MENTAL HEALTH COOPERATIVE, INC.

WELFARE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

JANUARY 1, 2011

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SUMMARY PLAN DESCRIPTION

I. INTRODUCTION

This booklet is the summary plan description for the Mental Health Cooperative, Inc. Welfare Benefits Plan (the "Plan"), which is sponsored by Mental Health Cooperative, Inc. (the "Plan Sponsor"). This booklet brings together information concerning all of the various welfare benefits sponsored by the Plan Sponsor.

The balance of this summary plan description will provide a brief overview of certain administrative information concerning the Plan, the different types of benefits available under the Plan, and certain rights all participants in the Plan have under the Employee Retirement Income Security Act of 1974 ("ERISA"). As you will note, the specific information concerning each type of benefit available under the Plan is summarized in separate documents (also referred to in certain instances as summary plan descriptions) that have been or will be made available to you. Those other documents are prepared by the Plan Sponsor or the insurance companies or other providers underwriting each type of benefit.

In the event any of the information concerning the Plan set forth in this summary plan description shall conflict with the Plan, the terms of the Plan shall control. Also, in the event that any of the summary plan descriptions or other documents previously noted regarding each type of benefit conflict with this summary plan description or the Plan, the terms of this summary plan description or the Plan shall control.

II. GENERAL PLAN INFORMATION

A. Name of the Plan

Mental Health Cooperative, Inc. Welfare Benefits Plan

B. Plan Administrator

Mental Health Cooperative, Inc.
275 Cumberland Bend Drive
Nashville, TN 37228

C. Type of Administration

Self and insurer administration.

D. Plan Sponsor

Mental Health Cooperative, Inc.
275 Cumberland Bend Drive
Nashville, TN 37228
(615) 743-1405

E. Plan Sponsor's Identification Number (EIN)

58-2018687

F. Plan Number

501

G. Type of Benefits Provided under the Plan

Medical, dental, group life, accidental death and dismemberment insurance, and long-term disability benefits. *Note: Each of the underlying benefits has its own eligibility criteria, which may vary depending on your employer and may change from time to time; you may not be eligible for some of the underlying benefits.*

H. Agent for Service of Legal Process

Mental Health Cooperative, Inc.
275 Cumberland Bend Drive
Nashville, TN 37228
(615) 743-1405

I. Plan Year

January 1 to December 31.

J. Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- If COBRA applies, 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.

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

Under federal law, a health plan or health insurance issuer generally may not restrict benefits for any hospital length of stay for a mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain preauthorization from the plan or the insurance issuer for prescribing stays within these time frames. Federal law generally does not prohibit the attending provider, after consulting with the mother, from discharging the mother or newborn earlier than the 48- or 96-hour periods.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the

Plan's decision or lack thereof concerning the qualified status of a 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 a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 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 at 1-866-444-EBSA (3272).

III. SUMMARY OF ELIGIBILITY, BENEFITS, AND FUNDING

A. ELIGIBILITY

1. *When Eligibility Begins*

Eligibility to participate in the Plan is determined under the terms of the various welfare benefits provided through the Plan. You may be eligible to participate in and receive certain benefits but not others. You must refer to the separate underlying benefit plan documents and, specifically, the separate eligibility provisions that set forth the conditions pertaining to eligibility to receive those specific benefits.

2. *Termination of Eligibility*

The circumstances under which your eligibility may be terminated are set forth in the underlying documents for the benefits offered under the Plan. You must refer to the separate underlying benefit plan documents to identify circumstances that may result in your disqualification, ineligibility, denial, loss, forfeiture, or suspension of the benefits provided therein.

B. PLAN BENEFITS

Several different types of benefits are available under the Plan. The benefits provided under the Plan are set forth in individual and separate documents noted

below. In other words, you must refer to the individual documents providing the benefits listed below in order to determine the specific benefits provided. The different types of benefits that are available to you are as follows:

- Medical and dental benefits
- Life insurance
- Accidental death and dismemberment insurance
- Long-term disability insurance

C. FUNDING

1. *Type of Funding*

Each individual benefit provided under the Plan may be funded through an insurance contract or may be self-funded. To determine the funding of one of the available welfare benefits, you must read the underlying plan documents with respect to that individual benefit.

2. *Source of Funding*

Contributions Made by Your Employer: Your employer may pay for some or all the cost of the individual welfare benefits under the Plan by paying a portion or all of the respective premiums. However, you must read each individual benefit plan document to determine whether your employer is paying for a portion or all of the premium cost with respect to that individual benefit.

Contributions Made by the Employee: Your employer may require participating employees to make contributions toward the cost of paying for the individual welfare benefits under the Plan in a manner consistent with the provisions of the underlying documents for any of the individual benefits.

IV. PROCEDURE FOR FILING OF CLAIMS

Attachments summarizing the different benefits available under the Plan may provide information on filing claims. Information on filing claims under your group health plan is provided in the attachment summarizing the group health plan. Please refer to those attachments for specific information, and, if other information is required, contact the Plan Administrator for assistance.

With respect to benefits provided under this Plan that are not group health plan benefits, and except to the extent benefits are provided under an insured arrangement for which the insurer is the claims administrator with exclusive fiduciary authority to determine eligibility for and the payment of benefits, the Plan Administrator shall determine any claim for benefits according to the standards imposed by 29 C.F.R. § 2560.503-1 and at a minimum shall make such determinations in compliance with the following:

A. INITIAL CLAIMS PROCEDURE

Claims for benefits may be filed with the organization responsible for administering each individual benefit offered under the Plan on forms supplied by that organization, if applicable.

Written notice of the disposition of a claim shall be furnished to you within ninety (90) days after the claim is filed, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial ninety (90)-day period; provided, however, that in no event shall such extension exceed a period of ninety (90) days from the end of such initial ninety (90)-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a final decision will be sent.

In the case of a claim for disability benefits, if disability is not determined by relying upon a determination of disability for Social Security purposes, then instead of the above, you will be provided with written or electronic notification of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that such an extension is necessary due to matters beyond the control of the Plan and your are notified, prior to the expiration of the initial 45 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that you are notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any such extension, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

You will be provided with written or electronic notification of any adverse benefit determination. Any electronic notification will comply with the standards imposed by 29 C.F.R. 2520.104b-1(c)(1)(i), (iii), and (iv). If a claim is wholly or partially denied, the notice shall set forth at least the following information in language calculated to be understood by you:

(1) the specific reason or reasons for the denial;

(2) specific reference to pertinent plan provisions, including any provisions of any insurance contract or administrative services agreement, or other documentation on which the denial is based;

(3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

(4) an explanation of the claims review procedure in the Plan and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review; and

(5) In the case of disability benefits where disability is not determined by relying upon a determination of disability for Social Security purposes:

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the specific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

B. APPEAL PROCEDURE

If your claim for benefits has been denied, and you want to submit your claim for review, you may file your claim for review, in writing, with the Plan. YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 60 DAYS AFTER YOU HAVE RECEIVED WRITTEN NOTIFICATION OF THE DENIAL OF YOUR CLAIM FOR BENEFITS. However, if your claim is for disability benefits and disability is not determined by relying upon a determination of disability for Social Security purposes, then instead of the above, you must file the claim for review no later than 180 days following receipt of notification of an adverse benefit determination.

You may review all pertinent documents relating to the denial of your claim and submit any issues and comments, in writing, to the Plan.

Your claim for review must be given a full and fair review. This review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, if your claim is for disability benefits and disability is not determined by relying upon a determination of disability for Social Security purposes, then:

(a) Your claim will be reviewed without deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

(b) In deciding an appeal of any adverse benefit determination that is based in whole or part on medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

(c) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

(d) The health care professional engaged for purposes of a consultation under (b) above will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

If your claim is denied, you will be provided with written notice of this denial within 60 days after the Plan's receipt of your written claim for review. There may be times when this 60 day period may be extended. This extension may only be made, however, when there are special circumstances which are communicated to you in writing within the 60 day period. If there is an extension, a decision will be made as soon as possible, but not later than 120 days after receipt by the Plan of your claim for review. However, if claim relates to disability benefits and disability is not determined by relying upon a determination of disability for Social Security purposes, then 45 days will apply instead of 60 days in the preceding sentences, and a decision will be made no later than 90 days after receipt by the Plan of your claim for review.

The decision to deny your claim on review will be communicated to you in writing or electronically and will include specific references to the pertinent Plan provisions on which the decision was based. Any electronic notification will comply with the standards imposed by 29 C.F.R. 2520.104b-1(c)(1)(i), (iii), and (iv).

The decision will also include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The decision will further describe any voluntary appeal procedures offered by the Plan and your right to bring an action under section 502(a) of ERISA.

In the case of disability benefits where disability is not determined by relying upon a determination of disability for Social Security purposes, the decision will also include:

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the specific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

If you have a claim for benefits which is denied upon review or ignored, in whole or in part, you may file suit in a state or federal court. If you have a claim for benefits which is denied upon review or ignored, in whole or in part, you may file suit in a state or federal court. You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

V. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

In accordance with Section 609(a) of ERISA, the Plan must, as required by law, observe the terms of any qualified medical child support order ("QMCSO"). A QMCSO is any judgment, decree or order (including approval of a settlement agreement) issued by a court either (1) pursuant to state domestic relations law and providing for child support or health benefit coverage with respect to a child of a participant in the Plan and relating to benefits under the Plan; or, (2) to enforce a state law relating to medical child support with respect to a group health plan.

The Plan does not have to comply with a medical child support order unless it is "qualified." For such an order to be qualified, it must satisfy the requirements of relevant sections of ERISA. Generally, the order must specify that it applies to benefits under the Plan. The order must include the name and last known mailing address of the participant and each child covered by the order. The order must also provide a reasonable description of the type of coverage to be provided by the Plan to each child, specify the period to which the order applies, and specify each plan to which the order applies. The order will not be qualified if it provides for any type or form of benefit or any other option not otherwise available under the Plan, except to the extent necessary to comply with state medical child support laws.

The Plan Administrator will review any order submitted and determine within a reasonable period of time whether the order is qualified. All persons named in the order will be

appropriately notified of the Plan Administrator's determination. You may obtain without charge a copy of the procedures governing qualified medical child support orders from the Plan Administrator.

VI. AMENDMENT AND TERMINATION

The Plan Sponsor, acting through any duly-authorized officer of the Plan Sponsor, reserves the right to terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan. No amendment shall deprive any participant or beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made; and no amendment shall provide for the use of funds or assets other than for the benefit of participants and their beneficiaries, except as may be specifically authorized by statute or regulation.