Summary Plan Description

of

COUNTY OF MECOSTA

GROUP INSURANCE PLAN

January 1, 2010

To Our Employees

This document is called a "Summary Plan Description." Its purpose is to explain the provisions of Employer's Group Insurance Plan ("Plan"). You are urged to read this Summary Plan Description carefully and to acquaint your family with its provisions.

The Plan is comprised of various fully insured benefits. Generally, the terms and conditions under which you may be eligible for and receive the benefits are set forth in the terms of each applicable insurance policy. Since the benefits under the Plan are provided solely through insurance coverages, Employer is not an insurer of any benefits. The sole source for benefits is each insurance company.

This document does not replace the provisions of the insurance policy(ies). Every effort has been made to make this Summary Plan Description as complete and accurate as possible. In the event of any difference between the Summary Plan Description and one of the insurance policies, the terms of the policy will control.

If you have any questions about your benefits under the Plan, please contact your Employer.

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GROUP INSURANCE PLAN

Employer provides various types of group insurance benefits to eligible employees. These insurance benefits are provided through a policy with each insurance carrier. Each insurance carrier is to provide you with a booklet or certificate describing the insurance benefits provided by that carrier.

The booklet or certificate will contain the following information:

- The eligibility conditions for any dependent coverage.
- A summary of benefits.
- A description of any deductibles, coinsurance or copayment amounts.
- A description of any annual or lifetime caps or other limits on benefits.
- Whether and under what circumstances preventive services are covered.
- Whether and under what circumstances prescription drugs are covered.
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures.
- Provisions governing the use of network providers (if any). If there is a network, the booklet or certificate will contain a general description of the provider network and you will be entitled to obtain a list of providers in the network from the insurer.
- Whether and under what circumstances coverage is provided for any out-of-network services.
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.
- Any conditions or limits applicable to obtaining emergency medical care.
- Any provisions requiring preauthorization or utilization as a condition to obtaining a benefit service.
- A summary of the claims procedures.

ELIGIBILITY AND PARTICIPATION

See the last section of this Summary Plan Description beginning on page 16 for a description of the eligibility and participation rules for each insured benefit.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Notwithstanding any contrary provision in any group health insurance policy under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a qualified medical child support order ("QMCSO"). Participants can obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

YOUR RIGHTS UNDER THE NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

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 the 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

YOUR RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Group health plan expenses for a mastectomy shall also include charges for the 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 relating to all stages of the mastectomy, including lymphedemas. Coverage shall be provided in a manner determined in consultation with the attending physician and the patient.

YOUR RIGHTS UNDER HIPAA

The federal law known as HIPAA provides participants with the following rights:

Pre-Existing Conditions/Certificates of Creditable Coverage

Group health plans may not impose pre-existing condition exclusions with respect to individuals beyond 12 months (18 months for late enrollees). Further, an individual's period of creditable coverage under another health plan must reduce the pre-existing condition exclusion. Group health plans and health insurance issuers must provide individuals with a certificate of creditable coverage following termination of coverage. Individuals may also request a certificate of creditable coverage if the request is made to the insurer within 24 months after coverage ends.

Special Enrollment Rights

If an individual experiences a loss of coverage or if an employee has a new dependent, an eligible employee and/or a dependent may have special enrollment rights to participate in the group health plan immediately without being required to wait until the next annual open enrollment period. For this purpose, a loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), the other coverage is an HMO and the individual no longer lives or works in the HMO service area, or coverage is lost due to the application of the other plan's maximum lifetime limit on all benefits. However, a loss of other coverage for this purpose does not include: 1) termination due to the nonpayment of required contributions, 2) termination for cause due to the filing of a fraudulent application or claim, or 3) termination where the individual voluntarily terminates other coverage. The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption. Enrollment must be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable.

In addition, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended HIPAA to establish new special enrollment rights beginning April 1, 2009 for employees and their eligible dependents who are eligible but not enrolled in the Plan if:

- The employee's or eligible dependent's Medicaid or state Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, and the employee requests coverage under the Plan within 60 days after such termination; or

- The employee or eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after such eligibility is determined.

Privacy and Security Rules

The Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing privacy and security regulations (collectively referred to as "HIPAA") restrict the Employer's and Plan's ability to use and disclose certain health information known as "protected health information" ("PHI") and requires that certain security measures be implemented with respect to any electronic PHI.

To the extent subject to HIPAA privacy laws, the Plan and the Employer intend to fully comply with HIPAA. However, the Plan and the Employer also intend to comply with the requirements of 45 C.F.R. § 164.530(k) so that the Plan and the Employer are not subject to most of HIPAA's privacy requirements. The Plan, through the Employer, has entered into insurance contracts and/or third party administrative and business associate agreements with Business Associates to perform all administrative functions on behalf of the Plan, including HIPAA compliance. As a result, the Authorized Employees of the Employer generally will not receive, use, maintain, disclose or transmit PHI or ePHI on behalf of the Plan. The Employer, in its capacity as the employer, typically will have access only to certain enrollment and disenrollment information regarding the Plan's participants (including participant name, social security number and election amount under the Plan) and to Summary Health Information. To the extent that the Employer is subject to HIPAA and its Authorized Employees actually receive, use, maintain, disclose or transmit PHI or ePHI, then the Employer will implement the administrative, technical and other safeguard policies and procedures required by HIPAA and as specified below.

Throughout this Section, various terms are used repeatedly. These terms have specific and definite meanings and generally have been capitalized throughout this Article. Whenever capitalized terms appear, they shall have the meanings specified in HIPAA. HIPAA generally defines PHI and electronic PHI as follows:

- PHI includes information that (i) the Plan creates or receives, (ii) relates to the past, present, or future health or medical condition of an individual and, (iii) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

- Electronic PHI is PHI that is transmitted by or maintained in electronic media (e.g. memory devices in computers, removable/transportable digital memory medium, etc.).

Use and Disclosure of PHI

The Plan can use or disclose PHI only in a manner consistent with HIPAA, which generally is for purposes of Payment and Health Care Operations. Payment generally means activities to obtain and provide reimbursement for the health care provided to an individual, including determinations of eligibility and coverage under the Plan, and other health care utilization review activities. Health Care Operations generally means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management, and administrative activities. PHI also may be used or disclosed as specifically permitted by HIPAA, including the following examples:

- The Plan may share PHI with government or law enforcement agencies when required to do so or when required to in a court or other legal proceeding;

- The Plan may share PHI to obey Workers' Compensation laws; and

- The Plan may share PHI with the individual if the individual requests access to PHI.

In other situations, the Plan will ask for the individual's written authorization before using or disclosing PHI.

Employer Certification

The Plan may disclose PHI to the Employer (including certain members of the Employer's workforce) only to perform administrative functions on behalf of the Plan in a manner consistent with HIPAA requirements, and as more fully described in the Employer's HIPAA Privacy and Security Policies and Procedures. In this regard, the Employer adopts and signs the Adoption Agreement as certification to the Plan that the Employer will appropriately safeguard and limit the use and disclosure of PHI that it receives from the Plan only to perform plan administration functions. Specifically, the Employer agrees to:

- Use or further disclose PHI only as permitted by and consistent with this Plan Document and HIPAA.

- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to Employer with respect to such information.

- Not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan.

- Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Rule of which it becomes aware.

- Make available information in accordance with the HIPAA Rules regarding individual access to PHI.

- Make available PHI for amendment in accordance with the HIPAA Rules.

- Make available the information required under the HIPAA Rules to provide an accounting of non-routine disclosures to the individual.

- Make internal practices, books, and records relating to PHI available to the Department of Health and Human Services for purposes of determining compliance as required by the HIPAA Rules.

- If feasible, return or destroy all PHI received from the Plan that Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Ensure adequate separation between the Plan and Employer.

- To the extent the Employer creates, receives, maintains or transmits any electronic PHI on behalf of the Plan, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the appointed Security Official any security incident of which it becomes aware, and it will implement reasonable and appropriate security measures for electronic PHI to ensure that the adequate separation provisions below are satisfied.

Workforce of the Plan

To the extent required by HIPAA, the Plan will designate a Privacy and Security Official. The Privacy and Security Official is the privacy and security fiduciary responsible for the Plan's compliance with the HIPAA Privacy and Security Rules. Compliance includes ensuring that appropriate administrative, physical and technical procedures and safeguards are in place to protect PHI and to reasonably and appropriately protect the integrity, confidentiality and availability of any electronic PHI that the Employer creates, receives, maintains or transmit on behalf of the Plan. This also includes ensuring that certain members of the Employer's Workforce comply with, are trained in and appropriately handle PHI and electronic PHI under the HIPAA Privacy and Security Rules, and understand the sanctions for HIPAA violations.

Certain employees of the Employer whose duties include administrative and management functions on behalf of the Plan also are considered part of the Workforce of the Plan and thus privacy and security fiduciaries of the Plan. Their access to PHI is limited to the minimum necessary information needed to perform administrative functions on behalf of the Plan, including using or disclosing Summary Health Information for the purpose of obtaining premium bids (including bids in connection with the placement of stop loss coverage) or making decisions to modify, amend or terminate the Plan, or enrollment or disenrollment information about participants. The Employer's HIPAA Privacy and Security Policies and Procedures includes a complete listing of the designated employees who serve as members of the Workforce with access to PHI or electronic PHI.

Adequate Separation between the Plan and Employer

The Employer shall allow access to PHI received from the Plan only to those Workforce members who have been specifically designated by Employer as individuals authorized to access PHI pursuant to the Employer's HIPAA Privacy and Security Policies and Procedures.

No other persons shall have access to PHI. These individuals who have authorized access to PHI only shall use and disclose PHI to the extent necessary to perform the plan administration functions that Employer performs for the Plan. These authorized individuals generally may not use or disclose PHI for purposes of payment, operation or other administrative functions of the Employer's non-group health benefit plans (e.g. disability, life insurance, workers compensation, dependent day care spending account plans etc.) or of any other non-plan activity such as employment related decisions without individual authorization. The Employer will ensure that the adequate separation between the Plan and Employer is supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

Violations of Privacy or Security Rules

If Employer becomes aware of violations of these HIPAA privacy or security rules, it shall arrange for the HIPAA Privacy or Security Officer appointed by Employer to consult with the person who has violated the privacy or security rules with respect to his or her obligations under the privacy or security rules. A person who violates these privacy or security rules may be subject to discipline up to and including discharge.

Individual Rights

The Plan (or the insurer) will provide Participants with certain individual rights to access, amend, account for or restrict uses or disclosures of PHI, as more fully described in the Plan's Notice of Privacy Practice and HIPAA.

SOURCES OF CONTRIBUTIONS AND COST OF BENEFITS

Employer makes contributions under the Plan on behalf of the employees who participate in the Plan. Employer applies its contributions under the Plan to purchase insurance coverage. Employees may be required to contribute to the cost of coverage. If employees are required to contribute to the cost of coverage, Employer will notify employees of the required premiums. If Employer maintains a Section 125 plan, required premiums may be paid on a pre-tax basis.

TERMINATION OF COVERAGE

In order to remain eligible for coverage under the Plan, you must remain an eligible employee actively working for Employer. See the last section of this Summary Plan Description entitled "Other Basic Information About the Plan" for details concerning the termination of coverage rules. However, in certain circumstances, you or your dependents may be eligible for COBRA continuation coverage and/or a conversion policy, as explained in the following sections.

COBRA CONTINUATION COVERAGE

During any calendar year following a calendar year in which Employer employed 20 or more employees (including all part-time employees, each of whom are counted as a fraction of a full-time employee) during at least 50% of the business days in the calendar year, each person who is a qualified beneficiary will have the right to elect to continue health insurance coverage pursuant to the federal law known as COBRA upon the occurrence of a qualifying event. (Small employers (under 20 employees) are not subject to COBRA.) If your Employer is subject to COBRA, COBRA continuation coverage allows you and your dependents (including a child for whom you are required to provide health insurance pursuant to a QMCSO) an opportunity to temporarily extend your health insurance coverage at group rates in certain instances where coverage would otherwise end.

The Plan Administrator may delegate some or all of its responsibilities with respect to COBRA to a third-party COBRA administrator. You and your spouse (if any) will be notified if a COBRA administrator is appointed. The notice will provide information as to which responsibilities the COBRA administrator has assumed, and whether notices required to be provided to the Plan Administrator should be sent to the COBRA administrator.

Eligibility

You and/or your dependents who are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to, adopted by, or placed for adoption with you during a period of COBRA continuation coverage, the newborn or newly-adopted child will also be a qualified beneficiary. However, the newborn or newly-adopted child's maximum continuation period will be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a qualified beneficiary to continuation coverage are "qualifying events." The qualifying events occur when health coverage is lost, even if Employer pays the cost of continuation coverage for a certain period of time. The qualifying events, the qualified beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours* or termination of employment**	Employee and Dependents	18
Employee's death	Dependents	36
Employee's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee's divorce/legal separation***	Dependents	36

* A reduction in hours due to a family or medical leave, as defined by the FMLA will not cause your participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a qualifying event. However, if you do not return to work at the end of the FMLA leave, a qualifying event will occur as of the last day of the FMLA leave.

** Continuation coverage is not available if employment is terminated for gross misconduct.

*** Elimination of your spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example) is not a qualifying event, but it also does not cause the subsequent divorce or legal separation to fail to be a qualifying event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the actual date of the divorce or legal separation.

Extension of Continuation Coverage

If you and/or your dependents become entitled to continuation coverage as a result of your termination of employment or reduction in hours, the 18-month continuation period may be extended for you and/or your dependents in the three circumstances described below ("extension events").

- **Second Qualifying Event** If a second qualifying event (divorce, legal separation, your death, or a dependent child's loss of eligibility for health coverage under the Plan) occurs during the initial 18-month period (or 29 months, if there is a disability extension), your dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of your termination of employment or reduction in hours. Notice of this second qualifying event must be provided to the Plan Administrator within 60 days of the date of the second qualifying event.

- **Employee's Entitlement to Medicare** If you become entitled to Medicare benefits during the initial 18-month period, your dependents may be eligible to elect continuation coverage for a period of 36 months, if, ignoring the original qualifying event, your entitlement to Medicare would have been a qualifying event under the Plan. The 36-month period begins on the date of your termination of employment or reduction in hours. Notice of your entitlement to Medicare in this situation must be provided to the Plan Administrator within 60 days of the date on which you became entitled to Medicare.

  A special rule applies if you became entitled to Medicare before your termination of employment or reduction in hours. In that situation, the maximum continuation period for your dependents may be extended, and may end on the later of: 36 months after the date of your Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of your termination of employment or reduction in hours. *Notice of your entitlement to Medicare in this situation must be provided to the Plan Administrator within 60 days of your termination of employment or reduction in hours.*

- **Social Security Disability Determination** Your dependents will be entitled to an additional 11 months of continuation coverage (up to 29 months total) in either of the following circumstances: (i) it is determined, before your termination of employment or reduction in hours, that you or one of your dependents are entitled to Social Security disability benefits; or (ii) within 60 days after your termination of employment or reduction in hours, it is determined that you or one of your dependents are entitled to Social Security disability benefits. Notice of the Social Security disability determination must be provided to the Plan Administrator within 60 days of the date of the disability determination (or within 60 days of your termination of employment or reduction in hours, if later) and before the end of the 18-month continuation period.

If there is a final determination that the disabled qualified beneficiary is no longer disabled, the disabled qualified beneficiary *must notify the Plan Administrator of that determination within 30 days of the date of the final determination.* In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the "Termination" subsection below).

Plan Administrator's Notice Obligations

The Plan Administrator will provide you and your spouse (if any) with certain information regarding your rights under COBRA in the following situations:

- **Notice of Eligibility to Elect COBRA** The Plan Administrator will generally notify qualified beneficiaries of their eligibility for continuation coverage within 44 days of a qualifying event.

  However, a special rule applies where the qualified beneficiary is required to provide the Plan Administrator with notice of a qualifying event in order to trigger the qualified beneficiary's eligibility for continuation coverage (see the "Qualified Beneficiary's Notice Obligations" subsection below). In that situation, the Plan Administrator will notify the qualified beneficiary of his or her eligibility for continuation coverage within 14 days of receiving notice of the qualifying event, but only if the notice of the qualifying event was submitted in accordance with the requirements described in the "Notice Procedures" subsection.

- **Notice of Unavailability of Continuation Coverage** The Plan Administrator will provide a notice of the unavailability of continuation coverage in the following situations:

  - Where the Plan Administrator determines that continuation coverage is not available after receiving notice of a potential initial qualifying event.

  - Where the Plan Administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential extension event.

    The determination that continuation coverage or an extension of continuation coverage is not available could be made because the Plan Administrator determines that no qualifying event or extension event occurred, or because the notice of the qualifying event or extension event was defective. A notice will be defective if it is not provided within the applicable time limit or is not provided in accordance with the requirements of the "Notice Procedures" subsection.

    The notice of unavailability of continuation coverage will be provided within 14 days of either: (i) the date that the notice of the potential qualifying (or extension) event is received by the Plan Administrator; or (ii) if additional information was requested by the Plan Administrator in order to supplement a defective notice, the deadline for submission of that information (if that date is later). Notice will be sent to the individual who submitted the notice of the qualifying event or extension event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

Qualified Beneficiary's Notice Obligations

In some situations, you and/or your dependents have the obligation to provide notice of a qualifying event or extension event to the Plan Administrator in order to trigger their eligibility for continuation coverage or an extension of continuation coverage. You and/or your dependents have this obligation in the following situations:

- **Notice of Certain Initial Qualifying Events** You, one of your dependents, or an individual acting on behalf of you and/or your dependents must inform the Plan Administrator of a qualifying event that is a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of:

    - The date of the qualifying event; or

    - The date the qualified beneficiary loses health insurance coverage under the Plan on account of that qualifying event.

- **Notice of an Extension Event** In order to qualify for an extension of the continuation coverage period due to an extension event described in the "Extension of Continuation Coverage" subsection, you, one of your dependents, or an individual acting on behalf of you and/or your dependent must notify the Plan Administrator of the extension event within the time limits that apply to that extension event as described in the "Extension of Continuation Coverage" subsection.

These notices must be provided in accordance with the requirements of the "Notice Procedures" subsection. If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the qualifying event or extension event.

Notice Procedures

This subsection describes the procedures a qualified beneficiary must follow to notify the Plan Administrator of qualifying events and extension events.

Employer is the Plan Administrator. Notification must be provided to Employer in writing at the address listed in the last section of this Summary Plan Description entitled "Other Basic Information About the Plan" and must contain all of the following information (as applicable):

- Your name.

- The name of the individual(s) for whom continuation coverage is being requested (i.e., the qualified beneficiary(ies)).

- The current addresses of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.

- The date of the qualifying event or extension event.

- The nature of the qualifying event or extension event (for example, a divorce).

- If the notice relates to a divorce, a copy of the judgment of divorce.

- If the notice relates to a legal separation, a copy of the judgment of separate maintenance or other relevant court documents establishing the legal separation.

- If the notice relates to your entitlement to Medicare, a copy of the document(s) establishing the entitlement.

- If the notice relates to a determination that a qualified beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.

- If the notice relates to a determination that a qualified beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

A notice that is not made in writing and/or does not contain all of the required information is defective and may be rejected.

If the Plan Administrator receives notice of a qualifying event or extension event that is defective because it is not in writing or does not contain all of the required information, the Plan Administrator will request the missing information. If the defective notice was provided by a representative of a potential qualified beneficiary, the Plan Administrator will send the request to the representative and each individual who is a potential qualified beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the Plan Administrator requests the additional information, the notice may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

The Plan Administrator may also request additional information or documentation that is deemed necessary to determine whether a qualifying event or extension event has occurred. If the Plan Administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

Qualified Beneficiary's Election of Continuation Coverage

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the Plan Administrator within 60 days after the later of:

- The date the qualified beneficiary loses health coverage on account of the qualifying event; or
- The date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage.

Notification is made by timely returning the election form to the Plan Administrator at the address specified in the election notice. If the qualified beneficiary does not choose continuation coverage during the 60-day period, his or her participation in the Plan will end as provided in the "Termination" subsection.

Special Trade Adjustment Assistance Election

Special COBRA rights may apply to you if you terminate employment or experience a reduction of hours and qualify for a "trade adjustment allowance" or "alternative trade adjustment assistance" under federal trade laws. In this situation, you are entitled to a second opportunity to elect COBRA continuation coverage for yourself and certain family members (if they did not already elect COBRA continuation coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after group health plan coverage ended.

If you qualify or may qualify for assistance under the federal trade laws, contact the Plan Administrator for additional information. You must contact the Plan Administrator promptly after qualifying for assistance under the federal trade laws or you will lose these special COBRA election rights.

Coverage

If a qualifying event occurs, the qualified beneficiaries must be offered the opportunity to elect to receive the group health insurance coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that if the qualified beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage. Alternatively, the qualified beneficiary may initially elect to purchase one or more of the medical, prescription drug, dental and vision coverages which are provided by Employer pursuant to any separate group health plans and/or which may be separately elected pursuant to Employer's Section 125 plan, if

applicable. However, each coverage is initially available only if the qualified beneficiary was receiving coverage immediately before the qualifying event.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to the qualified beneficiary and his or her dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during the annual enrollment period just as active employees.

Cost

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law).

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the qualified beneficiary initially elects continuation coverage.

Please note that for a limited time period, the American Recovery and Reinvestment Act of 2009 provides for a reduction in the COBRA continuation coverage premium under certain circumstances. If your employment is involuntarily terminated between September 1, 2008 and December 31, 2009, you may be eligible for a 65% reduction in the COBRA premium. This reduction is available for up to nine months. You will receive a special notice providing further details on the premium reduction if your employment is terminated within such dates.

Termination

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner for any of the following reasons:

- **Coverage Terminated** Employer no longer offers a group health plan to any of its employees.
- **Unpaid Premium** The premium for continuation coverage is not timely paid, to the extent payment is required.
- **Other Coverage** The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision will not apply during any time period the other group health plan contains an exclusion or limitation with respect to any pre-existing conditions, other than an exclusion or limitation which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to HIPAA.
- **Medicare** The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B).
- **Cause** The date on which a qualified beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-qualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

The Plan Administrator will notify the qualified beneficiary if continuation coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for

which the qualified beneficiary is eligible to elect continuation coverage. The notification will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage will terminate.

Questions

You and/or your dependents should contact the Plan Administrator at the address or telephone number listed at the end of this Summary Plan Description with any questions regarding COBRA that are not answered in this Summary Plan Description. You and/or your dependents may also contact the nearest District or Regional office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") or visit the EBSA's website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

Keep Plan Informed of Address Changes

To protect your rights under COBRA, it is important that you and your dependents keep the Plan Administrator informed of any changes in address. You should also keep a copy, for your records, of any notices that are sent to the Plan Administrator.

CONTINUATION OF HEALTH COVERAGE UPON MILITARY LEAVE

If you cease to be eligible for health coverage under the Plan due to service in the U.S. military, you and your eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). You and your dependents may also be entitled to elect to continue your health coverage under COBRA if you cease to be eligible for health coverage due to your military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

You may elect to continue health coverage under the Plan for yourself and your eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day you are absent from work to perform military service; or
- The period beginning on the first day you are absent from work to perform military service and ending with the date you fail to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If you give Employer advance notice of a period of military service that will be 30 days or less, the Plan Administrator will treat your notice as an election to continue your health coverage during your military service unless you specifically inform Employer, in writing, that you want to cancel your health coverage during your military leave. You will have to pay the required premiums for your health coverage, but you will not have to complete any additional forms or paperwork to continue your health coverage during your military service.

If you give Employer advance notice of a period of military service that will be 31 days or longer, the Plan Administrator will provide you with a notice of your right to elect to continue health coverage pursuant to USERRA and a form for you to elect USERRA continuation coverage for yourself and your eligible dependents. Unlike COBRA, your dependents do not have a separate right to elect USERRA coverage. If you want USERRA continuation coverage for any member of your family, you must elect it for yourself and all eligible dependents who are covered under the Plan when your military service begins.

If you choose USERRA continuation coverage, you must return the USERRA election form to the Plan Administrator within 60 days of the date it was provided to you. If you do not timely return the election form, USERRA continuation coverage will not be available to you and your eligible dependents.

A special rule applies if you do not give Employer advance notice of your military service. In that case, you and your eligible dependents will not be provided with USERRA continuation coverage during any portion of your military service, but you can elect to reinstate your health coverage (and the coverage of your eligible dependents) retroactive to the first day you were absent from work for military service under the following circumstances:

- You are excused from providing advance notice of your military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for you to provide advance notice or the advance notice was precluded by military necessity);
- You affirmatively elect to reinstate the coverage; and
- You pay all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

For the first 30 days of military service, your required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If your period of military service is more than 30 days, beginning on the 31st day of your military service your required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if you do not timely pay any required premiums for that coverage. If your USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated.

The initial premium must be paid within 45 days after the date you elect USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after you initially elect USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of your USERRA continuation coverage.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

CONVERSION PRIVILEGES

When you are no longer eligible under the Plan (either as an active participant or as a qualified beneficiary receiving continuation coverage), you may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility are set forth in the policy with each insurance carrier.

ADMINISTRATION

Employer is the Plan Administrator. The Plan Administrator is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan. However, because all benefits under the Plan are fully insured, the insurer has the ultimate discretion and authority to determine all questions of eligibility for

participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy.

AMENDMENT AND TERMINATION

Although Employer intends to maintain the Plan indefinitely, Employer has the authority to amend or terminate the Plan at any time. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits.

YOUR RIGHTS AS A PLAN PARTICIPANT

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 are entitled to:

Receive Information About the Plan and its Benefits

- Examine, without charge, at the Plan Administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and (if 100 or more participants) 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, any updated summary plan description and, if 100 or more participants, a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

- If there are more than 100 participants in the Plan, receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You are entitled to 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 on the rules governing your COBRA continuation coverage rights.

There may be a reduction or elimination of any exclusionary periods of coverage for pre-existing conditions under the 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, 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 any plan pre-existing condition exclusion which may be up to 12 months (or 18 months for late enrollees) after your enrollment date in your coverage.

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 Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently 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.

Enforce Participant's Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits 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 medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court shall 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 the participant's claim is frivolous.

Assistance With Questions

If you have any questions about the 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 the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER BASIC INFORMATION ABOUT THE HEALTH PLAN

1.	Name of Plan:	County of Mecosta Group Health Insurance Plan
2.	Name, Address, Telephone Number and Taxpayer Identification Number of Employer/Plan Sponsor:	County of Mecosta 400 Elm Street Big Rapids, MI 49307 (231) 592-0790 38-6005901
3.	Name and Address of Other Participating Related Employer(s):	None
4.	Plan Number:	502
5.	Type of Plan:	Group insurance plan providing health and welfare benefits
6.	Eligibility and Participation:	Each regular employee of Employer who works a minimum of 30 hours per week classified as full-time is eligible for the insurance coverage described in this Summary Plan Description the 1st billing date following 30 days from the date of hire/rehire. The billing date for this plan is the 1st of each month. Retirees who meet the qualifications established by the employer are also eligible for health benefits upon retirement.
7.	Termination of Coverage:	If employment is terminated on or before the 15th day of the month, coverage will end at 12 midnight on the date of termination. If employment is terminated after the 15th day of the month, coverage will terminate at 12 midnight on the last day of the month in which termination occurs. [However, coverage can be continued for an employee in certain situations such as during a medical leave of absence or a layoff. See Employer for details.]
8.	Type of Administration:	Insurer Administration
9.	Plan Administrator:	Plan Sponsor
10.	Agent for Service of Legal Process:	Controller/Administrator County of Mecosta 400 Elm Street Big Rapids, MI 49307
11.	Plan Fiscal Year End:	October 1 through September 30

OTHER BASIC INFORMATION ABOUT THE DENTAL PLAN

1.	Name of Plan:	County of Mecosta Group Dental Insurance Plan
2.	Name, Address, Telephone Number and Taxpayer Identification Number of Employer/Plan Sponsor:	County of Mecosta 400 Elm Street Big Rapids, MI 49307 (231) 592-0790 38-6005901
3.	Name and Address of Other Participating Related Employer(s):	None
4.	Plan Number:	503
5.	Type of Plan:	Group insurance plan providing health and welfare benefits
6.	Eligibility and Participation:	Each regular employee of Employer who works a minimum of 30 hours per week classified as full-time is eligible for the insurance coverage described in this Summary Plan Description the 1st billing date following 30 days from the date of hire/rehire. The billing date for this plan is the 1st of each month. Retirees who meet the qualifications established by the employer are also eligible for health benefits upon retirement.
7.	Termination of Coverage:	If employment is terminated on or before the 15th day of the month, coverage will end at 12 midnight on the date of termination. If employment is terminated after the 15th day of the month, coverage will terminate at 12 midnight on the last day of the month in which termination occurs. [However, coverage can be continued for an employee in certain situations such as during a medical leave of absence or a layoff. See Employer for details.]
8.	Type of Administration:	Insurer Administration
9.	Plan Administrator:	Plan Sponsor
10.	Agent for Service of Legal Process:	Controller/Administrator County of Mecosta 400 Elm Street Big Rapids, MI 49307
11.	Plan Fiscal Year End:	October 1 through September 30

OTHER BASIC INFORMATION ABOUT THE VISION PLAN

1.	Name of Plan:	County of Mecosta Group Vision Insurance Plan
2.	Name, Address, Telephone Number and Taxpayer Identification Number of Employer/Plan Sponsor:	County of Mecosta 400 Elm Street Big Rapids, MI 49307 (231) 592-0790 38-6005901
3.	Name and Address of Other Participating Related Employer(s):	None
4.	Plan Number:	504
5.	Type of Plan:	Group insurance plan providing welfare benefits
6.	Eligibility and Participation:	Each regular employee of Employer who works a minimum of 30 hours per week classified as full-time is eligible for the insurance coverage described in this Summary Plan Description the 1st billing date following 30 days from the date of hire/rehire. The billing date for this plan is the 1st of each month. Retirees who meet the qualifications established by the employer are also eligible for health benefits upon retirement.
7.	Termination of Coverage:	If employment is terminated on or before the 15th day of the month, coverage will end at 12 midnight on the date of termination. If employment is terminated after the 15th day of the month, coverage will terminate at 12 midnight on the last day of the month in which termination occurs. [However, coverage can be continued for an employee in certain situations such as during a medical leave of absence or a layoff. See Employer for details.]
8.	Type of Administration:	Insurer Administration
9.	Plan Administrator:	Plan Sponsor
10.	Agent for Service of Legal Process:	Controller/Administrator County of Mecosta 400 Elm Street Big Rapids, MI 49307
11.	Plan Fiscal Year End:	October1 through September 30

OTHER BASIC INFORMATION ABOUT THE LIFE/AD&D PLAN

1.	Name of Plan:	County of Mecosta Group Life/AD&D Insurance Plan
2.	Name, Address, Telephone Number and Taxpayer Identification Number of Employer/Plan Sponsor:	County of Mecosta 400 Elm Street Big Rapids, MI 49307 (231) 592-0790 38-6005901
3.	Name and Address of Other Participating Related Employer(s):	None
4.	Plan Number:	505
5.	Type of Plan:	Group insurance plan providing health and welfare benefits
6.	Eligibility and Participation:	Each regular employee of Employer who works a minimum of 30 hours per week classified as full-time is eligible for the insurance coverage described in this Summary Plan Description the 1st billing date following 30 days from the date of hire/rehire. The billing date for this plan is the 1st of each month.
7.	Termination of Coverage:	If employment is terminated on or before the 15th day of the month, coverage will end at 12 midnight on the date of termination. If employment is terminated after the 15th day of the month, coverage will terminate at 12 midnight on the last day of the month in which termination occurs. [However, coverage can be continued for an employee in certain situations such as during a medical leave of absence or a layoff. See Employer for details.]
8.	Type of Administration:	Insurer Administration
9.	Plan Administrator:	Plan Sponsor
10.	Agent for Service of Legal Process:	Controller/Administrator County of Mecosta 400 Elm Street Big Rapids, MI 49307
11.	Plan Fiscal Year End:	October 1 through September 30

OTHER BASIC INFORMATION ABOUT THE VOLUNTARY LIFE/AD&D PLAN

1.	Name of Plan:	County of Mecosta Group Voluntary Life/AD&D Insurance Plan
2.	Name, Address, Telephone Number and Taxpayer Identification Number of Employer/Plan Sponsor:	County of Mecosta 400 Elm Street Big Rapids, MI 49307 (231) 592-0790 38-6005901
3.	Name and Address of Other Participating Related Employer(s):	None
4.	Plan Number:	506
5.	Type of Plan:	Group insurance plan providing health and welfare benefits
6.	Eligibility and Participation:	Each regular employee of Employer who works a minimum of 30 hours per week classified as full-time is eligible for the insurance coverage described in this Summary Plan Description the 1st billing date following 30 days from the date of hire/rehire. The billing date for this plan is the 1st of each month.
7.	Termination of Coverage:	If employment is terminated on or before the 15th day of the month, coverage will end at 12 midnight on the date of termination. If employment is terminated after the 15th day of the month, coverage will terminate at 12 midnight on the last day of the month in which termination occurs. [However, coverage can be continued for an employee in certain situations such as during a medical leave of absence or a layoff. See Employer for details.]
8.	Type of Administration:	Insurer Administration
9.	Plan Administrator:	Plan Sponsor
10.	Agent for Service of Legal Process:	Controller/Administrator County of Mecosta 400 Elm Street Big Rapids, MI 49307
11.	Plan Fiscal Year End:	October 1 through September 30

OTHER BASIC INFORMATION ABOUT THE VOLUNTARY PRODUCTS PLAN

1.	Name of Plan:	County of Mecosta Group Voluntary Products Insurance Plan
2.	Name, Address, Telephone Number and Taxpayer Identification Number of Employer/Plan Sponsor:	County of Mecosta 400 Elm Street Big Rapids, MI 49307 (231) 592-0790 38-6005901
3.	Name and Address of Other Participating Related Employer(s):	None
4.	Plan Number:	507
5.	Type of Plan:	Group insurance plan providing health and welfare benefits
6.	Eligibility and Participation:	Each regular employee of Employer who works a minimum of 30 hours per week classified as full-time is eligible for the insurance coverage described in this Summary Plan Description the 1st billing date following 30 days from the date of hire/rehire. The billing date for this plan is the 1st of each month.
7.	Termination of Coverage:	If employment is terminated on or before the 15th day of the month, coverage will end at 12 midnight on the date of termination. If employment is terminated after the 15th day of the month, coverage will terminate at 12 midnight on the last day of the month in which termination occurs. [However, coverage can be continued for an employee in certain situations such as during a medical leave of absence or a layoff. See Employer for details.]
8.	Type of Administration:	Insurer Administration
9.	Plan Administrator:	Plan Sponsor
10.	Agent for Service of Legal Process:	Controller/Administrator County of Mecosta 400 Elm Street Big Rapids, MI 49307
11.	Plan Fiscal Year End:	October 1 through September 30