ENSIGN SERVICES, INC.

COMPREHENSIVE HEALTH AND WELFARE BENEFIT PLAN SUMMARY PLAN DESCRIPTION

YOUR SUMMARY PLAN DESCRIPTION

This document is the principal document, but only one of several documents that comprise the "summary plan description" of your Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan. Think of the Plan as an umbrella, or shell, under which are incorporated the various health and welfare benefit Component Programs sponsored by Ensign Services, Inc. and affiliates.

The *complete* summary plan description ("SPD") of the Plan is comprised of this document, and the one or more booklets or coverage certificates describing the benefits of the Component Program(s) under which you're enrolled. These booklets or certificates are issued to you by your Employer, or by the insurer or claims administrator of the Component Program(s).

The Component Programs that comprise (and provide benefits through) the Plan include:

- Ensign Services, Inc. Comprehensive Medical Benefit Program
- Ensign Services, Inc. Vision Benefit Program
- Ensign Services, Inc. Dental Benefit Program
- Ensign Services, Inc. Group Term Life Insurance Benefit Program
- Ensign Services, Inc. Accidental Death and Dismemberment Insurance Benefit Program
- Ensign Services, Inc. Flexible Benefit Program
- Ensign Services, Inc. Voluntary Whole Life Benefit Program
- Ensign Services, Inc. Voluntary Short Term Disability Benefit Program
- Ensign Services, Inc. Voluntary Long Term Disability Insurance
- Ensign Services, Inc. Voluntary Group Accident Insurance
- Ensign Services, Inc. Voluntary Critical Illness Insurance
- Ensign Services, Inc. Employee Assistance Program

If you are enrolled in one or more of these Programs, but did not receive a booklet or certificate describing the benefits for which you're eligible, please contact the Ensign Services, Inc. Human Resources Department ((949) 487-9500) and it will obtain copies for you.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

The Component Programs include a variety of different benefit programs. In order to qualify for a benefit under a particular Component Program you must meet the eligibility requirements under *that particular Program*.

The basic eligibility requirements for a particular benefit under a Component Program, how eligibility is maintained, and the options available if eligibility for that benefit is lost, are *summarized* in this document but are described in detail in the insurance contracts, insurance certificates and other Component Program documents issued by insurance carriers or your Employer. In all cases, the Plan may require certain documentation as proof of your eligibility. In no event may you or a Dependent participate in this Plan with respect to a particular benefit provided under a Component Program until the date specified by the Component Program.

For the purposes of this Plan, an "Eligible Employee" is any Employee who meets the eligibility requirements under a Component Program. A person is a "Dependent" of an Employee with respect to a benefit provided hereunder if such person is classified as a "Dependent" under the Component Program that provides such benefit.

Enrollment

If you are eligible for coverage under a Component Program of this Plan, you may enroll for coverage during your initial eligibility period. You may also enroll during the Plan's (or Component Program's) annual enrollment period, or during certain special enrollment periods after you acquire new Dependents or lose other coverage.

Generally, your and your Dependents' eligibility and coverage under a Component Program occur as specified below:

Group Comprehensive Medical Benefits

Employee Eligibility: All full-time Employees who work an average of 32 hours or more per week and have satisfied their waiting period.

Employee Effective Date:

Department Heads, Nurses & Therapists: First of the month following the later of (i) the date of

hire, or (ii) the date the Employee enters an eligible classification.
All Other Employees: First of the month following the later of (i) 90 days of employment, or (ii) the date the Employee enters an eligible classification.

Dependent Effective Date: The effective date of Employee's coverage or, if later, the first day of the month following the date the person becomes a Dependent, as long as (in both cases) the Dependent is enrolled within 30 days after becoming a Dependent.
Coverage Termination Date: First day of month following loss of eligibility.

Group Vision Benefits

Employee Eligibility: Same as for medical.
Employee Effective Date: Same as for medical coverage.
Dependent Effective Date: Same as for medical coverage, as long as (in both cases) the Dependent is enrolled within 30 days after becoming a Dependent.
Coverage Termination Date: Same as for medical coverage.

Group Dental Benefits

Employee Eligibility: Same as for medical.
Employee Effective Date: Same as for medical.
Dependent Effective Date: Same as for medical, as long as (in both cases) the Dependent is enrolled within 30 days after becoming a Dependent.
Coverage Termination Date: Same as for medical.

Group Term Life Insurance Benefits

Employee Eligibility: Same as for medical.
Employee Effective Date: Same as for medical.
Coverage Termination Date: Same as for medical.

Accidental Death and Dismemberment Benefits

Employee Eligibility: Same as for medical.
Employee Effective Date: Same as for medical.
Coverage Termination Date: Same as for medical.

Flexible Benefit Program Benefits

Employee Eligibility: Same as for medical.
Employee Effective Date: Same as for medical.
Coverage Termination Date: Same as for medical.

Voluntary Whole Life Benefits

Employee Eligibility: All full-time Employees who work an average of 32 hours or more per week and have satisfied their waiting period.
Employee Effective Date: The first of the month in which you have your first payroll deduction for premiums.
Dependent Effective Date: The first of the month in which you have your first payroll deduction for premiums.
Coverage Termination Date: End of period for which premiums paid.

Voluntary Short Term Disability Benefits

Employee Eligibility: All full-time Employees who work an average of 32 hours or more per week and have satisfied their waiting period.
Employee Effective Date: The first of the month in which you have your first payroll deduction for premiums.
Coverage Termination Date: End of period for which premiums paid.

Voluntary Long Term Disability Benefits

Employee Eligibility: All full-time Employees who work an average of 32 hours or more per week and have satisfied their waiting period.
Employee Effective Date:
Department Heads, Nurses & Therapists: First of the month after your hire date, provided you enroll within 30 days of your hire date.
All Other Employees: First of the month following 90 days of employment, provided you enroll within 90 days of your hire date.
Coverage Termination Date: End of period for which premiums paid.

Voluntary Group Accident Benefits

Employee Eligibility: All full-time Employees who work an average of 32 hours or more per week and have satisfied their waiting period.
Employee Effective Date: The first of the month in which you have your first payroll deduction for premiums.

Dependent Effective Date: The first of the month in which you have your first payroll deduction for premiums.
Coverage Termination Date: End of period for which premiums paid.

Voluntary Critical Illness Insurance

Employee Eligibility: All full-time Employees who work an average of 32 hours or more per week and have satisfied their waiting period.
Employee Effective Date: The date you return a signed application.
Dependent Effective Date: The date you return a signed application.
Coverage Termination Date: End of period for which premiums paid.

Employee Assistance Program

Employee Eligibility: All Ensign employees.
Employee Effective Date: The date of hire.
Coverage Termination Date: First day of the month following the loss of eligibility.

Please note that coverage may also terminate due to nonpayment of premiums, elimination of coverage by the Employer, disenrollment by the Employee, or any other reason permitted under the terms of the applicable Component Documents.

Notwithstanding any other provision of this document to the contrary, to the extent an applicable state law imposes upon this Plan or any Component Document of this Plan a more generous eligibility criteria than that reflected here, such other eligibility criteria shall apply to the extent, and only to the extent, required by such applicable law.

See also the booklets or certificates you received when you enrolled in the Component Program(s). Contact the Human Resources Department for more information about eligibility issues and coverage effective dates.

Changing Your Election During The Year
Generally, you cannot change your enrollment election during the year. However, if you or your Dependents experience certain "change in status" events, or if other special circumstances arise, you may be permitted to change your coverage election. Please refer to the Human Resources Department for more information on "change in status" and similar events. The terms of a particular Component Program will dictate whether, when and how you may change an election to participate in, or cease participation in that Program.

When Coverage Ends
The eligibility summary listed above also summarizes when coverage ends after you (or, in the case of a Dependent, the eligible Dependent) lose eligibility (for example, because you terminate employment or, in the case of a Dependent, the person ceases to be considered a Dependent under the Component Program).

Coverage for your covered Dependents ends when your coverage ends or, if earlier, when they cease to be considered an eligible Dependent under the applicable Component Program. In certain circumstances health benefits can be continued for you and/or your Dependents for a limited time. Please refer to the "Continuation Coverage" rules below.

Compliance with HIPAA
The Plan will comply with the special enrollment and nondiscrimination provisions of the Health Insurance Portability and Accountability Act of 1996, with respect to those benefits subject to HIPAA. These rules may have the effect of limiting or even eliminating a health program's application of a pre-existing condition restriction to you or a Dependent. These rules may require the Plan to provide benefits for reconstructive breast surgery following a mastectomy, and provide certain minimum benefits for nervous and mental benefits if a health benefit Component Program provides nervous and mental benefits. See the actual Plan document (available from the Human Resources Department) and the various booklets and coverage certificates that describe the benefits available under the Component Programs providing health benefits.

CONTINUATION COVERAGE

This section contains important information about the right to COBRA continuation coverage, which is a temporary extension of health insurance coverage under the Plan. COBRA continuation coverage can become available to you and to other members of your family who are covered under a health care component of the Plan when they would otherwise lose group health coverage. The "health care components" of this Plan are the following:

- Ensign Services, Inc. Comprehensive Medical Benefit Program
- Ensign Services, Inc. Vision Benefit Program
- Ensign Services, Inc. Dental Benefit Program
- Ensign Services, Inc. Health Flexible Spending Account

This section generally explains COBRA continuation coverage, when it may become available, and what one needs to do to protect the right to receive it. This section gives only a summary of COBRA continuation coverage rights. For more information, review the Plan document, a copy of which is available from the Plan Administrator.

Qualifying Events and Qualified Beneficiaries
COBRA continuation coverage is a continuation of coverage under a health care component of this Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below.

COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is an individual who is entitled to COBRA continuation coverage because they would otherwise lose coverage on account of a "qualifying event." Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

You become a qualified beneficiary if you lose coverage under a health care component of this Plan because either one of the following qualifying events happens:

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

Your spouse becomes a qualified beneficiary if he or she loses coverage under a health care component of the Plan because any of the following qualifying events happens:

- You die,
- Your hours of employment are reduced,
- Your employment ends for any reason other than your gross misconduct,
- You become enrolled in Medicare (Part A, Part B, or both), or
- You and your spouse are divorced or legally separated.

Dependent children will become qualified beneficiaries if they will lose coverage under a health care component of the Plan because any of the following qualifying events happens:

- You die,
- Your hours of employment are reduced,
- Your employment ends for any reason other than your gross misconduct,
- You become enrolled in Medicare (Part A, Part B, or both),
- You and the child's other parent become divorced or legally separated, or
- The child stops being eligible for coverage under the plan as a "Dependent child."

Notice Requirements
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. For qualifying events such as your divorce or legal separation or a Dependent child's losing eligibility for coverage as a Dependent child) you (or someone on your behalf) must notify the Plan Administrator. The Plan requires this notice to occur within **60 days** after the qualifying event occurs. The notice must be sent, ***in writing***, (describing the qualifying event and the date it occurred) to the person indicated below:

For COBRA qualifying events involving:

***Comprehensive medical coverage*:**
Ensign Benefits Call Center
27101 Puerta Real, Suite 450
Mission Viejo, CA 92691
(877) 352-8104

***Vision, Dental and Health Flexible Spending Account coverage*:**
Same as above.

Duration of COBRA Coverage
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is your death, enrollment in Medicare (Part A, Part B, or both), your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage may last for up to **36 months**.

When the qualifying event is the end of your employment or reduction in your hours of employment, COBRA continuation coverage may last for up to **l8 months**. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

First, if you or anyone in our family covered under a health care component of the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you (or someone on your behalf) notifies the Plan Administrator in a timely fashion, you and all other members of the family (who were covered by the health care component of the Plan at the time of the qualifying event) can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. ***The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage***. This notice should be sent, in writing, to the appropriate person described above, under the heading *"Notice Requirements."*

Second, if your family experiences another qualifying event while receiving COBRA continuation coverage (due to a qualifying event that allows you and the family to purchase up to 18 months of COBRA coverage), the spouse and Dependent children can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and Dependent children if during the initial 18-month period of COBRA coverage you die, enroll in Medicare (Part A, Part B, or both; provided that your enrollment in Medicare would have triggered a loss of coverage had it been the initial qualifying event), or get divorced or legally separated from your spouse. The extension is also available to a Dependent child when that child stops, during the initial 18-month COBRA period, being eligible under the Plan as a Dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent, in writing, to the appropriate person described above, under the heading "*Contact Persons for Giving Required Notices*."

Notwithstanding the foregoing, ***special COBRA rules apply to COBRA continuation coverage under the health flexible spending account ("FSA")***. The duration for which a qualified beneficiary may purchase COBRA coverage under a health FSA depends on a number of factors. In most cases COBRA coverage is not available beyond the end of the 12-month FSA coverage period in which the qualifying event occurred. In addition, if at the time of the qualifying event you have received health FSA benefit payments (during the 12-month coverage period) in an amount <u>*exceeding*</u> your contributions to the health FSA for that coverage period, then the qualified beneficiary is not eligible for COBRA coverage at all under the health FSA.

Special Trade Act Extension

Special COBRA rights apply to Eligible Employees who lose health coverage as a result of termination or reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period.

This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the Employee begins receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begins receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after the Employee's group health plan coverage ended.

The plan will not treat the period between the initial COBRA qualifying event and the first day of a special Trade Act COBRA election period as a break in creditable coverage for determining application of the plan's pre-existing condition exclusion.

If you qualify or may qualify for assistance under the Trade Act of 1974, you may contact the Ensign Services, Inc. Human Resources Department for additional information. You must contact the Human Resources Department promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights.

Early Termination Of COBRA Coverage
Once you elect to continue your coverage, your coverage may continue for the period described above, unless:

- If you were entitled to 29 months of COBRA continuation coverage (due to your or another person's disability), the Social Security Administration determines that you (or such other person) are no longer disabled;
- You become entitled to Medicare, after you elect COBRA continuation coverage;
- You fail to make a required monthly payment;
- You become covered—after the date you elect COBRA—under another employer group health plan and that coverage contains no exclusion or limitation with respect to any pre-existing condition, or the exclusion cannot be applied; or
- The Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

Application and Payment Procedures
After you experience a COBRA qualifying event (and provide any notice required by the preceding "Notification of a Qualifying Event" section of this booklet), you will be sent a more detailed notice and an Application for Continued Coverage. To continue coverage under COBRA, you must complete and return the Application to the Plan Administrator within 60 days from the later of the date the Application is sent to you or the date your coverage would otherwise terminate. You must also pay for your coverage as provided in the notices you receive regarding your right to elect COBRA coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of a portion of the premiums they are required to pay for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTF/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Questions and More Information
Questions concerning your Plan or your COBRA continuation rights should be addressed to:

***Comprehensive medical coverage*:**
Ensign Benefits Call Center
27101 Puerta Real, Suite 450
Mission Viejo, CA 92691
(877) 352-8104

***Vision coverage*:**
Same as above.

***Dental coverage*:**
Same as above.

***Health Flexible Spending Account*:**
Same as above.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability or 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.**

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

FMLA
If your participation in a health benefit offered under a Component Program of this Plan would terminate due to your taking an FMLA leave of absence, eligibility for the benefit will continue for the period of the leave or the maximum period of leave required under the FMLA, whichever is less. However, coverage will continue only as long as

any required Employee contributions are timely made. Employees on leave must make the same contribution as is required for active Employees. Coverage under other welfare benefits (other than health benefits) will continue or terminate during a period of FMLA leave to the same extent as the benefits continue or terminate during periods of leave under similar circumstances (that is, paid or unpaid leave, as the case may be) that is not FMLA leave.

USERRA

If participation in health benefits offered under a Component Program through this Plan would terminate due to your taking a leave of absence under the Uniformed Service Employment and Reemployment Rights Act of 1994, the benefits may continue for the period of leave or 18 months (24 months for coverage elected on or after December 10, 2004), whichever is less. However, coverage will continue only as long as you continue to timely make any required Employee contributions. If your USERRA leave is less than 31 days you must make the same contribution as is required for active Employees; if your leave is 31 days or longer you must pay up to 102% of the full cost (Employee and Employer contributions) of coverage, as determined by the Plan Administrator.

SCHEDULE OF BENEFITS

The Plan provides a variety of benefits under various benefit programs, including:

- Comprehensive medical benefit program
- Vision benefit program
- Dental benefit program
- Group term life insurance program
- Accidental death and dismemberment program
- Flexible benefit program
- Voluntary whole life benefit program
- Voluntary short term disability benefit program
- Voluntary long term disability benefit program
- Voluntary group accident program
- Voluntary critical illness program
- Employee Assistance Program

A Schedule of Benefits for a particular Component Program is provided to you in the booklet or certificate issued to you when you enrolled in the Program. Please refer to your applicable booklets or certificates for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage (those documents are incorporated into this SPD by reference). As noted in several places, if this summary conflicts in any way with a Component Program document, the Component Program document controls.

Provider Network

The Plan may use a network of providers for certain health care benefits. If you receive covered services from a network provider, usually the Plan pays a larger percentage of your expenses than if you received care from a non-network provider, but this does not mean that all services and supplies are automatically covered. If you have questions regarding coverage of a particular treatment, diagnostic test or supply, we strongly recommend that you contact the Human Resources Department for coverage information rather than rely on a physician or his or her staff, who deal with many different plans on a daily basis.

You can always find out if a particular provider is in the network or obtain a list of providers in your area at no charge by contacting the Human Resources Department.

Newborns' and Mothers' Health Protection Act (NMHPA)

The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or to less than 96 hours in the case of a Cesarean section. In addition, the Plan will not require a hospital, physician or other medical provider to obtain authorization or pre-certification from Ensign Services, Inc. or an insurer (if applicable) or their respective medical review specialist for prescribing any length of stay described above. However, these rules do not apply where the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay periods described above is made by the mother's or child's attending physician in consultation with the mother.

Coordination of Benefits

Benefits provided by health plans vary substantially. Coordination of Benefits (COB) applies when an individual has health care coverage through more than one group program. The purpose of COB is to ensure that the individual receives all of the coverage for which the individual is entitled, but no more than the actual cost for the care received. In other words, total payments from all of the coverages combined cannot be more than the total charges incurred.

The Plan will also coordinate benefits with all other group and private health plans when benefits are not payable for any illness, injury, disease or other condition for which a third party may be liable or legally responsible. "Third party" means an insurance carrier, organization or individual other than the participant or Dependent who suffers loss. It includes insurance carriers liable under no-fault and/or uninsured motorist policies.

Reimbursement

The rules in this "Reimbursement" section, and the following section titled, "Subrogation," apply to the extent the reimbursement and subrogation terms of an applicable Component Program document do not supply greater rights to the Plan (if the reimbursement and subrogation terms of an applicable Component Document supply greater rights, those terms apply).

To the extent permitted by law, when this Plan makes payments that, together with payments you receive or are entitled to receive from any Other Plan or Person, exceed the amount necessary to satisfy the intent of this provision or exceed the benefits properly payable, the Plan has the right to recover the payments to the extent of the excess. Recovery may be had from among one or more of the following: you; if you are an eligible Dependent or former eligible Dependent, your sponsor (the Employee or former Employee); any Other Plan, provider, or person to or for or with respect to whom such payments were made; any insurance company or Other Plan or Person that should have made the payment; and any other organizations.

Alternatively, the Plan may set-off the amount of the payments, to the extent of the excess, against any amount owing at that time or in the future under this Plan to one or more of the following: you, Plans, persons, providers, insurance companies, or other organizations.

These reimbursement rules also apply where this Plan makes payments of covered expenses incurred for treatment of an injury or sickness for which any Other Plan or Person is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the injury or sickness. If the Other Plan or Person makes payment to or on behalf of you as compensation for the injury or sickness, and this Plan is not subrogated with respect to the payment, this Plan is entitled to reimbursement from you (or anyone who received such payment on your behalf), from the payment made by the Other Plan or Covered Person, in an amount equal to (i) the lesser of the benefits paid by this Plan for treatment of the injury or sickness, or (ii) the amount of the payment made by the Other Plan or Covered Person. This provision shall not apply where the Other Plan is a medical plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Covered Person's covered expenses.

These reimbursement rules do not prevent the Plan from obtaining full reimbursement from you or, in the Plan's sole discretion, any other person who received payment on your behalf by, for example, apportioning the obligation to reimburse the Plan among you and any other person, such as your legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to obtain full reimbursement, to seek reimbursement from any person (such as your legal counsel) other than you (or the Person, such as a parent or legal guardian, who received payment on your behalf) where the Plan can be made whole entirely from amounts actually received by you (or the Person, such as a parent or legal guardian, who received such amounts on your behalf). This same rule shall apply to the Plan's rights to set-off as described above.

In addition, where an Other Plan or Person pays compensation to you or on your behalf for an injury or sickness for which an Other Plan or Person is or may be liable, and you incur (either before or after payment of such compensation) otherwise covered expenses for treatment of the injury or sickness, a special rule applies. In such a case, such otherwise covered expenses that were incurred after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, are excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by you or on your behalf, over the covered expenses which the Plan has already paid for treatment of the injury or sickness.

This Plan is not responsible for any costs or expenses (including attorneys' fees) incurred by you or on your behalf in connection with any recovery from any Other Plan or Person unless this Plan agrees in writing to pay a part of those expenses. The characterization of any amounts paid to you or on your behalf, whether in a settlement agreement or otherwise, do not affect

this Plan's right to reimbursement and to characterize otherwise covered charges as excludable covered expenses pursuant to these rules.

Subrogation

To the extent permitted by law, the Plan is subrogated, to the extent of benefits paid or payable by this Plan, to any monies (*i.e.,* "first dollar" monies) paid or payable by any Other Plan or Person by reason of the injury or sickness which occasioned or would occasion the payment of benefits by this Plan, whether or not those monies are sufficient to make you whole. The Plan is not responsible for any costs or expenses, including attorneys' fees, incurred by you or on your behalf in connection with any efforts to recover monies from any Other Plan, unless this Plan agrees in writing to pay a portion of those expenses. The characterization of any amounts paid to you or on your behalf, whether under a settlement agreement or otherwise, does not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of the payment.

These subrogation provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full satisfaction of its subrogation lien from you (or, in the Plan's sole discretion) any other Person who received payment on your behalf, such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among you and any other Person, such as your legal counsel.

This Plan is also subrogated (to the extent of benefits paid under this Plan) to any claim you may have against any Other Plan or Person for the injury or sickness that occasioned the payment of benefits under this Plan. This Plan will apply any monies collected from the Other Plan or Person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining shall be paid to you as soon as administratively practical.

The Plan Administrator shall determine which of the Plan's rights and remedies it is within the best interests of this Plan to pursue.

To the extent permitted by law, if you incur an injury or sickness under circumstances where compensation may be payable to you by some Other Plan or Person (as defined in this Section), the Plan may agree to pay benefits for that injury or sickness to the extent otherwise payable under the Plan, provided you or someone legally qualified and authorized to act for you in writing:

- Consents to the Plan's subrogation of any recovery or right of recovery you have with respect to the injury or sickness;
- Promises not to take any action that would prejudice the Plan's subrogation rights;
- Promises to reimburse the Plan for any such benefits payments to the extent that you receive a recovery from an Other Plan or Person, irrespective of how the recovery is made or characterized, and irrespective of whether the recovery is sufficient to make you whole. This reimbursement must be made within 30 days after you (or anyone on your behalf) receive the payment; and
- Promises to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose.

In the event you fail or refuse to execute whatever assignment, form or document requested by the Plan Administrator, the Plan shall be relieved of any and all legal, equitable or contractual obligation for any benefits or covered expense incurred by you and each member of your family, including claims then incurred but unpaid.

In the event the Plan is entitled by these rules to be reimbursed for benefits it has paid for treatment of your sickness or injury, and where you or someone (including an individual, estate or trust) on your behalf receives or is entitled to receive compensation for such sickness or injury from some other source, the Plan has a constructive trust on such compensation to the extent of the benefits paid by this Plan. The constructive trust is imposed upon the person or entity then in possession of the compensation.

For purposes of these reimbursement and subrogation rules, the following special definitions apply:

- "Covered Person" means a person covered under a Component Program providing health benefits, or a participating COBRA (or other coverage continuation) beneficiary who meets the eligibility requirements for coverage as

specified in this Plan and is properly enrolled under the Plan.

- "Other Plan" includes, but is not limited to, any of the following providing payments on account of an injury or Sickness:

  (i) Any group, blanket or franchise health insurance, or coverage similar to same;
  (ii) A group contractual prepayment or indemnity Plan, or coverage similar to same;
  (iii) A Health Maintenance Organization (HMO), whether group practice or individual practice association;
  (iv) A labor-management trusted plan or a union welfare plan;
  (v) An Employer or multiemployer Plan or Employee welfare benefit plan;
  (vi) A governmental medical benefit program;
  (vii) Insurance required or provided by statute;
  (viii) Automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of the insurance);
  (ix) Settlement or judgment proceeds (regardless of the manner in which the proceeds are characterized).

  The term "Other Plan" is construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

- "Person" means any individual, association, partnership, corporation or any other organization.

CLAIM PROVISIONS

Claim Filing Deadlines

You must apply for Plan benefits in writing on a form provided by the Plan Administrator or other appropriate person, unless a claim is filed directly by a provider of benefits. A claim for reimbursement of expenses under a particular Component Program must be submitted in a manner and within the time period specified in the contracts, booklets or certificates governing that Program. Claims shall be evaluated by the Plan Administrator or another person specified in the applicable Component Program documents and be approved or denied in accordance with the terms of the Plan, including the Component Program documents.

Payment of any claim will be made to you unless you authorized payment to any entity rendering covered services, treatment or supplies. If you die before all benefits have been paid, the remaining benefits may be paid to any relative of yours or to any person appearing to the Plan Administrator to be entitled to payment.

Action on Submitted Claims

Any time a claim for benefits receives an adverse determination (that is, the claim is denied in whole or in part), you or your Dependent (as the case may be) will receive written notice of such action.

Categories of Claims, "Applicable Periods," and Extensions.

- ***"Urgent care claims"***. Urgent care claims are requests for verification or approval of coverage for medical, dental or vision care or treatment where, if the request were not handled expeditiously the delay could jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to *severe pain* that cannot be adequately managed without the care or treatment that is the subject of the claim.

  The "applicable period" for an urgent care claim is generally no longer than the period necessary to decide the matter (that is, "as soon as possible"), but in no event longer than 72 hours. If the Plan cannot render a decision within 72 hours because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claim Supervisor will notify the Claimant within 24 hours of the specific information needed to complete the claim. The Claimant will have at least 48 hours to provide the required information. Within 48 hours after the earlier of (1) the Plan's receiving the required information or (2) the expiration of the period afforded to the Claimant to provide the information, the Claim Supervisor will notify the Claimant of the Plan's benefit determination. The Claimant may

agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

- ***"Pre-Service Claims"***. A pre-service claim is any request for approval of coverage for a medical, dental or vision care service or item that under the terms of the Plan requires advance approval. The "applicable period" for a pre-service medical, dental or vision claim is 15 days after receipt of the claim by the Plan. The Claim Supervisor may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Claim Supervisor will notify the Claimant within the timeframe of the reason for the extension and the date the Plan expects to render its decision.

  If the Claimant has not followed the Plan's procedures for filing a pre-service claim, the Claim Supervisor will notify the Claimant within 5 days of the proper procedures to be followed in order to complete the claim. Further, if the Plan cannot render a decision within 15 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension will describe the specific information needed to complete the claim; the Claimant will have at least 45 days from receipt of the notice to provide the required information; and the Plan has 15 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

- ***"Concurrent Care Claims"***. A concurrent care claim may be either an urgent care claim or a pre-service claim. Generally, it is a claim for an ongoing course of medical, dental or vision care treatment to be provided over a period of time or number of treatments. An adverse determination involving concurrent care will be made sufficiently in advance of any reduction or termination in treatment to allow the Claimant to appeal the adverse benefit determination. If a course of treatment involves urgent care, a request by the Claimant to extend the course of treatment will be decided as soon as possible, but not later than 24 hours after receipt of the request by the Claim Supervisor, provided that the request is made at least 24 hours prior to the expiration of treatment.

  Expiration of an approved course of treatment is not an adverse determination under this section. However, any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is an adverse determination and may be appealed. Notice will be provided a reasonable time before the coverage for treatments will stop; however, the Claimant does not have 180 days to appeal the Plan's decision, before the Plan may terminate the treatment (see the rules below, concerning the time a Claimant normally has to appeal an adverse benefit determination.)

- ***"Post-Service Claims"***. A post-service claim is a medical, dental or vision care claim that is not an urgent care, pre-service or concurrent care claim. The "applicable period" for a post-service claim is 30 days after receipt of the claim by the Plan. The Claim Supervisor may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Claim Supervisor will notify the Claimant within the timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

  If the Plan cannot render a decision within 30 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension will describe the specific information needed to complete the claim. The Claimant will have at least 45 days from receipt of the notice to provide the required information. The Plan will then have 15 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

- ***Claims for Benefits Other than Medical, Dental, Vision or Disability Benefits***. If the Plan includes benefits other than medical, dental, vision, or disability, the "applicable period" for deciding such claims is 90 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to one (1) ninety-day extension, but the Claim Supervisor will notify the Claimant of the need

for the extension prior to the beginning of any such extension period.

Please note that if the Claim Supervisor does not administer claims for benefits described above, references in this paragraph, and below, to the "Claim Supervisor" means the person or entity who administers such claims.

Form and Content of Notice of Adverse Determination on Claims

If a claim is denied in whole or in part, notice of the adverse determination will be provided to the claimant.

The notice will include the following:

- the specific reason or reasons for the adverse determination;
- reference to the specific Component Program provisions on which the determination is based;
- if applicable, a description of any additional information needed for the claimant to perfect the claim and an explanation of why such information is needed;
- a description of the Plan's review procedures, including the claimant's right to bring a civil action under Section 502(a) of ERISA;
- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or a statement that this will be provided without charge upon request; and
- in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

Right to Request Review

Any claimant who has had a claim for benefits denied in whole or in part, or is otherwise adversely affected by action on a claim, has the right to request review. Such request must be in writing, and must be made within a specified number of days after the claimant is advised of the initial adverse action. If written request for review is not made within such appeal period, the claimant will forfeit his or her right to review. The appeal periods vary depending on the Component Program involved:

- Medical Benefits 180 days
- Vision Benefits 180 days
- Dental Benefits 180 days
- Flexible Benefit Program 180 days
- EAP 180 days
- Life Insurance Benefits 60 days
- Accidental Death Benefits 60 days
- Voluntary Whole Life 60 days
- Voluntary Short Term Disability 60 days
- Voluntary Long Term Disability 60 days
- Voluntary Group Accident 60 days
- Voluntary Critical Illness 60 days

Review of Claim

The claim will be reviewed as provided under the applicable Component Program documents, and a copy of the decision will be furnished to the claimant.

See the complaint procedures portion of your Component Program booklet or certificate for specific rights and duties you may have regarding claims and appeals.

PLAN AMENDMENT AND TERMINATION

Ensign reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, Ensign reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. Ensign also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by Ensign will be done in accordance with Ensign's normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of Ensign Services, Inc., the Plan shall terminate unless the Plan is continued by a successor to Ensign.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Ensign to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. You may obtain a copy of Ensign's procedures governing QMCSO determinations, free of charge, by contacting the Plan Administrator. A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the plan administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

RECOVERY OF OVERPAYMENT

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

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:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites 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 Benefit 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 normally required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for Late Enrollees) after your enrollment date in your new 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 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 terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. 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 that 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.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

HIPAA PRIVACY AND SECURITY

The Plan may be required by federal, state and/or local law to keep confidential certain medical information about you that it acquires in the course of providing benefits to you. Any such obligation on the Plan and/or your Employer, and any rights you have, in this regard will be described in the various Component Program documents or in separate notices provided to you.

GRANDFATHERED STATUS UNDER FEDERAL HEALTH REFORM LAW

This Plan believes certain health coverage components of the Plan (specifically, the components to which subtitles A and C of Title I of the Patient Protection and Affordable Care Act of 2010 ("PPACA") generally would apply but for this section) are "grandfathered health coverage" under the PPACA. As permitted by the PPACA, grandfathered health coverage can preserve certain basic health coverage that was already in effect when that law was enacted. Being grandfathered health coverage means that the health coverage provided under this Plan may not include certain consumer protections of the PPACA that apply to other plans or coverages, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health coverage must comply with certain other consumer protections in the PPACA, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to grandfathered health coverage and what might cause health coverage to change from grandfathered status can be directed to the Ensign Benefits Call Center, 27101 Puerta Real, Suite 450, Mission Viejo, CA 92691
(877) 352-8104

An interested person may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or

www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health coverage.

PLAN INFORMATION

Plan Name:	Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan
Plan Number:	506
Type of Plan:	Welfare benefit plan providing benefits under the following programs: Comprehensive medical benefit program Vision benefit program Dental benefit program Employee Assistance Program Group term life insurance program Accidental death and dismemberment program Flexible benefit program Voluntary whole life benefit program Voluntary short term disability benefit program Voluntary long term disability program Voluntary group accident program Voluntary critical illness program
Plan Year:	12-month period beginning January 1 and ending December 31.
Plan Sponsor:	Ensign Services, Inc. 27101 Puerta Real, Suite 450 Mission Viejo, CA 92691 (949) 487-9500 Employer ID No.: 11-3645368
Affiliated Employers:	See Appendix II
Plan Administrator:	Ensign Services, Inc. 27101 Puerta Real, Suite 450 Mission Viejo, CA 92691 (949) 487-9500
Named Fiduciary:	Ensign Services, Inc. 27101 Puerta Real, Suite 450 Mission Viejo, CA 92691 (949) 487-9500
Sources of Contributions:	Employee contributions and Employer contributions.
Funding Medium:	Benefits are provided through one or more insurance contracts and the Component Programs referenced in Appendix I, purchased with contributions by the Participating Employer(s) and with specified Employee contributions, as applicable.
Type of Administration:	Some benefits under the Plan are self-insured, but administered by a third-party administrator (please note that although one or more benefits are administered by an insurance company, the insurance company in those cases does not insure or guarantee the benefits that it administers; see Appendix I for the identity of the third-party administrator(s)). The Plan Sponsor maintains a stop-loss or reinsurance policy to protect the Plan Sponsor against catastrophic loss under the comprehensive medical benefit program offered under this Plan. However, the stop-loss insurance merely reimburses the Plan Sponsor for benefits it funds under the program, and is not to be construed as "insuring" the comprehensive medical benefits under the program. Some benefits under the Plan are insured by one or more insurance companies. The third-party administrators and/or insurance companies are listed in the Appendix at the back of this booklet.
Agent for Legal Process:	Service of legal process may be made upon the Plan Administrator.

Actions Against the Plan	Except to the extent provided under the terms of a Component Program document where such terms are required by applicable law, no legal action may be brought to recover from or with respect to this Plan prior to the earlier of (i) the date you have exhausted all administrative remedies under this Plan, and (ii) the date that is eighteen months from the time written proof of loss is required to be given.

IMPORTANT NOTICE

This document (and the booklets and certificates it incorporates by reference) is only a summary of your Plan. The actual Plan document and, particularly the Component Program documents it incorporates by reference, and any appendices to those documents, set forth your rights and obligations under the Plan (unless those documents purport to merely summarize those benefits). In the event this summary is in any way ambiguous or inconsistent with the terms of the actual Plan document or one or more Component Program documents that the Plan incorporates by reference, those documents control over this summary.

APPENDIX
OF
CLAIM ADMINISTRATORS AND INSURERS

Group Comprehensive Medical Benefits

Benefits provided under a self-insured arrangement with:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927-2540
(888) 235-1765

Benefits provided under an insured arrangement with:

Kaiser Permanente of California
P.O. Box 7004
Downey, CA 90242-7004
(800) 464-4000

Group Vision Benefits

Benefits provided under a self-insured arrangement with:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105
(800) 877-7195

Group Dental Benefits

Benefits provided under an insured arrangement with:

CIGNA – Dental HMO
5300 West Tulare Avenue
Visalia, CA 93277
(800) 244-6224

Benefits provided under a self-insured arrangement with:

CIGNA - Dental PPO
5300 West Tulare Avenue
Visalia, CA 93277
(800) 244--6224

Group Term Life Insurance Benefits

Benefits provided under an insured arrangement with:

ING Employee Benefits
20 Washington Avenue South
Minneapolis, MN 55401
(877) 352-8104

Group Accidental Death and Dismemberment Benefits

Benefits provided under an insured arrangement with:

ING Employee Benefits
20 Washington Avenue South
Minneapolis, MN 55401
(877) 352-8104

Group Flexible Benefit Program Benefits

Benefits administered by:

Discovery Benefits
P.O. Box 2926
Fargo, ND 58108
(866) 451-3399

Voluntary Whole Life Benefits

Benefits provided under an insured arrangement with:

Unum
1 Fountain Square
Chattanooga, TN 37402
(800) 635-5597

Voluntary Short Term Disability Benefits

Benefits provided under an insured arrangement with:

Unum
1 Fountain Square
Chattanooga, TN 37402
(800) 635-5597

Voluntary Long Term Disability Benefits
Benefits provided under an insured arrangement with:

Unum
1 Fountain Square
Chattanooga, TN 37402
(800) 635-5597

Voluntary Group Accident Benefits

Benefits provided under an insured arrangement with:

Unum
1 Fountain Square
Chattanooga, TN 37402
(800) 635-559

Voluntary Critical Illness Benefits

Benefits provided under an insured arrangement with:

Unum
1 Fountain Square
Chattanooga, TN 37402
(800) 635-559

Employee Assistance Program

Benefits provided through

ComPsych Guidance Resources
455 North Cityfront Plaza Drive
13th floor
Chicago, IL 60611
(877) 533-2363

APPENDIX II
AFFILIATED EMPLOYERS

Brownsville Care Associates, Inc.
Alta Vista Rehabilitation and Healthcare
27-1142705

Ensign San Dimas LLC
Arbor Glen Care Center
33-0929291

Avenues Healthcare, Inc.
Arlington Hills Healthcare Center
42-1709611

City Heights Health Associates LLC
Arroyo Vista Nursing Center
06-1703553

Arvada Healthcare, Inc.
Arvada Care and Rehabilitation Center
26-3853114

Atlantic Memorial Healthcare Associates, Inc.
Atlantic Memorial Healthcare Center
30-0474094

Monroe Healthcare, Inc.
Beatrice Manor
45-2380214

Bayshore Healthcare, Inc.
Bella Vista Transitional Care Center
26-0242141

Glendale Healthcare Associates LLC
Bella Vita Health and Rehabiliation Center
02-0550410

Downey Community Care LLC
Brookfield Healthcare Center
57-1159625

Redbrook Healthcare Associates LLC
Brookside Healthcare Center
86-1069267

Camarillo Community Care, Inc.
Camarillo Healthcare Center
81-0676866

Richmond Senior Services, Inc.
Cambridge Health & Rehabilitation Center
11-3785428

Rosenburg Senior Living, Inc.
Cambridge Square Retirement Center
11-3785430

Windsor Lake Healthcare, Inc.
Canterbury Gardens Independent and Assisted Living Community
27-3239783

Stanton Lake Healthcare, Inc.
Careage Estates of Falls City
45-2380258

Cherokee Healthcare, Inc.
Careage Hills Rehabilitation and Healthcare
45-2380336

Great Plains Healthcare, Inc.
Careage Home Care
90-0727076

Lindahl Healthcare, Inc.
Careage of Wayne
45-2380297

Bernardo Heights Healthcare, Inc.
Carmel Mountain Rehabilitation and Healthcare Center
33-1127449

Carrollton Heights Healthcare, Inc.
Carrollton Health and Rehabilitation Center
56-2616401

Presidio Health Associates LLC
Catalina Healthcare Center
57-1159638

Marion Health Associates, Inc.
Chateau Des Mons Care and Assisted Living
26-4083540

Claremont Foothills Health Associates LLC
Claremont Care Center
06-1703550

Central Avenue Healthcare, Inc.
Clarion Wellness and Rehabilitation Center
80-0728124

Ensign Cloverdale LLC
Cloverdale Healthcare Center
94-3406848

Randolph Healthcare, Inc.
Colonial Manor of Randolph
45-2379788

Connected Healthcare, Inc.
Connected Home Health
45-3951495

Jordan Health Associates, Inc.
Copper Ridge Health Care
27-0811910

North Mountain Healthcare LLC
Coronado Healthcare Center
32-0085493

Keystone Hospice Care, Inc.
Custom Care Hospice and Home Health
27-0460713

Glendale Healthcare Associates LLC
Desert Sky Assisted Living
02-0550410

Spring Valley Assisted Living, Inc.
Desert Springs Senior Living
45-0609702

24th Street Healthcare Associates LLC
Desert Terrace Healthcare Center
04-3605446

Sawtooth healthcare, Inc.
Discovery Care Center
45-5466463

Immediate Clinic Seattle, Inc.
Doctor's Express
45-3989799

South Valley Healthcare, Inc.
Draper Rehabilitation and Care Center
26-0311892

Alpowa Healthcare, Inc.
Elite Home Health and Elite Hospice
46-1704501

Emblem Healthcare, Inc.
Emblem Hospice
45-3989711

Lynnwood Health Services, Inc.
Emerald Hills Rehabilitation and Skilled Nursing
68-0624041

Gypsum Creek Healthcare, Inc.
Fort Dodge Health and Rehabilitation
90-0727006

C Street Health Associates LLC
Glenwood Care Center
06-1712072

Pomerado Ranch Healthcare, Inc.
Golden Acres Living and Rehabilitation Center
26-0241988

Brown Road Senior Housing LLC
Grand Court of Mesa
68-0538221

McAllen Care Associates, Inc.
Grand Terrace Rehabilitation and Healthcare
27-1142444

Savoy Healthcare, Inc.
Heritage Gardens Rehabilitation and Healthcare
27-1931093

Highland Healthcare LLC
Highland Manor Health & Rehabilitation Center
06-1639210

Riverside Healthcare, Inc.
Hillcrest Health Care Center/Mica Hill Estates Assisted Living
90-0726820

Olympus Health, Inc.
Holladay Healthcare Center
38-3747071

Granite Healthcare, Inc.
Homecare Solutions
45-3128364

Cornerstone Healthcare, Inc.
Horizon Home Health & Hospice
27-1598308

Zion Healthcare, Inc.
Hurricane Health and Rehabilitation
45-2107023

Chateau Julia Healthcare, Inc.
Julia Temple Healthcare Center
26-3852965

Spring Creek Healthcare, Inc.
La Villa Rehabilitation and Healthcare Center
46-1760865

Grand Villa PHX, Inc.
Lake Village Nursing & Rehabilitation Center
20-8422854

Casa Linda Retirement, Inc.
Lakeland Hills Assisted Living
45-0642596

Tradewind Healthcare, Inc.
Legacy Rehabilitation and Living
46-0858953

Lemon Grove Health Associates LLC
Lemon Grove Care and Rehabilitation Center
57-1159618

Victoria Ventura Assisted Living Community, Inc.
Lexington Assisted Living
27-3872204

Lowell Healthcare, Inc.
Littleton Care and Rehabilitation Center
26-3852670

Ramon Healthcare Associates, Inc.
Mission Care Center
51-0532246

Valley View Health Services, Inc.
Monte Vista Hills Healthcare Center
45-4050084

Market Bayou Healthcare, Inc.
Montebello Wellness Center
27-2011426

Sunland Health Associates LLC
Montecito Post Acute Care and Rehabiliation
32-0085492

Washington Heights Healthcare, Inc.
Mt. Ogden Health & Rehabilitation Center
57-1237937

Radiant Hills Health Associates LLC
North Mountain Medical & Rehabilitation Center
57-1207623

Ensign Willits LLC
Northbrook Nursing and Rehabilitation Center
33-0980394

Northern Oaks Healthcare, Inc.
Northern Oaks Living & Rehabilitation Center
75-3072922

Oceanview Healthcare, Inc.
Oceanview Healthcare and Rehabilitation
26-4324352

Southside Healthcare, Inc.
Omaha Nursing and Rehabilitation Center
46-2101687

Hueneme Healthcare, Inc.
Orem Rehabilitation and Nursing Center
26-0242103

RenewCare of Scottsdale Inc.
Osborn Health and Rehabilitation
84-1717466

Homedale Healthcare, Inc.
Owyhee Health and Rehabiliation Center
45-5471714

Hoquiam Healthcare, Inc.
Pacific Care Center
26-0133524

Bakorp L.L.C.
Pacific Mobile Diagnostics
20-3625798

Gate Three Healthcare LLC
Palm Terrace Healthcare Center
75-3162623

West Escondido Healthcare LLC
Palomar Vista Healthcare Center
71-0948008

Ensign Panorama LLC
Panorama Gardens Nursing & Rehabilitation Center
94-3367212

Cardiff Healthcare, Inc.
Paramount Health and Rehabilitation
26-0242031

Park Waverly Healthcare LLC
Park Avenue Health and Rehabilitation
32-0085494

Manor Park Healthcare LLC
Park Manor Rehabilitation Center
06-1639207

GO Assisted, Inc.
Park Place Assisted Living
45-4073082

Ensign Montgomery LLC
Park View Gardens at Montgomery
94-3375000

JRT Healthcare, Inc.
Parke View Rehabilitation & Care Center
27-1275615

Price Healthcare, Inc.
Pinnacle Nursing and Rehabiliation
27-0811966

Empirecare Health Associates, Inc.
Plymouth Tower Care Center
26-3897086

Empire Health Associates, Inc.
Plymouth Tower Living Center
95-2625490

Pocatello Health Services, Inc.
Pocatello Care and Rehabilitation Center
65-1289858

Ensign Palm I LLC
Premier Care Center for Palm Springs
94-3406846

Riverview Healthcare, Inc.
Provo Rehabilitation and Nursing
27-0811946

Symbol Healthcare, Inc.
Puget Sound Home Health
61-1698685

Union Hill Healthcare, Inc.
Redmond Care and Rehabilitation Center
46-2103063

Moss Bay Senior Living, Inc.
Redmond Heights Senior Living
46-2101880

Fossil Creek Healthcare, Inc.
Richland Hills Rehabilitation and Healthcare Center
46-1290621

GEM Healthcare, Inc.
River's Edge Rehabiliation & Living Center
27-1275531

Thomas Road Senior Housing, Inc.
Rose Court Senior Living
45-3822645

Bell Villa Care Associates LLC
Rose Villa Healthcare Center
57-1159634

Wildcreek Healthcare, Inc.
Rosewood Rehabiliation Center
80-0758011

Ensign Sabino LLC
Sabino Canyon Rehabilitation & Care Center
33-0921282

Salado Creek Senior Care, Inc.
Salado Creek Living & Rehabilitation Center
75-3072928

Wood Bayou Healthcare, Inc.
San Marcos Rehabilitation and Healthcare Center
27-1931165

HB Healthcare Associates LLC
Sea Cliff Healthcare Center
32-0073769

Rose Park Healthcare Associates, Inc.
Shoreline Healthcare Center
75-3072916

Lakewood Healthcare, Inc.
Sloan's Lake Rehabilitation Center
27-0710890

Ensign Sonoma LLC
Sonoma Healthcare Center
33-0980392

Southland Management LLC
Southland Care and Southland Living
33-0937134

Piney Lufkin Healthcare, Inc.
Southland Rehabilitation and Healthcare Center
26-3800897

Successor Healthcare, Inc.
St. Joseph Villa SNF, ALF & Marian Center
27-4177524

Grassland Healthcare and Rehabiliation, Inc.
Stillhouse Rehabiliation and Healthcare Center
45-5071125

Ensign Santa Rosa LLC
Summerfield HealthCare Center
33-0916188

Youngtown Health, Inc.
Sunview Health and Rehabiliation Center
27-1254304

Silver Lake Healthcare, Inc.
Symbii Home Health and Hospice
45-1366496

Pomerado Ranch Healthcare, Inc.
The Cottages at Golden Acres
26-0241988

Chaparral Healthcare, Inc.
The Courtyard Rehabilitation and Healthcare Center
46-0858941

Ensign Whittier West LLC
The Orchard Post Acute Care
94-3367210

La Jolla Skilled, Inc.
The Springs at Pacific Regent La Jolla
45-0612341

Livingston Care Associates, Inc.
Timberwood Nursing & Rehabilitation Center
76-0825002

Ensign Pleasanton LLC
Ukiah Healthcare Center
20-0535730

Upland Community Care, Inc.
Upland Rehabilitation and Care Center
65-1254985

Harlingen Healthcare, Inc.
Veranda Rehabilitation and Healthcare
27-1142676

Vesper Healthcare, Inc.
Vesper Hospice
80-0873191

Victoria Ventura Healthcare LLC
Victoria Care Center
06-1712078

Costa Victoria Healthcare LLC
Victoria Healthcare and Rehabilitation Center
71-0948014

McAllen Community Healthcare, Inc.
Village Healthcare and Rehabilitation
75-3072930

Vista Woods Health Associates LLC
Vista Knoll Specialized Care Facility
06-1703543

Wellington Healthcare, Inc.
Wellington Place Living & Rehabilitation Center
75-3072926

Prairie Creek Healthcare, Inc.
West Bend Care Center & Prairie Creek ALF
45-2380507

Ensign Whittier East LLC
Whittier Hills Health Care Center
94-3367211

Town East Healthcare, Inc.
Willow Bend Nursing & Rehabilitation Center
20-8422475

Southern Oaks Healthcare, Inc.
Wisteria Place SNF. ALF & ILF
27-4019232

Red Rock Healthcare, Inc.
Zion's Way Hospice and Home Health
45-4049725