

SUMMARY PLAN DESCRIPTION

FOR

HEALTH WAY OF SAN DIEGO COUNTY TRUST FUND

PARTICIPATING EMPLOYER

Name: _____
Address: _____

Phone #: _____

INTRODUCTION

This document, along with the benefit information furnished by your insurance provider(s), 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 HEALTH WAY OF SAN DIEGO COUNTY TRUST FUND BENEFIT PLAN ("Plan"). Benefits under the Plan are provided through several insurance and managed care providers, 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 health insurance issuer.

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 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 Health Way of San Diego County Trust Fund Benefit Plan. Si tiene alguna dificultad entendiendo cualquier parte de este folleto comuniquese con el Administrador del Plan a su oficina en 1120 South Bascom Avenue, San Jose, CA 95128. 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 (408) 288-4400 para asistencia.

SUMMARY PLAN DESCRIPTION

A. Basic Plan Information

1. **Name of Plan.**

HEALTH WAY OF SAN DIEGO COUNTY TRUST FUND BENEFIT PLAN
("Plan").

2. Name and Address of Plan Sponsor.

United Way of San Diego County
4699 Murphy Canyon Road
San Diego, CA 92123
(619) 492-2010

3. Participating Employer.

The employer identified at the top of page one. 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 Employer Identification Number (EIN): 33-0681183.

5. Plan Number (PN): 501.

6. Type of Plan and Funding.

This is a welfare benefit Plan that provides insured group medical and supplemental benefits through a multiple employer trust fund. All benefits are fully insured. Contributions are paid by participating employers to the trust fund. The trust name is HEALTH WAY OF SAN DIEGO COUNTY 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:

Pamela Barrett, Group Benefits Manager
Health Way of San Diego County Trust Fund
c/o United Administrative Services, Inc.
1120 South Bascom Avenue
San Jose, CA 95128

8. Agent for Service of Legal Process.

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

David P. Wolds, Attorney at Law
Wolds Law Group, PC
4747 Executive Drive, Suite 250
San Diego, CA 92121

Service of legal process may also be made on the Plan Administrator identified in the preceding Section or on any Plan Trustee identified in the following section.

9. Plan Trustees.

The names and addresses of the Plan Trustees are:

Barbara L. Alderson, Chairperson
Health Way of San Diego County Trust Fund
4761 Valdina Way
San Diego, CA 92124-2438

Donald V. Tartre, Secretary
Health Way of San Diego County Trust Fund
645 Front Street, #2102
San Diego, CA 92101

Raymond Uzeta
Health Way of San Diego County Trust Fund
5026 Triana Street
San Diego, CA 92117

Howard W. Brotman
Health Way of San Diego County Trust Fund
6640 Fisk Avenue
San Diego, CA 92122

John S. Hawkins
Health Way of San Diego County Trust Fund
c/o Cloud 9 Shuttle, Inc.
123 Camino de la Reina, Suite 200 East
San Diego, CA 92108

Lenore Lowe
Health Way of San Diego County Trust Fund
c/o Non-profit Management Solutions
8265 Vickers Street, Suite C
San Diego, CA 92111-2106

Bob Marchetti
Health Way of San Diego County Trust Fund
c/o Community Research Foundation
1202 Morena Blvd., Suite 300
San Diego, CA 92110

10. Source of Plan Contributions.

Contributions are made by Participating Employers for their employee Participants covered under the Plan. Contributions are set at amounts needed to pay premiums for coverage under the group policy and to pay for Plan expenses.

11. Plan Year.

The Plan Year is March 1 through February 28.

12. Plan Benefits.

Your employer has elected to participate in the Plans marked below:

- Group Health Insurance/HMO Plan (High Option)
Provided by UnitedHealthcare
- HMO Plan (Mid Option)
Provided by UnitedHealthcare
- Group Health Insurance/HMO Plan (Low Option)
Provided by UnitedHealthcare
- Group Health Insurance/PPO Plan (High Option)
Provided by UnitedHealthcare
- PPO Plan (Low Option)
Provided by UnitedHealthcare
- Group Dental Insurance HMO
Provided by United Concordia
- Group Dental Insurance PPO
Provided by United Concordia
- Group Vision Plan
Provided by MES Vision
- Group Employee Assistance Program (EAP)
Provided by Mutual of Omaha Insurance Company
- Group Life Insurance (\$15,000)
Provided by Mutual of Omaha Insurance Company
- Group Life Insurance (\$25,000)
Provided by Mutual of Omaha Insurance Company
- Group Life Insurance (\$50,000)
Provided by Mutual of Omaha Insurance Company
- Group Life Insurance (3 times salary up to \$500,000)
Provided by Mutual of Omaha Insurance Company
- Chiropractic Insurance
Provided by American Specialty Health Plans

- Long Term Disability Insurance Benefits
Provided by Mutual of Omaha Insurance Company

Details of the Plans selected above are provided by the individual insurance carriers and will either be provided along with this Summary Plan Description or with your enrollment application materials.

In addition, your employer:

- has elected to participate in the Health Way of San Diego County Trust Fund Cafeteria Plan ("Cafeteria Plan"). In addition, to participate in the Cafeteria Plan component, your employer has elected to participate in the following flexible spending accounts:
 - Health Care Spending Account with the following maximum annual reimbursement:
 - \$500
 - \$1,000
 - \$2,500
 - Dependent Care Spending Account
- has not elected to participate in the Health Way of San Diego County Trust Fund Cafeteria Plan ("Cafeteria Plan").

Details of the Cafeteria Plan will be provided along with this Summary Plan Description or with your Cafeteria Plan enrollment materials.

13. Role of Health Insurance Issuer.

The benefits provided under the UnitedHealthcare Plans are insured and underwritten by UnitedHealthcare. Administrative services in connection with this health Plan, including payment of claims, are performed by UnitedHealthcare. Should you have any questions for the insurer, you may direct inquiries to:

UnitedHealthcare
5816 Corporate Avenue, Suite 190
Cypress, CA 90630

The group dental insurance benefits provided under the United Concordia Dental Plans are insured and underwritten by United Concordia. Administrative services in connection with this dental Plan, including payment of claims, are performed by United Concordia. Should you have any questions for the insurer, you may direct inquiries to:

United Concordia
4401 Deer Path Road
Harrisburg, PA 17110

The benefits provided under the MES Vision PPO Plan are insured and underwritten by MES Vision. Administrative services in connection with the vision Plan, including the payment of claims, are performed by MES Vision PPO Plan. Should you have any questions for the insurer, you may direct inquiries to:

MES Vision
P.O. Box 25209
Santa Ana, CA 92799-5209

The benefits provided under the Mutual of Omaha Life Insurance Plan are insured and underwritten by Mutual of Omaha Insurance Company. Administrative services in connection with the group life insurance Plan, including the payment of claims, are performed by Mutual of Omaha Insurance Company. Should you have any questions for the insurer, you may direct inquiries to:

Mutual of Omaha Insurance Company
3-1 Group Life Claims
Mutual of Omaha Plaza
Omaha, NE 68175

The chiropractic benefits provided by American Specialty Health Plans is insured and underwritten by American Specialty Health Plans. Administrative services in connection with chiropractic benefits, including payment of claims, are performed by American Specialty Health Plans. Should you have any questions for the insurer, you may direct inquiries to:

American Specialty Health Plans
777 Front Street
San Diego, CA 92101

The benefits provided under the Mutual of Omaha Employee Assistance Program are insured and underwritten by Mutual of Omaha Insurance Company. Administrative services in connection with the Group Employee Assistance Program, including payment of claims, are performed by Mutual of Omaha Insurance Company. Should you have any questions for the insurer, you may direct inquiries to:

Mutual of Omaha Insurance Company
P.O. Box 6560
Sherwood, AZ 72124

The benefits provided under the Mutual of Omaha Long Term Disability Plan are insured and underwritten by Mutual of Omaha Insurance Company. Administrative services in connection with the Long Term Disability Plan, including payment of claims, are performed by Mutual of Omaha Insurance Company. Should you have any questions for the insurer, you may direct inquiries to:

Mutual of Omaha Insurance Company
P.O. Box 6560
Sherwood, AZ 72124

14. Filing a Claim.

Procedures for submitting claims and obtaining benefits are outlined in the insurance provider's benefits information materials. Plan Participants and beneficiaries can obtain a copy of these procedures, without charge, from the Plan Administrator.

15. Appealing a Claim Denial.

The Trustees have delegated the review of denied benefit claims to the health benefits providers identified above. 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 is provided with this Summary Plan Description. 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.

16. 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.

17. 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.

18. Statement of ERISA Rights.

As a participant in the Plan 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. Receive Information About Your Plan and Benefits

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 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 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.

b. Continue Group Health Plan Coverage

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

c. Prudent Actions by Plan Fiduciaries

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

d. Enforce Your Rights

If your claim for a 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 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 it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against 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.

e. 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 publication hotline of the Employee Benefits Security Administration.

19. Maternity Benefits.

Group health Plans and health insurance issuers 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 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 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

20. 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 Administrator.

B. Eligibility Rules

The following information describes the conditions pertaining to your eligibility to receive benefits. A detailed summary of benefits is furnished by your insurance provider and certain limits on participation may be included in your employer's subscription agreement. Please contact the Plan Administrator if you have any questions regarding your coverage.

1. Coverage of Employees.

The Participating Employer has elected to offer coverage to the following employees:

- () All employees
- () All employees except those who have waived coverage by signing a written declination of coverage in accordance with the Addendum to the Adoption Agreement.

2. Eligibility of Employees.

a. Becoming Insured.

Reported Employees will become eligible for coverage on the first day of the month following the eligibility waiting period elected by their employer of _____ months of employment. You must be actively at work on the effective date of your insurance. Employees who are covered by a collective bargaining agreement are not eligible to participate.

b. Termination of Your Insurance.

Unless you are entitled to coverage under the Family and Medical Leave Act of 1993 ("FMLA"), your insurance will end on the earliest date shown below:

- (1) The last day of the calendar month in which you cease to qualify as an eligible employee. The Plan deems the employee-employer relationship to end on the date the employee stops full-time active work for a participating employer.
- (2) The last day of the month in which your employer ceases to be a participating employer.
- (3) The last day of the month in which your participating employer has paid premiums for your insurance.
- (4) The date the group policy terminates.

c. Insuring Dependents.

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;
- (3) Reach an eligibility date.

Eligible Dependent - The term "dependent" means only your spouse or domestic partner and 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 and includes and child covered pursuant to a QMCSO.

Age Limits for Dependent Children - Effective November 1, 2010, 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. Individuals whose coverage ended, who were denied coverage, or who were not eligible for coverage because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Plan, if otherwise eligible. Individuals may request enrollment for such dependents for 30 days from the date of notice. Adult children are not eligible for coverage if they are eligible for coverage under another employer-sponsored plan other than one provided to a parent. For more information, please contact the Plan Administrator.

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.

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.

d. Insuring Domestic Partners.

You may elect to recognize a domestic partner as eligible for dependent coverage. To be eligible, an employee requesting domestic partner coverage and the domestic partner must meet certain criteria. In addition, only a person who meets the definition of domestic partner may become insured for domestic partner coverage under the group policy. To become insured, the employee and the domestic partner, among other things, must:

- (1) Have a common residence;
- (2) Not be married to someone else or be a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;
- (3) Be capable of consenting to the domestic partnership.
- (4) Not be related by blood in a way that would prohibit marriage; and
- (5) Both be at least the minimum age of consent in the state in which you reside.

e. 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.
- (3) The date your employees' insurance ends.

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

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") provides new enrollment rights of eligible individuals. The Plan is amended effective April 1, 2009, to provide the following special enrollment rights for individuals who are eligible for coverage under the Plan but are not enrolled for coverage:

- (1) 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
- (2) 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.

4. 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.

If you are a Participating Employee, you have a right to elect continuation coverage if you lose coverage (or your premium payments or contributions for coverage increase) for one of the following qualifying events:

- (a) Termination of your employment (for reasons other than gross misconduct), or:
- (b) Reduction in the hours of your employment, if the reduction causes you to no longer be eligible for coverage under the Plan.

If you are the spouse of a Participating Employee, you have the right to elect continuation coverage if you lose coverage for one of the following qualifying events:

- (a) The death of your spouse;
- (b) Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment which cause a loss or reduction of Plan coverage;
- (c) Divorce or legal separation from your spouse; or
- (d) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

A dependent child of a Participating Employee has the right to elect continuation coverage if health coverage under the Plan is lost for one of the following qualifying events:

- (a) The death of the employee parent;
- (b) The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in the employee parent's hours of employment causing the loss of coverage;
- (c) The parents' divorce or legal separation;
- (d) The employee parent becomes entitled to Medicare benefits (Part A, Part B, or both); or
- (e) You cease to be a "dependent child" under the Plan.

In addition, if a Participating Employer declares Chapter 11 bankruptcy, retired employees and qualified beneficiaries covered under the Plan are eligible for continuation coverage if they lose coverage (including a substantial elimination of coverage) within one year before or after the bankruptcy proceedings begin.

Under the law, the Participating Employee or a family member has the responsibility to notify the Plan Administrator of a divorce, legal separation or a child losing dependent coverage under the Plan. You or your family member must provide written notice no later than 60 days after the date of the event, or after the day coverage is lost because of the qualifying event, whichever is later. You must provide this notice to the Plan Administrator. The Plan Administrator will notify you of your rights to elect continuation coverage. Under the law, you must elect continuation coverage within 60 days after Plan coverage ends, or if later, 60 days after the date of the notice of your right to elect continuation coverage.

A Participating Employee, or the spouse of the Participating Employee, may elect continuation coverage for all family members, including a new spouse or new dependent child born, adopted or placed for adoption during the COBRA continuation coverage period. If a covered employee or spouse of a covered employee elects COBRA without specifying whether the election is for self-only coverage, the election will be considered to be on behalf of all other qualified beneficiaries with respect to that qualifying event. The Participating Employee, his or her spouse and the dependent children, however, each have an independent right to elect continuation coverage. To ensure that you, your spouse and/or dependents receive notice of the right to continuation coverage pursuant to COBRA, you should keep the Plan Administrator informed of the current addresses of family members. A spouse or dependent child may elect coverage even if the Participating Employee does not elect it.

If you elect continuation coverage, you will receive coverage identical to coverage provided under the Plan at that time to similarly situated active employees or family members. You must pay the entire premium for your continuation coverage, and the rate may include an additional 2 percent (2%) to cover administrative expenses. If you are entitled to a COBRA continuation coverage extension due to disability, you may be required to pay up to 150 percent of the premium costs during the extension period.

If you lose group health coverage because of the employee's death, divorce, legal separation, employee's entitlement to Medicare benefits, or loss of status as dependent under the Plan, coverage may be extended for 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the Medicare entitlement. Otherwise, when you lose group health coverage because of a termination or reduction in hours of employment, coverage may be extended for 18 months. If coverage is lost at a date later than the date of the Qualifying event, the maximum coverage period will be 18 months from the date of coverage loss.

If a second qualifying event occurs, continuation coverage for your spouse and the dependent children in your family may be extended up to a total of 36 months. The extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If the Social Security Administration determines that you (or your spouse or dependent child, if applicable) are disabled during the first 60 days of the continuation period, or in the case of a child born to or placed for adoption with a covered employee during a COBRA coverage period, during the first 60 days after a child's birth or placement for adoption, then your continuation coverage period as well as your spouse's and any dependent's continuation coverage periods may be extended from 18 months to 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period. To qualify, you (or your spouse or dependent child, if applicable) must notify the Plan Administrator during the initial 18 month continuation coverage period and within 60 days after the latest of (a) the date the qualifying event occurs, (b) the date of the SSA determination, or (c) the date of loss of coverage because of the qualifying event. If there is a final determination that the qualified beneficiary is no longer disabled, the Plan Administrator must be notified within 30 days of the determination by the qualified beneficiary, and any coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

Continuation coverage terminates (even before the end of the maximum coverage period) when any one of the following events occurs:

- (a) The Participating Employer or the Plan no longer provides group health coverage to any employees;
- (b) The premium for continuation coverage is not timely paid;
- (c) You, or your spouse or dependent child, become covered as an employee or dependent under another employer's Plan that does not exclude or limit coverage for a qualified beneficiary's pre-existing conditions;
- (d) You, or your spouse or dependent child, become entitled to Medicare benefits;
- (e) You, or your spouse or dependent child, have extended continuation coverage due to a disability and then the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled;
- (f) The maximum required COBRA continuation period expires; or

- (g) For such cause, as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

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 U.S. Department of Labor's Employee Benefits Security Administration ("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.

In order 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.

5. 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 means the Armed Forces, and the Army National Guard, when you are engaged in active duty or training, or inactive duty training. Uniformed services also includes 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. Your coverage will be reinstated without any preexisting condition exclusions or waiting periods, unless you have an injury or illness incurred during your military service.

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.

In order 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.

6. Grandfathered Health Plan Status Under the Patient Protection and Affordable Care Act (PPACA).

This Plan believes that this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan or coverage under the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

7. Restrictions on Lifetime Limits for Coverage of Benefits.

Effective March 1, 2011, any lifetime limits on the dollar value of medical benefits under the Plan no longer apply. Any 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.

8. Patient Protection Disclosure.

Effective March 1, 2011, under the Affordable Care Act, the Plan provides the following additional patient protections:

The Plan generally 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) 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 the Plan Administrator.