[INSURED]

SUMMARY PLAN DESCRIPTION *

FOR THE

TUSCOLA COUNTY MEDICAL CARE FACILITY

TUSCOLA COUNTY MEDICAL CARE FACILITY EMPLOYEE BENEFITS PLAN

EFFECTIVE APRIL 1, 2018

NON-UNION EMPLOYEES

THIS DOCUMENT SHOULD BE PROVIDED TO ALL

PARTICIPANTS AND BENEFICIARIES WHENEVER A

BENEFITS SUMMARY AND/OR CERTIFICATE DESCRIBING

INSURED BENEFITS IS PROVIDED UNDER THE PLAN

* This document has been prepared by Clark Hill PLC for Michigan Planners, Inc. for use by Michigan Planners, Inc. clients in connection with their sponsored, fully insured welfare plans. It is designed to supplement benefit description booklets and/or insurance certificates describing benefits, and such documents should always be examined together as the Summary Plan Description for the Plan. It is recommended that prior to adoption, the Plan Sponsor should have this Summary reviewed by its attorneys.

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EFFECTIVE APRIL 1, 2018

Contents

THE PLAN

Tuscola County Medical Care Facility (the "Employer") has established the Tuscola County Medical Care Facility Employee Benefits Plan (the "Plan"). This Summary Plan Description is intended, in combination with the applicable Benefits description(s) and/or certificate(s) provided by the Insurer, to describe applicable Plan terms. If you do not have a copy of the Benefits description(s) or certificate(s), you should request one from the Plan Administrator at 1285 Cleaver Road, Caro, MI 48723, 1-989-673-4117.

THIS BOOKLET, ALONG WITH THE APPLICABLE BENEFIT DESCRIPTION BOOKLET AND/OR CERTIFICATE PREPARED BY THE INSURER(S), COVERS THE HIGHLIGHTS OF THE PLAN, AND ATTEMPTS TO DO SO IN AN EASY-TO-UNDERSTAND MANNER. IT IS PREPARED WITH THE DETAIL THE GOVERNMENT REQUIRES. IF THERE IS ANYTHING YOU DO NOT UNDERSTAND, YOU SHOULD CONTACT THE EMPLOYER (THE "PLAN ADMINISTRATOR"). ALSO, SINCE THIS IS A SUMMARY, YOU SHOULD KNOW THAT IF THIS BOOKLET SAYS ANYTHING THAT DISAGREES WITH THE INSURANCE CONTRACT THAT GOVERNS THE PLAN, THE CONTRACT IS THE ONE THAT MUST BE FOLLOWED.

PART I – Information About Plan Benefits and Eligibility

WHAT IS THE PURPOSE OF THE PLAN?

The Plan has been established by the Employer to provide you with an opportunity to receive the benefits described in the applicable benefit description booklet, benefit summary and/or certificate provided with this document. Applicable deductibles, coinsurance or co-payments, and annual or lifetime caps, and other exceptions and limitations should also be described there.

WHAT TYPE OF PLAN IS IT?

The Plan is not a welfare benefit plan governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The benefits provided under the Plan and described in this SPD are fully-insured.

WHO RUNS THE PLAN?

The Employer is the Plan Sponsor. The Employer is the Plan Administrator.

The Employer may select and/or remove the Insurer(s), enter(s) into policies with the Insurer(s), and amend or terminate the Plan or any benefit under the Plan at any time in its sole discretion.

The Plan Administrator has responsibility for administration of the Plan, except that the Insurer(s) shall be the administrator of, and have sole responsibility, authority, and discretion with respect to benefits provided pursuant to the Plan insurance policy (and/or HMO contract, if applicable) which that Insurer insures. The Plan Administrator may delegate its duties to other individuals or entities.

The decisions of the Plan Administrator and, with regard to a particular Plan benefit and/or benefit level, of the applicable Insurer shall be final and binding on all persons.

WHAT BENEFITS ARE PROVIDED UNDER THE PLAN?

The benefits currently offered to eligible Employees under the Plan are listed below:

- Group Health Insurance
- Group Dental Insurance
- Group Vision Insurance
- Group Voluntary Life and AD&D Insurance
- Group Voluntary Long Term Disability Insurance
- Group Voluntary Short Term Disability Insurance

A description of the benefits (and applicable deductibles, co-payments and co-insurance and applicable limits) provided by the Plan is provided to you along with this document in the

applicable benefits booklet(s) and/or certificate(s) provided with this document. If you do not have it, you can get a copy from the Plan Administrator.

In addition, each year during Open Enrollment, the Employer will provide you with the applicable information on your benefits choices for the upcoming Plan Year.

WHAT DETERMINES YOUR ELIGIBILITY?

You are eligible to participate in the Plan if you are an Employee and you satisfy the following:

Benefit	Eligibility Standard
Group Health Insurance	Part-time employee working at least 16 hours per week and full-time employee working at least 30 hours per week.
Group Dental Insurance	Part-time employee working at least 16 hours per week and full-time employee working at least 40 hours per week.
Group Vision Insurance	Part-time employee working at least 16 hours per week and full-time employee working at least 40 hours per week.
Group Voluntary Life and AD&D Insurance	Part-time employee working at least 30 hours per week and full-time employee working at least 40 hours per week.
Group Voluntary Long Term Disability Insurance	Part-time employee working at least 30 hours per week and full-time employee working at least 40 hours per week.
Group Voluntary Short Term Disability Insurance	Part-time employee working at least 30 hours per week and full-time employee working at least 40 hours per week.

For Plan purposes, the term Employee excludes those individuals designated by the Employer as independent contractors, as evidenced by issuance of Form 1099, regardless of any later recharacterization as an Employee for the period in question.

If eligible, you will become a Participant on the date listed below:

Benefit	Date Eligible to Participate
Group Health Insurance	The eligible employee will be effective on the first day of the month following 30 days of employment.

Group Dental Insurance	The eligible employee will be effective on the first day of the month following 30 days of employment.
Group Vision Insurance	The eligible employee will be effective on the first day of the month following 30 days of employment.
Group Voluntary Life and AD&D Insurance	The eligible employee will be effective on the first day of the month following 30 days of employment.
Group Voluntary Long Term Disability Insurance	The eligible employee will be effective on the first day of the month following 30 days of employment.
Group Voluntary Short Term Disability Insurance	The eligible employee will be effective on the first day of the month following 30 days of employment.

If your employment terminates or you are no longer an eligible Employee, or you fail to pay the Employee required portion of a premium, if any (and as determined from time to time by the Employer) you will cease to be a Participant. However, you may be able to extend coverage if that Plan benefit is provided to you through a group health plan (e.g., health, prescription drug, dental and vision) and your Employer is subject to COBRA, as later described. Also, you should contact the applicable Insurer directly to determine if there are conversion rights that allow you to continue coverage.

You will no longer be eligible to be a Participant in the Plan on the date on which the Plan terminates.

ARE DEPENDENTS ELIGIBLE FOR COVERAGE?

Your Eligible Dependents are outlined in the table below:

Benefit	Eligible Dependents
Group Health Insurance	Legal spouse; Dependent children, as defined by the Affordable Care Act, are eligible until the end of the calendar year in which they turn 26 years old.
Group Dental Insurance	Legal spouse; Unmarried children (including legally adopted and, step-children if they depend on the employee for most of their support and maintenance) under age 20 or to age 26 if

	enrolled as full-time students at accredited schools. Excluded is any dependent on active duty in any armed force.
Group Vision Insurance	Legal spouse; Unmarried children (including legally adopted and, step-children if they depend on the employee for most of their support and maintenance) under age 20 or to age 26 if enrolled as full-time students at accredited schools. Excluded is any dependent on active duty in any armed force.
Group Voluntary Life and AD&D Insurance	Lawful spouse or Registered Domestic Partner (as defined within the insurance policy); Unmarried children (natural, step, or other child as defined within the insurance policy) from birth to age 19 or 23 years if a full-time student and who is not in active military service.

WHAT IF YOU TERMINATE EMPLOYMENT AND ARE LATER REHIRED BY THE EMPLOYER?

If you are a Participant in the Plan, terminate employment with the Employer and are later rehired, your participation in the Plan upon your rehire is determined as follows:

Benefit	Rehire Policy
Group Health Insurance	If an employee terminates their seniority and is re-hired, they will go through the probationary period.
Group Dental Insurance	If an employee terminates their seniority and is re-hired, they will go through the probationary period.

Group Vision Insurance	If an employee terminates their seniority and is re-hired, they will go through the probationary period.
Group Voluntary Life and AD&D Insurance	If an employee terminates their seniority and is re-hired, they will go through the probationary period.
Group Voluntary Long Term Disability Insurance	If an employee terminates their seniority and is re-hired, they will go through the probationary period.
Group Voluntary Short Term Disability Insurance	If an employee terminates their seniority and is re-hired, they will go through the probationary period.

WHAT HAPPENS IF YOU TAKE A LEAVE OF ABSENCE?

Coverage for a particular benefit during a leave of absence is outlined in the respective benefit's Booklet or certificate, or the Employer's leave of absence policy.

If coverage for a particular benefit is provided by reason of your pre-tax deferrals pursuant to a Code Section 125 Cafeteria Plan and the Employer is subject to the Family and Medical Leave Act of 1993, as amended ("FMLA"), and you are absent from work due to an approved leave of absence which is then covered under the FMLA while you are a Participant and while the Employer is subject to the FMLA, you will continue to be a Participant in the Plan during the leave to the extent provided by the Code Section 125 Cafeteria Plan.

WHAT ARE THE SOURCES OF CONTRIBUTIONS AND COSTS OF BENEFITS?

The Employer, in connection with the Plan, on behalf of the Employees who participate in the Plan, purchases insurance coverage. Employees may be required to contribute to the cost of coverage. If Employees are required to contribute to the cost of coverage, the Employer will notify Employees of the required premiums.

ARE THE BENEFITS PROVIDED THROUGH INSURANCE?

The benefits offered under the Plan are currently provided through the following insurance contract(s) as follows:

Benefit	Insurer	Insurer Address & Telephone Number

Group Health Insurance	Blue Care Network	20500 Civic Center Dr., Southfield, MI 48076 1-800-662-6667
Group Dental Insurance	Guardian	7 Hanover Square, New York, NY 10004 1-800-541-7846
Group Vision Insurance	Guardian	7 Hanover Square, New York, NY 10004 1-800-877-7195
Group Voluntary Life and AD&D Insurance	Dearborn National Life Insurance Company	1020 31st Street, Downers Grove, IL 60515 1-800-348-4512
Group Voluntary Long Term Disability Insurance	Dearborn National Life Insurance Company	1020 31st Street, Downers Grove, IL 60515 1-800-348-4512
Group Voluntary Short Term Disability Insurance	Dearborn National Life Insurance Company	1020 31st Street, Downers Grove, IL 60515 1-800-348-4512

WHAT IS THE PLAN'S ANNUAL OPEN ENROLLMENT PERIOD?

The Plan's annual Open Enrollment Period is held prior to the start of each Plan Year. The Employer will let you know ahead of time when the Open Enrollment Period will begin and end for a particular Plan Year. During this period the Employer will provide you with information on your benefit choices for the upcoming Plan Year and the applicable procedure for making your elections.

CAN I CHANGE MY BENEFIT ELECTIONS OUTSIDE OF THE OPEN ENROLLMENT PERIOD?

If you obtain Plan benefits pursuant to a Cafeteria Plan election governed by Section 125 of the Internal Revenue Code ("Code"), you cannot change your benefit elections during the Plan Year outside an Open Enrollment Period, unless you experience a "Change in Status Event" and the change you want to make is consistent with the Change in Status Event. Such a change must be allowed by the Cafeteria Plan and the Code Section 125 regulations.

PART II – Special Enrollment Rights, Group Health Plan Notices

(This Part II of the SPD applies only to group health insurance coverage and not to other Plan benefits (such as excepted benefits under HIPAA);

SPECIAL ENROLLMENT RIGHTS

If you are an Employee and (1) you are eligible to enroll for group health insurance coverage under this Plan and decline the coverage for yourself because you have other health insurance; (2) you are a Participant and have a Dependent(s) eligible to enroll for coverage under this Plan for whom you declined coverage under this Plan because he/she has other health insurance; or (3) you and any Dependent(s) are eligible to enroll for coverage under the Plan and you decline coverage for any of you because you and/or your Dependent(s) have other health insurance; you are entitled to a special enrollment for yourself alone, for yourself and your Dependent(s), or if you are a Participant, for your Dependent(s), as applicable, under this Plan if coverage under the other insurance terminates or is discontinued for one of the following reasons: (a) the other health insurance was under a COBRA continuation provision and the coverage has been exhausted; (b) the other health insurance was terminated due to loss of eligibility (including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but excluding, for example, loss due to failure to timely pay premiums or due to termination for cause); or if employer contributions toward the other insurance were terminated. YOU MUST REQUEST SPECIAL ENROLLMENT FOR YOURSELF OR FOR YOUR DEPENDENT(S) WITHIN 30 DAYS AFTER THE COBRA CONTINUATION COVERAGE IS EXHAUSTED; WITHIN 30 DAYS AFTER COVERAGE UNDER THE OTHER INSURANCE IS TERMINATED, IF THE TERMINATION IS DUE TO LOSS OF ELIGIBILITY; OR WITHIN 30 DAYS AFTER EMPLOYER CONTRIBUTIONS TO THE OTHER INSURANCE CEASE. Coverage will become effective in accordance with the Policy and applicable law.

If (1) you are an eligible Employee and have met any applicable waiting period to become a Participant and decline group health insurance coverage under the Plan, and a person becomes your eligible Dependent through marriage, birth, adoption, or placement for adoption, (2) you are a Participant and you marry, or are married and your Spouse is not enrolled and a child becomes your eligible Dependent through marriage, birth, adoption, or placement for adoption, or (3) you are an eligible Dependent and you add an eligible Dependent through marriage, birth, adoption, or placement for adoption; you are entitled (as an Employee who is not a Participant) to enroll yourself alone or yourself and your Spouse and/or Dependent(s), or if you are a Participant, you are entitled to enroll your Spouse and/or Dependent(s) by a special enrollment. YOU MUST REQUEST SPECIAL ENROLLMENT FOR ELIGIBLE DEPENDENT(S) WITHIN 30 DAYS OF THE LATER OF THE DATE DEPENDENT COVERAGE IS MADE AVAILABLE UNDER THIS PLAN OR THE DATE OF MARRIAGE, BIRTH, ADOPTION OR PLACEMENT FOR ADOPTION. Coverage will become effective in accordance with the Policy and applicable law.

SPECIAL ENROLLMENT RIGHTS UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (“CHIPRA”)

Effective April 1, 2009, you or your eligible Dependents who are eligible for participation in, but are not currently enrolled in, the Employer's group health plan may elect to enroll in the Employer's

group health plan if you or your eligible Dependents:

a) lose coverage under Medicaid or a state child health insurance plan and you request coverage under the Employer's group health plan within 60 days of the loss of such coverage; or

b) become eligible for a premium assistance subsidy under the Employer's group health plan through Medicaid or a state child health insurance plan and you request coverage under the Employer's group health plan within 60 days of becoming eligible for such assistance.

For additional information regarding your special enrollment rights pursuant to CHIPRA, please contact the Plan Administrator.

LATE ENROLLMENT

If an Employee enrolls for coverage more than 31 days after his or her Date of Eligibility, or more than 31 days after his or her Dependent's date of eligibility, or if an Employee wishes to re-enroll after having terminated coverage while continuing to be eligible, the Employee, and/or his or her eligible Dependents are considered "late entrants". Late entrants must wait to enroll in the Plan until the next Open Enrollment, or as otherwise determined by the Plan Administrator. This rule does not apply if an individual is eligible for a Special Enrollment.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Pursuant to federal law, the Plan will pay for the following benefits for any Participant who is receiving insured benefits under the Plan covering a mastectomy and who elects breast reconstruction, subject to applicable annual and lifetime Plan limits, co-payments and deductibles:

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

These benefits will be provided in a manner as determined in consultation with the attending physician and the patient. The Plan may not deny an eligible Employee or an eligible Dependent eligibility or continued eligibility to enroll or to renew coverage solely to avoid providing these benefits.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a deliver by cesarean section. However, the Plan or issuer may pay

for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier.

In addition, the Plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

PART III – Continuation Coverage, QMCSO, Privacy Rules

(This Part III of the SPD applies only to group health insurance coverage (e.g., health, prescription drug, dental and vision) and not to other Plan benefits)

CONTINUATION COVERAGE UNDER COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

A group health plan is subject to COBRA if it is maintained by an employer (determined on a controlled-group basis) that normally employed 20 or more employees for at least 50% of the employer's usual business days during the preceding calendar year.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your covered dependent children could become qualified beneficiaries if group health coverage under the Plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. (Information about monthly costs of continuation coverage will be provided to you upon becoming eligible for COBRA).

The Employer reserves the right to hire a COBRA Plan Administrator at any time for purposes of COBRA compliance.

If you are an Employee, you will become a qualified beneficiary if you lose your group health coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are a spouse of an eligible Employee, you will become a qualified beneficiary if you lose your group health coverage under the Plan because of any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose group health coverage under the Plan because any of the following qualifying events occur:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child".

To the extent required by law, rights similar to those described above shall apply to retirees and dependents if the Employer commences a bankruptcy proceeding and such individual's coverage would be substantially limited as a result.

When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours, death of the Employee or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the Qualifying Event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and spouse, or a dependent child losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Tuscola County Medical Care Facility; 1285 Cleaver Road, Caro, MI 48723; Phone: 1-989-673-4117.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered eligible Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If you or a covered dependent want to receive continuation coverage, you must actively elect the coverage by submitting the election form to the Employer, or the COBRA Plan Administrator, if applicable.

How Long is COBRA Continuation Coverage?

The law requires that a qualified beneficiary be afforded the opportunity to maintain continuation coverage for up to 36 months after the date of a qualifying event other than loss of coverage due to termination of employment (for reasons other than gross misconduct) or reduction in hours. In the case of termination of employment (other than for reasons of gross misconduct or reduction in hours), the required continuation coverage period is 18 months after the date of the qualifying event.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the group health coverage under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 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 of continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

The 18-month period of coverage (for spouse and dependents) discussed above may be extended to 36 months if another Qualifying Event (e.g., divorce, legal separation, death, Medicare entitlement, or loss of dependent child status) occurs during the initial 18-month period of coverage. The Employee, spouse (former spouse) or dependent must notify the Employer in writing within 60 days of the occurrence of such second event.

Early Termination of COBRA Coverage

COBRA coverage may end earlier than the maximum coverage period if:

- COBRA premiums are not paid on a timely basis;
- Employer ceased to maintain group health coverage under the Plan;
- Qualified beneficiary obtains other group health coverage that does not contain any exclusion or limitation with respect to any pre-existing condition;
- Qualified beneficiary first becomes, after a COBRA election, entitled to Medicare; or

- A qualified beneficiary who was disabled within first 60 days of COBRA coverage and who extended coverage for up to 29 months is finally determined to be no longer disabled.

What is the Cost of COBRA Coverage?

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount can be up to 102% of the total cost (employer and Employee contributions plus a 2% administrative fee) of the group health coverage under the Plan for active plan participants and beneficiaries who are not receiving COBRA coverage. The cost of coverage can be increased to 150% of the total cost during any period extending beyond the initial 18-month coverage period.

If You Have Questions

Questions concerning COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) Or, if the group health plan is subject to COBRA, you may contact the Employer at: Tuscola County Medical Care Facility; 1285 Cleaver Road, Caro, MI 48723; Phone: 1-989-673-4117.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of you or your family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

CONTINUATION COVERAGE UNDER "USERRA"

If you are a member of the uniformed services and are called into active duty, you can continue your coverage in Plan under the Uniformed Services Employment and Reemployment Rights Act ("USERRA") as follows: for the first 31 days, your health coverage (and that of your covered Dependents) will continue at the same cost as though you were an active Employee. After that date, you can continue your coverage (and that of your covered Dependents) for up to 24 months at your own expense. You must notify the Employer before your active service begins or as soon as possible thereafter. You are entitled to no more than five (5) years of total absence from the Employer for all uniformed service. This provision is fully subject to the Company's USERRA policies. This provision should be interpreted as only providing the minimum coverage required by law.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If the Plan receives a Qualified Medical Child Support Order applicable to group health insurance, the Plan will consider the Alternate Recipient named in such Order to be your Dependent Child

under the Plan. The Plan will reimburse the Alternate Recipient or his custodial parent or legal guardian for qualified medical expenses paid by the Alternate Recipient or his custodial parent or legal guardian.

If the Plan receives a medical child support order, the Plan Administrator will notify you and the Alternate Recipient of:

- The Plan's receipt of such order;
- The Plan's procedure for determining whether the order is a Qualified Medical Child Support Order; and
- The right of the Alternate Recipient to designate a representative for receipt of notices that are sent to the Alternate Recipient regarding the medical child support order.

Within a reasonable period after receiving a medical child support order, the Administrator will determine whether the order is a Qualified Medical Child Support Order and will notify you and the Alternate Recipient of such determination. This determination will be subject to Plan claims and claims review procedures.

Generally, a Qualified Medical Child Support Order will exist if it is a judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction and:

- clearly specifies the name and last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the Order;
- clearly specifies the type of health coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
- clearly specifies each plan to which such Order applies; and
- does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1396g of Title XIX of the Social Security Act.

If an order is a Qualified Medical Child Support Order the definition of “Dependent Children” under the Plan shall not exclude:

- a child born out of wedlock;
- a child not claimed as a Dependent on your Federal income tax return; and a child that does not reside with you.

Once the Plan Administrator determines that it has received a Qualified Medical Child Support Order, the Alternate Recipient will be covered under the Plan as of the latest of:

- the first day of the month specified in the Order;

- the first day of the month following the determination by the Plan Administrator; or

- the earlier of the first day of the month following the receipt by the Plan of the first premium payment required for coverage, if any, or the effective date of a court or administrative order requiring your Employer to withhold from your Compensation, your share, if any, of premiums for health coverage and to pay such share of premiums to the Plan.

If the Order requires you to provide group health coverage for the Alternate Recipient and you fail to make application to obtain such coverage, the Alternate Recipient may be enrolled in family coverage upon application by the Alternate Recipient's other parent or by the State Agency administering the Social Security Act.

Coverage for an Alternate Recipient will terminate:

- When the Qualified Medical Child Support Order is no longer in effect;

- When the Alternate Recipient's age exceeds the maximum age under which a Dependent Child may participate under the Plan.

- When the Employer is provided written evidence that the Alternate Recipient is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment; or

- The Employer has eliminated Dependent health coverage for all of its Employees.

To the extent that the Plan and any fiduciary acts in accordance with the Plan in treating a medical child support order as being (or not being) a Qualified Medical Child Support Order, the Plan's obligation to you and each Alternate Recipient will be discharged by any payment made.

PRIVACY RULE

The Plan is subject to the privacy rules of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and the Plan will only use protected health information (as defined by HIPAA Privacy Rules) for purposes related to health care treatment, payment for health care, and health care operations, and only in accordance with the uses and disclosures permitted by HIPAA, and as authorized or consented to by Participants or beneficiaries pursuant to HIPAA.

PART IV – Your Rights Under the Plan

IF YOU DISAGREE WITH ANY DETERMINATION OF YOUR BENEFITS, WHAT SHOULD YOU DO?

Benefit Claims

The Insurer(s) of the Plan benefits for which the determination was made has full responsibility for policy claims and claims review procedures, and the Insurer is responsible for the resolution of

benefit claims in accordance with all applicable laws, including the Patient Protection and Affordable Care Act, as amended ("PPACA"). Claims procedures are described in the applicable Benefit Booklet(s) or other writing provided by the applicable Insurer. If you do not have a copy of the applicable claims procedures or the Benefit Booklet(s) you should contact the Plan Administrator to obtain a copy.

Non-Benefit Claims

With regard to non-benefit claims (e.g., eligibility, QMCSO, etc.), the Plan Administrator has adopted the following Claims Review Procedure.

If you have a non-benefit claim, your initial non-benefit claim should be written and personally delivered or mailed, certified mail, return receipt requested, to the Plan Administrator. Your non-benefit claim should state your name and address, the specific basis for your claim, and any additional material which you desire to present to the Plan Administrator for consideration.

The Plan Administrator, upon receipt of an initial non-benefit claim, shall make a determination and provide written notification of its determination to you within 30 days after its receipt of your non-benefit claim. This period may be extended one time by the Plan Administrator, provided the Plan Administrator both (i) determines that such an extension is necessary due to matters beyond the control of the Plan, and (ii) notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide such non-benefit claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from the receipt of the notice within which to provide such information.

The Plan Administrator shall provide you with written notification of an adverse determination. The notification shall set forth: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a description of any additional material or information necessary for you to perfect your non-benefit claim, if any, and an explanation as to why such material or information is necessary; (iv) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review; (v) any internal rules, guidelines, protocols or similar criterion on which the Plan Administrator relied in making its determination; (vi) any new or additional evidence or rationale that is considered, relied on or generated by (or at the direction of) the Plan in connection with the non-benefit claim and your right to respond to such new or additional evidence or rationale before the final claim determination is made; and (vii) the availability of, and contract information for, the applicable office of health insurance ombudsman.

You may appeal an adverse determination. To do so, you must submit, within 180 days following the receipt of the Plan Administrator's adverse determination, a written request for review to the Plan Administrator stating the specific basis for such request, and any additional materials you wish to submit. In connection with your request for review, you may request, in writing, copies of all documents, records, and other information upon which the Plan Administrator relied in making

its determination. The Plan Administrator shall provide all such documents to you free of charge.

The Plan Administrator shall take into account all documents, records and other information submitted by you, without regard to whether such information as submitted or considered in the initial determination. Upon review of your request for review, if the claim involves a concurrent claim for benefits, the Plan Administrator shall not take into account or afford deference to its initial determination and shall see to it that a determination is made by the appropriate individual(s).

The Plan Administrator shall notify you of the Plan's determination on review within 30 days after receipt by the Plan of your request for review. If additional time is required by the Plan Administrator in order to make a determination, the Plan Administrator may extend this period by 30 days by notifying you in writing before the expiration of the initial 30 days.

The Plan Administrator shall provide you with written notification of the Plan's determination on review. In the case of an adverse determination, such notification shall set forth: (i) the specific reasons for the adverse determination; (ii) the specific Plan provisions on which the benefit determination is based; (iii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records and other information relevant to a non-benefit claim, including any new or additional evidence or rationale that is considered, relied on or generated by (or at the direction of) the Plan in connection with the non-benefit claim and your right to respond to such new or additional evidence or rationale before the final non-benefit claim determination is made; (iv) a statement that you have a right to bring a civil action; and (v) a description of any internal rule, guideline, protocol or other similar criterion, upon which the Plan Administrator relied in making its determination.

The decision of the Plan Administrator shall be final and binding.

Rescission of Plan Coverage

With regard to a claim involving a rescission of Plan coverage ("rescission claim") the Plan Administrator has adopted the following Claim Review Procedure.

A "rescission" is a cancellation or discontinuance of coverage that has retroactive effect; provided, however that a cancellation or discontinuation that (1) has only a prospective effect, or (2) is effective retroactively due to the failure to timely pay required premiums or contributions towards the cost of Benefit coverage under the Plan is not a rescission.

If you have a rescission claim, your initial claim should be written and personally delivered or mailed, certified mail, return receipt requested, to the Plan Administrator. Your rescission claim should state your name and address, the specific basis for your claim, and any additional material which you desire to present to the Plan Administrator for consideration.

The Plan Administrator, upon receipt of an initial rescission claim, shall make a determination and provide written notification of its determination to you within 30 days after its receipt of your claim. This period may be extended one time by the Plan Administrator, provided the Plan

Administrator both (i) determines that such an extension is necessary due to matters beyond the control of the Plan, and (ii) notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide such rescission claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from the receipt of the notice within which to provide such information.

The Plan Administrator shall provide you with written notification of an adverse determination. The notification shall set forth: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a description of any additional material or information necessary for you to perfect your rescission claim, if any, and an explanation as to why such material or information is necessary; (iv) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review; (v) any internal rules, guidelines, protocols or similar criterion on which the Plan Administrator relied in making its determination; (vi) any new or additional evidence or rationale that is considered, relied on or generated by (or at the direction of) the Plan in connection with the rescission claim and your right to respond to such new or additional evidence or rationale before the final claim determination is made; and (vii) the availability of, and contract information for, the applicable office of health insurance ombudsman.

You may appeal an adverse determination. To do so, you must submit, within 180 days following the receipt of the Plan Administrator's adverse determination, a written request for review to the Plan Administrator stating the specific basis for such request, and any additional materials you wish to submit. In connection with your request for review, you may request, in writing, copies of all documents, records, and other information upon which the Plan Administrator relied in making its determination. The Plan Administrator shall provide all such documents to you free of charge. The Plan Administrator shall take into account all documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial determination. Upon review of your request for review, if the claim involves a concurrent claim for benefits, the Plan Administrator shall not take into account or afford deference to its initial determination and shall see to it that a determination is made by the appropriate individual(s).

The Plan Administrator shall notify you of the Plan's determination on review within 30 days after receipt by the Plan of your request for review. If additional time is required by the Plan Administrator in order to make a determination, the Plan Administrator may extend this period by 30 days by notifying you in writing before the expiration of the initial 30 days.

The Plan Administrator shall provide you with written notification of the Plan's determination on review. In the case of an adverse determination, such notification shall set forth: (i) the specific reasons for the adverse determination; (ii) the specific Plan provisions on which the benefit determination is based; (iii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records and other information relevant to a non-benefit claim, including any new or additional evidence or rationale that is considered, relied

on or generated by (or at the direction of) the Plan in connection with the non-benefit claim and your right to respond to such new or additional evidence or rationale before the final non-benefit claim determination is made; (iv) a statement that you have a right to bring a civil action; and (v) a description of any internal rule, guideline, protocol or other similar criterion, upon which the Plan Administrator relied in making its determination.

If your rescission claim is denied by the Plan Administrator upon appeal, you may file for external review by an independent review organization by following the applicable State external review process, or if the State external review process does not apply, by following the applicable federal external review process as then in effect. For additional information on the applicable external review process, you should contact the Plan Administrator.

WHAT ELSE SHOULD YOU KNOW ABOUT THE PLAN?

Plan Identification Numbers: The Internal Revenue Service has assigned the Employer, the Employer Identification Number 38-2843978. The Employer has assigned the Plan the number 501.

Plan Sponsor: Tuscola County Medical Care Facility; 1285 Cleaver Road, Caro, MI 48723; Phone: 1-989-673-4117

Plan Administrator: Employer; 1285 Cleaver Road, Caro, MI 48723; Phone: 1-989-673-4117

Plan Year: For recordkeeping purposes, the Plan Year begins on January 1 and ends on the following December 31.

Legal Service: Service of process can be made upon the Plan Administrator.

Amendment and Termination: The Employer has the right to amend, modify or terminate the Plan by resolution of its Tuscola County Department of Human Services Board of Directors at any time.

Further Information: If there is anything in this booklet which you do not understand, contact the Plan Administrator.

APPENDIX A

OPT OUT PLAN

If, pursuant to a plan subject to Internal Revenue Code Section 125 (also known as a cafeteria plan), you are offered by the Employer the choice, prior to the beginning of each Plan Year and with the consent of the Insurer, to irrevocably opt out of group health insurance, and to receive cash in lieu of such coverage, then you (and your dependents) will not be provided health insurance coverage. The amount of such cash-in-lieu payment and when you will receive such payment will be communicated to you during each Open Enrollment Period. Any cash-in-lieu payment will be treated as compensation for tax purposes and will be subject to appropriate deductions.

You may not change your election during the year except on account of and consistent with a "Change in Status" as defined in the Employer's Section 125 Cafeteria Plan and as permitted pursuant to regulations issued under Internal Revenue Code Section 125.