SUMMARY PLAN DESCRIPTION
WRAP DOCUMENT

FOR THE

SERVICE
BENEFIT TRUST FUND
WELFARE BENEFIT PLAN

SPONSORED BY
THE CARSON CITY CHAMBER OF COMMERCE

(Effective October 1, 2023)

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SUMMARY PLAN DESCRIPTION FOR THE

SERVICE BENEFIT TRUST FUND
WELFARE BENEFIT PLAN
SPONSORED BY THE CARSON CITY CHAMBER OF COMMERCE

PARTICIPATING EMPLOYER
INFORMATION AND BENEFITS OFFERED

Name: _____

Address: _____

_____

_____

Phone No.: _____

PREAMBLE

This Summary Plan Description describes the plan benefits provided to you by your employer (identified above). The plan was selected by your employer in its Adoption Agreement with the Trust Fund. The Trust Fund is a Multiple Employer Welfare Arrangement (MEWA) that is administered by the Trustees. Your employer's participation in the Trust Fund does not create a joint employer relationship between it and any other employer.

I. PLAN BENEFITS

A. Health Benefits for Employees

Your employer has elected to provide certain health insurance benefits. A summary of the benefits provided under the Plan are set forth in the attached Evidence of Coverage and Schedule of Benefits documents. The Evidence of Coverage and Schedule of Benefits describe the types of benefits, scope of coverage, prerequisites to being covered and other details regarding the benefits. You must read the Evidence of Coverage and Schedule of Benefits to understand your benefits.

B. Coverage of Employees

The Participating Employer will make contributions for employees who work at least 30 hours per week, as described in the Evidence of Coverage document.

C. Eligibility of Reported Employees

The obligation to contribute for monthly reported employees will begin on the first day of the month following [*employer to select one prior to distribution to employees*]:

( ) the date of hire,
( ) 30 days or one month after the date of hire, whichever is less, or
( ) 60 days or two months after the date of hire, whichever is less.

II. REQUIRED DISCLOSURES

This document, along with the attached Evidence of Coverage and Schedule of Benefits furnished by Hometown Health, is your Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (“ERISA”). This summary highlights your rights and obligations under the SERVICE BENEFIT TRUST FUND WELFARE BENEFIT PLAN ("Plan"). Benefits under the Plan are provided by Hometown Health, which has contracted with the Trust, and are subject to the provisions of the Plan, the Trust Agreement, your employer’s Adoption Agreement and the determination of the plan administrator or Hometown Health.

Since this is only a summary, all of the details of the Plan are not covered, and you should contact the Plan Administrator or health insurance issuer(s) if you still have questions about your coverage. The Plan Sponsor reserves the right to change or discontinue the Plan at any time. This Summary Plan Description does not create a contract of employment.

Noticia de Asistencia de Lenguaje Extranjero: Este folleto contiene un sumario en ingles de sus derechos del plan y los beneficios bajo Service Benefit Trust Fund. Si tiene alguna dificultad entendiendo cualquier parte de este folleto communiquese con el Administrador del plan a su oficina en Hometown Health, 10315 Professional Circle, Reno, Nevada 89521. Horas de oficina son de 8:30 a.m. a 5:00 p.m. de Lunes a Viernes. Tambien se puede comunicar con el Administrador por telefono al (775) 982-3000 para asistencia.

A. Basic Plan Information

1. Name of Plan

SERVICE BENEFIT TRUST FUND WELFARE BENEFIT PLAN (“Plan”).

2. Name and Address of Plan Sponsor

Carson City Chamber of Commerce
1900 S Carson St
Carson City, NV 89701
Phone: (775) 882-1565
EIN: 88-0067398

3. Participating Employer

The Plan allows participation of more than one employer. You may receive upon written request of the Plan Administrator information as to whether a particular employer participates in the Plan.

4. Plan Trust Employer Identification Number (EIN)

93-6527140

5. Plan Number (PN)

501

6. Type of Plan and Funding

This is a welfare benefit plan that provides group medical and supplemental benefits through a multiple employer trust fund. All benefits are fully insured. Contributions are paid by participating employers directly to the insurer. The Plan is not collectively bargained. The trust name is the Service Benefit Trust Fund ("Trust Fund")

7. Plan Administrator and Type of Administration

The Plan is administered by a professional plan administrator. If you have questions about the Plan, please contact:

Hometown Health Administrators
10315 Professional Circle
Reno, Nevada 89521
(775) 982-3000

8. Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Carson City Chamber of Commerce
Attn: Ronni Hannaman
1900 S Carson St
Carson City, NV 89701

Service of legal process may be made upon a plan trustee or the plan administrator.

9. Plan Trustees

The addresses of the Plan Trustee(s) are:

Julie Ann Evans
1027 Ladera Drive
Carson City, NV 89701

James Hardiman
4551 E Fifth St
Carson City, NV 89701

Stephen Jones
400 Eagle Station Lane
Carson City, NV 89701

Kris Wells
605 Sugar Tree Ct
Reno, NV. 89511

10. Named Fiduciary

The Named Fiduciary(ies) for the Plan are the Trustees. The Named Fiduciary may delegate its duties in writing.

The Claims Fiduciary(ies) have generally been designated to act on behalf of the Named Fiduciary for purposes of claims administration.

11. Source of Plan Contributions

Contributions are made by Participating Employers for their employee participants and beneficiaries, including dependents. Contributions are set at amounts needed to pay premiums for coverage and to pay for Plan expenses.

12. Plan Year

The Plan Year is the calendar year.

13. Health and Life Insurance Benefits

Your employer participates in the plans identified in the Evidence of Coverage and Schedule of Benefits.

14. Role of Health Insurance Issuer

The benefits provided under the Plans are insured and underwritten by Hometown Health Providers Insurance Company, Inc. and Hometown Health Plan, Inc (together, "Hometown Health"). Administrative services in connection with the health insurance Plan, including payment of claims, are performed by Hometown Health. Should you have any questions for the insurer, you may direct inquiries to:

Hometown Health
10315 Professional Circle
Reno, Nevada 89521
(775) 982-3000

15. Filing a Claim for Benefits

Procedures for submitting claims and obtaining benefits are outlined in the Evidence of Coverage document. Plan Participants and beneficiaries can obtain a copy of these procedures, without charge, from the Plan Administrator.

16. Appealing a Claim Denial

The Trustees have delegated review of denied insurance benefit claims and adverse benefit determinations to the individual health benefit provider(s) identified above ("Claims Fiduciary"). The Claims Fiduciary is responsible for adjudicating claims for benefits under the Plan, and for deciding any appeals of adverse claim determinations. Claims Fiduciary will have the authority, in its discretion, to interpret the terms of the

Plan, including the insurance policies, to decide questions of eligibility for coverage or benefits under the Plan and to make any related findings of fact. All decisions made by the Claims Fiduciary will be final and binding on participants and beneficiaries of the Plan to the full extent permitted by law.

These claims review and appeal procedures will constitute the sole and exclusive procedures under the plan available to a participating employee or beneficiary who is dissatisfied with the disposition of a benefit claim and will comply with the requirements of ERISA. A copy of such procedures can be obtained, without charge, from the Plan Administrator. No lawsuit may be brought with respect to plan benefits until all such administrative procedures have been exhausted for every issue deemed relevant by the participating employee or beneficiary.

17. Continuation of the Plan

The Plan Sponsor and Participating Employers intend to continue the Plan, but reserve the right to terminate or change the Plan at any time.

18. Termination of the Plan

The Plan Sponsor and Participating Employers do not promise the continuation of any benefits nor do they promise any benefit at or during retirement. The Plan may be terminated at any time by the Trustees. Benefits may be terminated also by the Participating Employer's failure to make contributions or by the termination or expiration of the Participating Employer's agreement adopting the Plan.

Upon termination of the Trust Fund, the Trustees will wind up the affairs of the Trust Fund, and any remaining funds will be used to continue payment of benefits to Participants and their beneficiaries under the Plan.

19. Statement of ERISA Rights

As a Plan Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ('ERISA"). ERISA provides that all Plan Participants shall be entitled to:

(a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor;

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies;

(c) 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; and

(d) 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.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your employer 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. 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 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 which 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 domestic relations order or a medical child support order, you may file suit in federal court.

If you have executed an Arbitration Agreement and Class Action Waiver, your right to file a claim shall be subject to the terms of that agreement.

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.

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 publication hotline of the Employee Benefits Security Administration.

B. Eligibility and Participation Rules

To determine whether you or your spouse and/or dependents are eligible to participate in the Plan, and how to enroll, please read the eligibility section in the attached Evidence of Coverage. The eligibility section also includes rules pertaining to qualified medical child support order ("QMCSO") determinations. Please contact the Plan Administrator if you have any questions regarding your coverage.

1. Open Enrollment

An open enrollment period is a time established by the employer when eligible employees and their eligible family members have the option to enroll in the plan or make changes to current plan coverage. The annual open enrollment period is the month immediately preceding the renewal date of coverage.

2. Termination of Your Insurance

Your coverage will terminate as described in the attached Evidence of Coverage.

3. Eligibility of Dependents

(a) Insuring Dependents.

Eligibility of dependents is subject to the terms outlined in the Evidence of Coverage and the Adoption Agreement. Your employer allows the following category of dependent to be covered under the Plan. [*employer to select one prior to distribution to employees*]:

( ) Employee only
( ) Employees and dependent children
( ) Employees, spouses and dependent children
( ) Employees, spouses, domestic partners and dependent children

Only a person who meets the definition of dependent may become insured for dependents' insurance under the group policy. To become insured, the person must:

(1) Qualify as a dependent;

(2) Be enrolled for the dependents' insurance through your participating employer; and

(3) Reach an eligibility date.

Eligible Dependent – The term "dependent" means only your spouse or domestic partner and unmarried child of an age within the Age Limits for Dependent Children shown below. The definitions of "child" and "dependent" are outlined in the insurance providers' benefit information materials including any child pursuant to a QMCSO. A child shall be deemed, for this insurance, to be a dependent of not more than one person. The term "dependent" does not include a person who is: (a) an eligible employee; or (b) on active duty in any armed forces.

Age Limits for Dependent Children – Dependent health coverage is available to children until the child reaches the age of 26. Eligibility of the child does not depend upon marital status, student status, or tax dependency of the child. Children up to age 26 can stay on their parent's coverage even if they have another offer of coverage through an employer.

Exception to Age Limits – If an unmarried dependent child, when he or she reaches the age limit shown above, is insured under the group policy, chiefly depends on you for support and maintenance, and is continuously unable to get self-sustaining work due to a physical or mental handicap, the child will continue to qualify as a dependent for coverage until the earlier of the following dates: (a) the date he or she recovers from the handicap; and (b) the date he or she no longer chiefly depends on you for support and maintenance. See the Evidence of Coverage for more information.

Eligibility Date – A dependent's eligibility date is the later of: (a) your eligibility date; or (b) the date the person qualifies as your dependent.

(b) Termination of a Dependent's Insurance.

A dependent's insurance will end on the earliest date shown below:

(1) The last day for which premiums are paid for your dependents' insurance;

(2) The last day of the month in which the person no longer qualifies as a dependent; or

(3) The date your employees' insurance ends.

4. Coverage of Former Medicaid or State Children's Health Insurance Program Participants

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") provides enrollment rights of eligible individuals. The Plan provides the following special enrollment rights for individuals who are eligible for coverage under the Plan but are not enrolled for coverage:

(a) An employee or eligible dependent who is covered under Medicaid or the State Children's Health Insurance Program ("SCHIP") and loses coverage under Medicaid or SCHIP because the employee or dependent is no longer eligible for such coverage may request coverage under the Plan within sixty (60) days of the loss of Medicaid or SCHIP coverage. Like other special enrollment rights under the Plan, qualified individuals may enroll in the Plan outside of the regular open enrollment period; and

(b) An employee or eligible dependent who becomes eligible for a premium assistance subsidy in the Plan under Medicaid or SCHIP may request coverage under the Plan within sixty (60) days after such eligibility is determined. State-specific notices will be provided to employees regarding the state-provided subsidy after they have been issued by the Department of Labor and Division of Health and Human Services.

5. HIPAA Special Enrollment Period

HIPAA Special Enrollment Periods apply only to group "Health Coverage", and not to any other Component Benefit Plan offered under this Plan (e.g., life, disability, etc.). If you, your Spouse, and/or eligible Dependents are entitled to special enrollment rights, you may change your group Health Coverage elections to correspond with the special enrollment right. For example, if you declined enrollment in the medical plan offered under this Plan for yourself or your eligible Dependents because you or they had other medical coverage and eligibility for such other coverage is subsequently lost (for example, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA coverage), you may be able to elect medical coverage (and if applicable, dental and/or vision coverage) under the Plan for yourself and your eligible dependents who lost such coverage. You are required to request enrollment in writing within 30 days after your or your Dependents' other coverage ends (or after the Participating Employer stops contributing toward the other coverage).

In addition, you may make a change to your Health Coverage due to your marriage or the birth, adoption, or placement for adoption of a child with you. Written requests received within 30 days of the birth of a child or adoption or placement for adoption of a child with you will permit you, your child(ren) and your eligible Spouse/domestic partner, if elected, to be covered retroactively to the date of birth, adoption or placement for adoption. Written requests received within 30 days of your marriage will permit you, your eligible Spouse/domestic partner and your Dependent children, if elected, to be added to your coverage prospectively on the first day of the month following the date of your written request.

You may also cancel or modify your medical insurance during the current Plan Year if the reason for canceling or modifying your election is on account of your, your Spouse and/or your eligible Dependent (i) losing coverage under a Medicaid Plan under Title XIX of the Social Security Act; (ii) losing coverage under a State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (iii) becoming eligible for group health plan premium assistance under Medicaid or SCHIP. However, to cancel or

modify your medical insurance, you must make a written election to the Plan Administrator no later than 60 days after the loss of coverage or eligibility for premium assistance.

An individual who loses coverage as a result of either a failure to pay premiums on a timely basis or for cause (such as for making a fraudulent claim or an intentional misrepresentation of a material fact in connection with prior health coverage) does not have the right to enroll under this Subsection.

Other Mid-Year Enrollment Changes Period: Generally, you cannot change the enrollment elections you have made after the beginning of the Plan Year, other than during an Annual Enrollment Period or HIPAA Special Enrollment Period. However, there are certain other limited situations when your enrollment elections may be changed during the Plan Year, such as if you experience a change in your employment or family status. Please review your Section 125 Cafeteria Plan, if any, for a more information regarding the events that may permit a mid-year enrollment change under this Plan.

6. Continuing Coverage (COBRA)

You, your spouse, and/or your covered dependents may elect to continue your coverage under the Plan through federal legislation called COBRA. You will be required to pay premiums for this continued coverage. COBRA coverage procedures are explained in the attached Evidence of Coverage.

Questions concerning this Plan, or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the EBSA or visit the EBSA website at www.dol.gov/ebsa. Addresses and telephone numbers of Regional and District EBSA offices are available through EBSA's website.

To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. In addition, even if your dependent children are covered under a QMCSO, you, and/or your spouse should notify this office immediately of his, her or their address(es). You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

7. Continuing Coverage (USERRA)

If you experience a leave of absence from your employment to perform service in the uniformed services, the Uniformed Services Employment and Reemployment Rights Act ("USERRA") provides you with rights to elect to continue your coverage under the Plan that is separate from and in addition to COBRA continuation coverage rights.

Uniformed services mean the Armed Forces, and the Army National Guard, when you are engaged in active duty or training, or inactive duty training. Uniformed services also include full-time National Guard duty, the commissioned corps of the Public Health

Service, and any other persons designated by the President in a time of war or national emergency. Service in the uniformed services means voluntary or involuntary duty, active duty, and inactive duty for training. It also includes periods away from work for an examination to determine fitness to perform duty.

If you are a Participating Employee, you have a right to elect continuation coverage under USERRA for yourself and your covered dependents if you would otherwise lose coverage under the Plan because of service in the uniformed services. Unlike under COBRA, your dependents do not have an independent right to elect USERRA continuation coverage.

Under USERRA, you may elect to continue coverage under the Plan up to the lesser of (a) 24 months or (b) the date you return or should have returned to active employment, or, if applicable, applied for reemployment. Unlike COBRA, there are no additional qualifying events that would entitle you to extend the period of continuation coverage beyond the 24-month period. In addition, there is no entitlement under USERRA for any extension based on your disability or the disability of a qualified beneficiary. USERRA continuation coverage is identical to coverage provided under the Plan to similarly situated individuals.

USERRA continuation coverage is similar to COBRA continuation coverage, but it is not identical, and there are important differences. If you elect both USERRA and COBRA continuation coverage, they will run concurrently. If you elect continuation coverage under both federal laws, you will be provided with the coverage that is most favorable to you. For example, if your COBRA continuation coverage terminates at the end of an 18-month period, you may continue to receive continuation coverage under USERRA up to a total of 24 months. Similarly, if your COBRA continuation coverage terminates before the maximum period because you become covered under another employer's plan, you may continue USERRA continuation coverage up to a total of 24 months.

USERRA continuation coverage terminates when any one of the following events occurs:

(a) The date on which you fail to return from military service to active employment or apply, if applicable, for reemployment as required under USERRA;

(b) The end of the maximum 24-month period, beginning on the date on which your military leave of absence began;

(c) You fail to make a timely payment for your continuation coverage;

(d) The date on which you are discharged from military service under other than honorable conditions, or under conditions that prohibit your reinstatement under USERRA; or

(e) The Participating Employer no longer provides group health coverage to any employees.

To qualify for USERRA continuation coverage, you must provide your employer with advanced notice of your military service, as required under USERRA. You will receive a notice from the Plan Administrator regarding USERRA continuation coverage and an Election Form. Like COBRA, you must elect USERRA continuation coverage by returning the election form to the Plan Administrator within the 60-day period identified in the election form. If you fail to return the election form during this time period, you will lose the right to continuation coverage under USERRA. There are limited exceptions when it would be unreasonable or impossible under the circumstances to provide a timely notice, such as military emergency.

Like under COBRA, you must pay the entire cost of continuation coverage under USERRA for your coverage and coverage for any dependents. In addition, you will be required to pay a 2 percent administration fee along with each premium payment.

The costs of continuation coverage will be identified in the Election Form provided to you by the Plan Administrator. Like COBRA continuation coverage, your initial premium payment(s) must be made within 45 days of your electing USERRA continuation coverage. Subsequent payments must be made on a monthly basis. You will be provided a grace period of 30 days after the first day of the coverage period to make each monthly payment. Failure to pay premium costs before the end of the grace period will result in the loss of continuation coverage.

If your coverage under the Plan is terminated as a result of your service in the uniformed services, your coverage will be reinstated upon your return to active employment under the requirements of USERRA.

Questions concerning your rights to USERRA continuation coverage should be addressed to the Plan Administrator. For more information on your rights under USERRA, contact the nearest office of the Department of Labor Veterans' Employment and Training Service ("VETS") or access the VETS website at www.dol.gov/vets.

To protect your and your dependents' rights under USERRA, you should keep the Plan administrator informed of any changes in your or the addresses of family members. You should also keep a copy, for your records, of any notices or form that you send to the Plan Administrator.

8. Participation During FMLA Leave

If your Participating Employer is a large employer subject to the Family and Medical Leave Act of 1993, you will have the right to continue any Health Coverage during the period of leave if Health Coverage was in effect prior to the date on which the leave began. However, you have different options with regard to your Health Coverage, depending upon whether the FMLA Leave is paid leave or unpaid leave and you will be responsible for any premium payments during the leave. You will need to arrange for payment of premiums during your FMLA leave with your Participating Employer. For

information regarding continuation of coverage under Component Benefit Plans other than Health Coverage during FMLA Leave, contact your Participating Employer.

9. Other Paid and Unpaid Leaves

Employees in California may be eligible for leave under the California Family Rights Act (CFRA), Pregnancy Disability Leave Law (or PDL), or other California laws. In some instances, these state laws may allow employees to continue their group health coverage during these leave periods.

Furthermore, in some cases, Participating Employers may allow an employee to go on a leave of absence that is not subject to FMLA, CFRA, USERRA, or PDL; in these instances, the employee may no longer satisfy the eligibility requirements of the Plan, including the Component Benefit Plans, and Plan participation and benefits will terminate.

The Plan Documents for each Component Benefit Plan describe in more detail any rights, limitations, and obligations Participants may have to benefits while on paid or unpaid leave, including FMLA, CFRA, USERRA, or PDL leave. Participants should contact their Participating Employer for additional information about any rights they may have to leave and to benefits while on leave.

Participation Upon Rehire: If you terminate your employment with your Participating Employer and are then rehired, you may be permitted to resume participation in the Component Benefit Plans, if and when you satisfy the eligibility requirements applicable to those Component Benefit Plans. Please check with your Participating Employer for more information.

10. Maternity Benefits

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

11. Qualified Medical Child Support Order

A Qualified Medical Child Support Order ("QMCSO") issued by a court or a state agency requires the Plan to provide health coverage to the child(ren) of a Plan participant. The Plan has adopted Qualified Medical Child Support Order Procedures to determine whether a particular order qualifies as a QMCSO. Plan participants and beneficiaries can

obtain, without charge, a copy of these procedures from the Plan Administrative Manager.

Participating employers that receive a QMCSO or a National Medical Support Notice from a state agency should provide affected participants with the following forms available from the Department of Child Support Services website: Statement of Obligor's Rights and Procedures Regarding a National Medical Support Notice (NMSN) or Health Insurance Assignment Order; Request and Notice of Hearing Regarding Health Insurance Assignment; and Information Sheet and Instructions for Request and Notice of Hearing Regarding Health Insurance Assignment.

12. No Assignment

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this Plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances. An insurer or Claims Fiduciary may pay benefits under the Plan directly to a provider. Such direct payment may not be interpreted or relied upon as the authority to assign any other rights under this Plan to any party, including, but not limited to, a provider of healthcare services/items.

13. Restrictions on Lifetime Limits for Coverage of Benefits

Individuals whose medical coverage ended because they reached a lifetime limit under the Plan are eligible to enroll in the Plan if they meet eligibility requirements.

Individuals have 30 days from the date of notice to request enrollment. For more information, contact the Plan Administrator.

14. Patient Protection Disclosure

The Plan provides certain patient protection under the Patient Protection and Affordable Care Act. If the Plan requires 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, the health insurance issuer 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 the Plan Administrator.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Plan or health insurance issuer or from any other person (including a primary care provider) 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 the Plan Administrator.

15. Mental Health Parity Act.

The group health plan must generally comply with the provisions of the Mental Health Parity and Addiction Equity Act of 2008, including that the group health plan's financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) that are applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

16. Special Rule for Women's Health

If a health benefit plan available under the Plan provides medical and surgical benefits for mastectomy procedures, it shall provide coverage for reconstructive surgery following mastectomies. This expanded coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the health benefit plan or coverage.

17. HIPAA Privacy and Security

The Plan will use and disclose protected health information (PHI), as defined in 45 CFR § 160.103, to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations as defined in the Plan HIPAA Privacy Notice (as defined in 45 CFR § 164.520) distributed to Participants and as otherwise permitted by the HIPAA privacy rules.

18. Compliance with Other Laws

The Plan will comply with applicable laws, including the Genetic Information Nondiscrimination Act and the Consolidated Appropriations Act of 2021.

19. Coordination of Benefits; Subrogation and Reimbursement

If your spouse or dependents are enrolled in a medical or dental coverage under this Plan as well as another employer-sponsored plan, such as your spouse's plan at work, the medical or dental coverage under this Plan coordinates its coverage with the other

plan. See the attached Evidence of Coverage for the coordination of benefits provisions that apply.

The attached Evidence of Coverage contains information about the Plan's right to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant, the Participant shall be responsible for refunding the overpayment to the Plan to the fullest extent permitted by law. The Plan reserves the right to be made whole without offsets for attorney's fees, to the extent permitted by law. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurer, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurer's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurer, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurer. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

20. Nondiscrimination Policy.

The Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Trust Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Trust Fund provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The Trust Fund also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Hometown Health. If you believe that the Trust Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Hometown Health, 10315 Professional Circle, Reno, Nevada 89521 or phone (775) 982-3000.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Hometown Health is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department

of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

21. Governing Law.

To the extent not preempted by ERISA, questions concerning the proper interpretation of the terms of this summary plan description shall be determined in accordance with the law of the State of Nevada. It is intended that this Plan meet all applicable requirements of the Internal Revenue Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, article, or provision of this Plan and the Code or ERISA, the provisions of the Code or ERISA shall be deemed controlling, and any conflicting part, clause, article, or provision of this Plan shall be deemed superseded to the extent of the conflict.

22. Language Access.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(775) 982-3000.

Chinese: 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 1-(775) 982-3000.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-(775) 982-3000.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-(775) 982-3000.

Korean: 번으로 전화해 주십시오.주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-(775) 982-3000.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-(775) 982-3000.

Persian (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما بگیرید. تماس 1(800) 274-4550 با ف می باشد.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-(775) 982-3000.

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-(775) 982-3000.（まで、お電話にてご連絡ください。

Arabic: ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-(775) 982-3000.

Panjabi: ਿ◌ਧਆਨ ਿ◌ਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿ◌ਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-(775) 982-3000 'ਤੇ ਕਾਲ ਕਰੋ।

Mon-Khmer (Cambodian): লয্ কর নঃ িযদ আিপন বাংলা, কথা বেলত পা◌েরন, তা◌েহল ি◌নঃখরচায় ভাষা সহায়তা িপেরষবা উপল ◌েআছ্। ◌েফান কর ন ১ 1-(775) 982-3000

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-(775) 982-3000

Hindi: ध्यान द: यद आप हद बोलते ह तो आपके ि◌लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-(775) 982-3000 पर कॉल कर।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-(775) 982-3000.