visits/sessions for all modalities combined per calendar year. Coverage for these therapies are provided for rehabilitative and habilitative separately, as per the medical necessity of these services. Habilitative therapy does not require that an injury or illness preceded the need for service. Outpatient cardiac rehabilitation and pulmonary rehabilitation therapy coverage is limited to 60 visits/sessions for all modalities combined per calendar year.		
Skilled Nursing Facility Thereafter	$1,000 copay per admit 0-	Balance 100%
Limited to 100 days per calendar year.		
Spinal Manipulations and Adjustments	$30 copay	Balance
Limited to 20 visits per calendar year and 100 visits per lifetime.		
TMJ-Related Services	depends upon type of service	Balance
Limited to an annual maximum of one (1) surgery and a lifetime maximum of two (2) surgeries.		
Transplant Services	(benefits are based on types of services provided)	
Urgent Care Center Services, per visit	$30 copay	Balance
Virtual Visits	$15 copay	Balance
All Other Covered Charges	-0-	100%

REFERRAL AND CERTIFICATION/PRE-CERTIFICATION REQUIREMENTS

Compliance Requirements - A referral from a covered person's Primary Care Physician (PCP) and certification or pre-certification from Hometown Health Providers Insurance Company is required for all referrals to other physicians and providers including:

- All inpatient stays and services in any type of facility, including acute and skilled care, admissions for mental health care, drug or alcohol detoxification, rehabilitation, obstetrical and observation stay.
- Inpatient mental health and substance abuse services
- Procedures performed in a Same Day Surgery or Ambulatory Center
- Office Visits to Specialist (excluding Chiropractic, Mental Health and In Office Procedures)
- Colonoscopies other than those for preventive screening
- Outpatient cardiac rehabilitation
- Outpatient pulmonary rehabilitation
- Home health care
- Healthcare services and supplies, including but not limited to, oxygen, oxygen-related equipment and all any durable medical equipment (DME) in excess of $100
- Prosthetic and Orthopedic devices (DME) over $100
- High Tech Imaging including CT Scans, MRIs, PET scans and nuclear medicine
- Diagnostic Cardiology Imaging including CT scan, CT angiograms, nuclear cardiology
- Transplant Services
- Dialysis
- Infusion
- Pain Management to include Trigger-Point Injections
- Upper Endoscopy
- Parenteral Nutrition
- Radiation Therapy
- Nutrition
- Outpatient mental health services for greater than 12 visits per calendar year
- Wound Care Services to include Hyperbaric Treatment
- Medications specified by Hometown Health Providers
- Upon confirmation of pregnancy, Hometown Health Providers ***must*** be notified
- Certain high cost pharmaceuticals and biological meds. A current list of these is available on the website; www.hometownhealth.com

Hospital Admission – For elective hospital admission, a covered person is responsible for making sure Hometown Health Providers Ins. Co. is notified at least five (5) business days before admission. Hometown Health Providers Ins. Co. will review the physician's recommendation to determine whether a hospital stay is necessary or if the procedure can be safely performed in an alternative setting.

For an emergent or urgent hospital admission, the covered person is responsible for making sure Hometown Health Providers Ins. Co. is notified within 24 hours, the next business day or as soon as reasonable after admission. If the covered person is incapacitated and he or she (or a friend or relative) cannot notify Hometown Health Providers Ins. Co. within the above stated times, notification must be received by Hometown Health Providers Ins. Co. as soon as reasonably possible.

An "emergent" hospital admission is one that results from the sudden and unexpected onset of a condition that requires medical or surgical care and where, in the absence of such care, the covered person could reasonably

be expected to suffer serious bodily injury or death. Examples include heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal injuries, and other acute conditions as are determined to be emergencies.

An "urgent" hospital admission is for an injury or serious illness which is less severe than an emergency but requires care within a short time. This includes complications of pregnancy.

As part of the pre-certification process, Hometown Health Providers Ins. Co. will also review for alternative methods or locations of medical care or treatment not otherwise listed as covered charges under this SPD.

Certification/pre-certification by Hometown Health Providers Ins. Co. does not guarantee that charges are covered under the Plan. Payment is subject to all the terms of the Plan.

Inpatient/Outpatient Surgery – A covered person is responsible for making sure Hometown Health Providers Ins. Co. is notified at least five (5) business days before inpatient or outpatient surgery is performed. Hometown Health Providers Ins. Co. will review the physician's recommended course of treatment. Benefits will be paid only for pre-certified inpatient/outpatient surgery.

Other Services and Supplies – For all other pre-certification requirements, a covered person is responsible for making sure that Hometown Health Providers Ins. Co. is notified prior to receipt of the service or supply.

Contracted physicians and providers are aware that Hometown Health Providers Ins. Co. needs to be notified to obtain pre-certification for the services listed above. Non-contracted physicians and providers may not know or attempt or notify Hometown Health Providers Ins. Co. to obtain pre-certification for services. A covered person should verify that Hometown Health Providers Ins. Co. has pre-certified services to prevent penalties resulting from lack of pre-certification or use of non-covered services.

Members may elect to seek services from non-preferred healthcare providers provided the member pays the additional deductible and coinsurance amounts and any additional charges over a usual and customary charge for the service provided. Members also may be required to obtain prior authorization before seeking services from non-preferred providers. It is the member's responsibility to ensure that the appropriate prior authorizations are in place for both in-network and out of network non-emergency services.
No benefits will be paid for healthcare services or supplies determined not a covered benefit or which does not meet Hometown Health Providers Ins. Co. criteria and protocols.

Penalty for Non-Compliance – If a covered person fails to call Hometown Health Providers Ins. Co. as required, benefits will be reduced to 50% of the Plan's normal liability and this benefit reduction will not apply towards the out-of-pocket maximums.

If certification/pre-certification is denied for a hospital admission as not covered or not medically necessary, no benefits will be paid for hospital and related charges. No benefits will be paid for inpatient/outpatient surgery or any other healthcare services or supplies which are determined to be: 1) not covered, or 2) not medically necessary. No benefits will be paid for healthcare services or supplies determined as not meeting Hometown Health Providers Ins. Co. criteria and protocols.

See Part 4 Utilization Management Program in the Summary Plan Description for more information.