Weldon, Williams and Lick, Inc.
Medical and Section 125 Plan

Amendments
Summary Plan Description
Plan Document

WELDON WILLIAMS & LICK

Gastric Bypass Surgery Requirements as of 1/1/2012

1. Participant must **contact a Plan Approved Gastric Bypass Surgeon** to get details about the surgery and see if participant meets the requirements of the surgeon.

2. Participant must **then call the WW&L Clinic to make an appointment to see the Dietary Nurse to begin six months of successful weight management classes before approval** will be considered for the bypass procedure.

3. **Participant will sign a contract with the Clinic's Dietary Nurse**. Under the contract, during the following six months, the participant will be required to keep a food journal, have an exercise regimen in place and report to the clinic regularly for weigh in and blood work as requested by the Clinic.

4. **After the six month period, the Dietary Nurse will certify and approve the surgery if the participant has successfully completed the requirements and feels that the participant is a candidate for gastric bypass surgery.** Successful completion will be shown through weight loss, blood work, commitment and motivation.

5. The participant will make arrangements with a plan approved surgeon for surgery. **The surgery must be pre-certified and authorized by the current WW&L pre-cert company after** the WW&L Clinic nurse has approved the participant's successful completion of the six month program.

6. Within the contract that the participant signs at the beginning of this process, there will be a stipulation that after the surgery is completed, **the participant will continue with monthly monitoring at the WW&L Clinic** on an ongoing basis per the Dietary Nurse's instruction, including food journal, blood work and the exercise regimen, as the nurse deems necessary.

All gastric bypass patients, past, present and future, are strongly urged to continue the ongoing support at the WW&L Clinic with monthly monitoring of your progress and support from the Dietary Nurse instruction. Gastric Bypass surgery is a life changing procedure to your body that includes dietary restrictions that must be followed to be successful, i.e. , to not have complications or weight gain. There is a lifetime maximum limit of $50,000 for surgical intervention of Morbid Obesity and the treatment of complications related to such surgery, and is limited to one Morbid Obesity related surgery per lifetime.

Weldon, Williams and Lick, Inc.
Group Medical Plan and Section 125 Plan

Amendment No. 3 and Summary of Material Modification

Effective January 1, 2012

The Weldon, Williams and Lick, Inc. Group Medical Plan and Section 125 Plan is hereby amended as follows:

1. *To amend the Deductible for In-Network and Out-of-Network benefits in the Medical Schedule of Benefits on page 6 as follows:*

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK	OUT-OF-NETWORK
GENERAL INFORMATION		
Deductible	Individual: $500 Family: $1,000	Individual: $500 Family: $1,000
	Eligible Expenses applied toward the In-Network Deductible are also applied toward the Out-of-Network Deductible, and vice versa.	

2. *To amend the Preventative Care benefit in the Medical Schedule of Benefits on page 8 as follows:*

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK	OUT-OF-NETWORK
Preventative Services	Plan pays 100% of 1st $500; thereafter, Plan pays 80% after Deductible	After Deductible, Plan pays 60%
	Preventive care includes: cancer screenings, mammograms, physical exams, gynecological exams, dexa scans, and immunizations (for Dependent Children under the age of 18 months).	
	The first billed procedure of the year for the following procedures will be covered as Preventive Care regardless of the diagnosis filed: mammograms; pap smears; colonoscopies; PSA tests; and routine physicals. Any of these procedures occurring a second time within the calendar year will not be covered as Preventive Care.	

3. *To delete and replace the paragraph for Specialty Drugs, as found on page 24 of the Medical Benefits Section of the plan document with the following:*

Specialty Drugs
The Plan will cover specialty drugs when obtained from the Plan's selected specialty pharmacy provider. Specialty drugs are high-cost drugs used to treat complex or rare conditions including multiple sclerosis, Rheumatoid arthritis, hepatitis C, and hemophilia. The drugs are often self-injected or administered in a physician's office or through home health services.

Specialty Drugs that are self-injected may be covered through the Plan's Prescription Drug Benefit.

Specialty Drugs administered in a physicians' office or through home health services may be covered via the medical benefits. Unlike other prescription drugs obtained from a retail Pharmacy or mail order Pharmacy (and administered by the Plan's pharmacy benefits manager, ECRx via LDI Specialty Pharmacy), a HCFA claim form must submitted (typically by the specialty drug pharmacy) in order to receive payment for specialty drugs.

4. *To delete and replace the Morbid Obesity Benefit as found on page 19 of the Medical Benefit Section with the following:*

Morbid Obesity

Medically Necessary Charges for treatment of obesity are excluded, unless the Covered Person has been diagnosed by a Plan approved Physician as having Morbid Obesity, and the following qualifications are met.

Qualifications for bariatric surgery will consist of:

- Successful completion of 6 month weight loss program through the WWL clinic
- Authorization for surgery will be cited through Case Management
- Diagnosis of Morbid Obesity from a Plan approved physician, supported by Case Management findings.

Medically necessarily, Surgical Intervention of Morbid Obesity must be performed by a Plan approved physician through a Centers of Excellence facility. Surgical Procedures for Morbid Obesity performed by non Plan approved physician will not be considered a covered benefit. Covered Persons should contact the customer service phone number on their identification card for more information.

Surgical Treatment - If surgical intervention of Morbid Obesity is recommended by a Plan approved Physician (via an approved Center of Excellence), the Plan will cover the surgical procedure, if the Covered Person has been covered under the Plan for a period 12 consecutive months.

For surgical intervention of Morbid Obesity that result from such surgery, the Coinsurance for services rendered by the Plan approved Physician will be 80% and will be subject to the Covered Person's current calendar year Deductible as set forth in the Plan's Summary Plan Description. The Covered Person will pay the remaining 20% of Eligible Expenses, up to the Covered Person's calendar year In-Network Out-of-Pocket maximum.

The Plan will only consider the following surgeries:

1. Gastric Bypass
2. Lap-Band

There is a separate Lifetime Maximum Limit of $50,000.00 for surgical intervention of Morbid Obesity and the treatment of complications related to such surgery, and is limited to one Morbid Obesity related surgery per lifetime. The Coinsurance for the surgical intervention of Morbid Obesity and any complications in connection therewith will apply to the Covered Person's calendar year In-Network Out-of-Pocket maximum.

The plan will not consider:

1. Charges related to additional procedures which may be needed as a result of physical changes associated with the subsequent weight-loss, including (but not limited to), panniculectomy, abdominoplasty, thighplasty, brachiplasty, and mastopexy are not covered, unless deemed medically necessary;

2. Non-surgical treatments such as a Physician-supervised diet and/or exercise programs, and;

3. Reversal on gastric bypass (Duodenal-Switch surgery) and lap-band procedures.

5. *Delete and replace the Prescription Drug Schedule of Benefits found on page 10 with the following schedule:*

Prescription Drug Schedule of Benefits		
Retail Pharmacy		
Copayments per 0-31 day supply	Align Network Pharmacy	Other Network Pharmacies
Generic	$2	$7
Preferred Brand	$25	$25
Non-Preferred Brand	$50	$50
Drugs on the $4 Wal-Mart Drug list	$2 Copayment at Wal-Mart	N/A
If a member requests a brand name drug when a generic may be dispensed, the member will pay the appropriate brand name copay, plus the cost difference between the generic and brand name drug. *Certain over-the-counter antihistamines and Proton Pump Inhibitors are covered when prescribed by a physician. At any retail pharmacy these are covered with a $7 member copay for up to a 31 day supply. These will be available by mail order for a $14 member copay for up to a 90 day supply. Only the specific medications below are included in this benefit provision:* *All forms of Alavert, Claritin, Zyrtec* *All forms of Prevacid 24 hour, Prilosec, Zegerid*		
Maximum per fill	0-31 day supply for non-maintenance medications. Note: After a member has received two 30 day supplies of a maintenance medication, the member may receive up to a 90 day supply of that medication at retail.	

Specialty Medications: Some medications must be dispensed through the Specialty Pharmacy Program. Call the Member Service number for Prescription Benefits as shown on the member ID card for more information. **Specialty Medications have a 20% copay, with a copay maximum of $150 per specialty drug per month.**	
Mail Order Pharmacy	
	Copayments:
Generic	$14
Preferred Brand	$50
Non-Preferred Brand	$100
If a member requests a brand name drug when a generic may be dispensed, the member will pay the appropriate brand name copay, plus the cost difference between the generic and brand name drug.	
Maximum per fill	90 days

6. The Prescription Drug Benefits section beginning on page 31 is deleted and replaced with the following:

PRESCRIPTION DRUG BENEFITS

PHARMACY INFORMATION

Under the Plan, the Plan Sponsor has contracted with a pharmacy benefits manager to assist with the management and administration of the Prescription Drug Benefits under the Plan. The pharmacy benefits manager is ECRx.

Under this Plan, a Covered Person may obtain prescription drugs from a Retail Pharmacy or a Mail Order Pharmacy. The Retail Pharmacy is typically used when the Covered Person needs to order a prescription on a short-term basis. When purchasing covered prescription drugs from a Retail Pharmacy, the Covered Person will be required to pay the applicable Copayment and each prescription will be subject to a 31-day dispensing limit. The Covered Person is not required to file a claim form in connection with prescription drugs obtained from a Retail Pharmacy.

The Mail Order Pharmacy is typically used when the Covered Person needs to order prescription drugs in a larger supply (e.g. maintenance drugs). In order to use the Mail Order Pharmacy, the Covered Person will need to contact the pharmacy benefits manager. When purchasing prescription drugs from the Mail Order Pharmacy the Covered Person will need to submit a prescription drug request/claim form. However, in some cases the Covered Person may be able to obtain the prescription drug over the telephone (e.g. when obtaining refills). When purchasing prescription drugs from the Mail Order Pharmacy, the Covered Person will be required to pay the applicable Copayment and each prescription will be subject to a 90-day dispensing limit.

In addition, the Plan will cover certain over-the-counter drugs with a prescription. Please refer to the Prescription Drug Schedule of Benefits for additional information.

Prior Authorization
The Covered Person must obtain prior authorization for certain covered drugs. The Covered Person should contact the pharmacy benefits manager to determine which drugs require prior authorization. In order to obtain prior authorization, contact the pharmacy benefits manager at the phone number appearing on the identification card. The Covered Person will be asked to provide certain information to

assist in the determination of drug's Medical Necessity. Failure to obtain prior authorization for the covered drugs that require prior authorization will result in a loss of Coverage for such drugs.

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

Prescription Drug benefits are not provided for the following:

1. **Administration Charges.** The Plan will not cover charges for the administration or injection of any drug;

2. **Appetite Suppressants.** The Plan will not cover appetite suppressants, unless specified otherwise;

3. Blood Glucose Monitors. The Plan will not cover Blood Glucose Monitors under the prescription benefit;

4. Contraceptives. The Plan will not cover oral contraceptives, injectable contraceptives, implantable contraceptives such as Norplant, or contraceptive devices, unless deemed Medically Necessary;

5. **Cosmetic.** The Plan will not cover any prescription used for treatment only to improve appearance;

6. **Drugs without Prescriptions.** The Plan will not cover drugs that do not require a prescription by federal law, except where noted;

7. **Emergency Allergic Reactions Kits.** The Plan will cover Emergency Allergic Reaction Kits with a maximum of 2 kits per fill.

8. **Excess Prescription Refills.** The Plan will not cover any prescription refilled in excess of the number of times specified by the Physician;

9. **Fertility Medication.** The Plan will not cover fertility medication, unless specified otherwise;

10. **Growth Hormones.** The Plan will cover growth hormones, only when prior authorized;

11. **Immunization Agents and Blood Expenses.** The Plan will not cover immunization agents, bio Logical sera, blood or blood plasma;

12. **Impotence Medication.** The Plan will not cover impotency medication, unless specified otherwise;

13. **Inappropriate Charges.** The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed inappropriate or unnecessary by the AMA or is otherwise deemed inappropriate or unnecessary in accordance with accepted medical standards and practice;

14. **Inpatient Prescription Drugs.** The Plan will not cover any medication which is to be taken by or administered, in whole or in part, while the Covered Person is a patient in a Hospital, a convalescent Hospital, rest home, sanitarium, Skilled Nursing Facility, or nursing home or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

15. **Non-Covered Medical Condition.** The Plan will not cover any prescription drug services or charges for any condition not covered under the Medical Benefits;

16. **Non-Covered Medication.** The Plan will not cover any medication that is not specifically listed as a Covered Prescription Drug under this Summary Plan Description;

17. **Physician/Provider Administered Medication.** The Plan will not cover medication that is to be administered by a physician, nurse or anyone other than the patient in a normal home setting;

18. **Refills After One Year from Order.** The Plan will not cover any refill dispensed after one year from the Physician's original order;

19. **Smoking/Tobacco Cessation.** The Plan will not cover any prescription used for the treatment of smoking cessation, unless specified otherwise;

20. **Termination Date.** The Plan will not cover any prescription filled or refilled after termination of Coverage; and

21. **Therapeutic Devices.** The Plan will not cover therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, insulin syringes or needles when prescribed alone and syringes or needles for other than diabetic use.

The Plan Document and Summary Plan Description are hereby amended to reflect these changes. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:

Weldon, Williams and Lick, Inc.

Signed

4/10/12

Date

Weldon, Williams & Lick, Inc.
Group Hospital Plan & Section 125 Plan

Amendment No. 2
Effective Date: 01/01/2011

The *Weldon, Williams & Lick, Inc. Group Hospital Plan & Section 125 Plan* is hereby amended, as follows:

1). To add language to the Medical Benefits section of the Plan Document.

A.) ONCOLOGY PHARMACEUTICAL AND CLINICAL MANAGEMENT PROGRAM

This provision describes a special medical management program designed for certain aspects of care received by cancer patients who are beneficiaries under the Plan.

Your Plan has entered into an arrangement with Biologics, a company specializing in oncology management, to assist you and your oncologist during the course of cancer treatment when administered either in an outpatient setting (e.g., in the physician's office or other covered outpatient setting) or an inpatient setting. The program applies to the plan of treatment and the provision of other oncology pharmaceuticals to be used in connection with your cancer treatment.

In order to initiate these oncology management services, your oncologist should contact your Plan Administrator to verify Plan benefits. At that time, your oncologist will be asked to contact Biologics and to provide to your assigned Biologics' Oncology Nurse Specialist (ONS) a copy of the treatment plan that your oncologist has prescribed for you. Once the oncologist has contacted Biologics, your assigned ONS will contact you periodically to provide support, education, and answer any questions you might have about your disease and your treatment plan. Your assigned Oncology Nurse Specialist will remain in contact with you and your oncologist for the duration of your chemotherapy treatment plan. In addition, clinical oncology pharmacists will be available to you and your oncologist on a 24/7 basis by contacting 1.800.983.1590. You will be encouraged to call this number if you have questions regarding the cancer drugs being used to treat your cancer, related side effects and other quality of life issues.

If your oncologist determines that oral anti-cancer drugs and/or supportive medications should be taken in your home following the inpatient or outpatient chemotherapy, your oncologist should contact Biologics, and those drugs will be sent directly to your home address or another location if you prefer, in time to meet the medication schedule specified by your oncologist. A clinical oncology pharmacist will call you to discuss the medications and answer any questions you may have about the specific drugs you are taking at home.

Unless your oncologist has entered into an agreement with Biologics to accept other reimbursement rates, the payment for all drugs used in the treatment of cancer will be limited to the rate of Average Sales Price plus 10%. Average Sales Price is the price calculated by pharmaceutical manufacturers and submitted to the Centers for Medicare and Medicaid Services (CMS) on a quarterly basis.

In order to receive benefit payments under the Plan, your oncologist's chemotherapy plan of treatment must be received by Biologics and must not be deemed by the Plan Sponsor to be Experimental and/or Investigational, as defined in the Plan Documents. If any of the drugs prescribed by your oncologist requires specific pathology results or molecular marker results to validate their use, these results must be provided to Biologics prior to validation of your treatment regimen.

B. EXPERIMENTAL AND/OR INVESTIGATIONAL

The Plan may not pay for or otherwise cover the cost of drugs considered Experimental and/or Investigational.

In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where either (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology or (2) the drug is provided in association with a Phase II, III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or an NCI-sponsored group and standard treatment (i) has been or would be ineffective, (ii) does not exist, or (iii) there is no clearly superior non-investigational alternative that can be delivered more cost efficiently, each as determined by the Plan Sponsor.

2) To delete exclusion number 20 of the General Exclusions (page 35), and replace it as follows.

20. **Professional Medical Standards.** The Plan will not cover charges for services and supplies which are not provided in accordance with generally accepted professional medical standards or for experimental treatment except as provided herein;

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:

Weldon, Williams & Lick, Inc.

By: Tracy Green

Title: CFO

Date: 3/29/11

WELDON, WILLIAMS & LICK, INC.
GROUP HOSPITAL PLAN

Amendment No. 1
Effective January 1, 2011

The Weldon, Williams & Lick, Inc. Group Hospital Plan (the "Plan") is hereby amended as follows:

1. *To add the following new reference to the Article entitled "General Plan, ERISA and Plan Administration Information":*

Patient Protection and Affordable Care Act

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

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

Weldon, Williams and Lick, Inc.
711 North A Street
Ft. Smith, AR 72901
(479) 783-4113

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

2. *Delete the following reference to "Michelle's Law Notification"::*

Michelle's Law Notification
Michelle's Law Notification means the extension of coverage to full-time student Dependents at postsecondary educational institutions who experience a Medically Necessary Leave of Absence, for up to one year, if both of the following conditions are met:

1. The Plan receives written certification from the Dependent's treating Physician certifying that:
    a. The Dependent is suffering from a serious Illness or Injury; and
    b. The Leave of Absence from the postsecondary institution is a Medically Necessary Leave of Absence.

2. The loss of student status would cause a loss of health coverage under the terms of the Plan without the application of Michelle's Law.

The one-year period begins with the first day of the Medically Necessary Leave of Absence and may end before the year ends, if the Dependent's coverage under the Plan would terminate for any reason.

3. *To amend the following paragraph in the reference to "Eligible Dependents" as follows:*

- If you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the date the *dependent* becomes eligible, or the event date, provided you make written application for the *dependent* and agree to make any required contributions, within 31 days of the date of eligibility.

4. *To add the following new language in the section entitled "Applying For Coverage and Effective Dates":*

Special Enrollment for Previously Enrolled *Covered Persons*

Dependents who had ceased to be eligible to enroll in the *Plan* prior to the passage of the Patient Protection and Affordable Care Act shall be provided with a 30 day special enrollment opportunity. This special enrollment opportunity will begin December 1, 2010. All *dependents* whose coverage under this *Plan* had previously ended, or who were denied coverage (or were not eligible for coverage) because the availability of *dependent* coverage of *children* ended before age 26, are eligible to enroll, or re-enroll in the *Plan* or coverage under this special enrollment period. Coverage for *dependents* who enroll through this special enrollment opportunity must take effect no later than January 1, 2011.

Covered persons who were previously enrolled, but were terminated from *Plan* participation because of a prior lifetime limitation provision shall be provided with a 30 day special enrollment opportunity. This special enrollment opportunity will begin December 1, 2010. All *covered persons* whose coverage under this *Plan* had previously ended, or who were denied coverage (or were not eligible for coverage) because the prior lifetime limitation had been reached, are eligible to enroll, or

re-enroll in the *Plan* or coverage under this special enrollment period. Coverage for *covered persons* who enroll through this special enrollment opportunity must take effect no later than January 1, 2011.

5. *To remove all references to "Lifetime Maximum Benefits" from the Plan.*

6. *To add the following language to the section on "Pre-existing Condition Waiting Period"*

The pre-existing condition limitation does not apply to any covered person who has not yet reached age 19.

7. *To replace the reference to "Eligible Dependents" with the following language:*

If you are eligible for coverage, you may also cover your eligible dependents under the Plan. Eligible dependents include:

1. The Spouse (refer to Definitions section) of the Covered Employee;
2. Your child(ren) up to age 26 who are not eligible to enroll in another employer-sponsored health plan.
    a. Children are your natural or lawfully adopted children (including children placed for adoption), stepchildren and persons for whom you are the legal guardian.
    b. Children are eligible if they are covered under the terms of a court decree (a QMCSO).
    c. Your children who are unable to support themselves because of a permanent mental or physical handicap and are dependent on you for support and maintenance, and are considered dependents for income tax purposes. These children must have been covered by this Plan prior to reaching the age 26. You must provide proof of the child's disability to the claims administrator within 31 days after his or her coverage would otherwise end. Thereafter, you must provide proof of the disability once per year.

Persons not meeting the above criteria are not eligible for coverage. For example - parents, grandparents, and adult siblings.

The Plan Administrator has the right to request information needed to determine the patient's eligibility when a claim is filed. In addition, the Plan Administrator has the right to request that the Covered Employee provide proof of the continuance of the incapacity and dependence of any Dependent Child to determine his or her availability of other employer-sponsored health plan coverage.

8. *To add the following new definitions to the Plan:*

"Essential health benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; *emergency*

services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (i), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Emergency services" means, with respect to an *emergency medical condition*:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a *hospital*, including ancillary services routinely available to the emergency department to evaluate such *emergency medical condition*; and

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the *hospital*, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

9. *To delete the following definition from the Plan:*

"***Michelle's Law***" means H.R. 2851.

10. *Update medical claims administrator to: HealthSCOPE Benefits*

P. O. Box 99006
Lubbock, TX 79490-9006
www.healthscopebenefits.com

11. To amend the Deductible section of the Medical Plan Schedule of Benefits to read as follows:

GENERAL INFORMATION		
Deductible	Individual: $450 Family: $900	Individual: $450 Family: $900
	Eligible Expenses applied toward the In-Network Deductible are also applied toward the Out-of-Network Deductible, and vice versa.	

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:

Weldon, Williams & Lick

By: Mary Gere

Title: CEO

Date: 6/18/11

Summary Plan Description

for

WELDON, WILLIAMS & LICK, INC.

Group Hospital Plan and Section 125 Plan

Revision and Restatement Date: January 1, 2010

TABLE OF CONTENTS

ADOPTION AGREEMENT

The Weldon, Williams and Lick, Inc. Group Medical Plan and Section 125 Plan (the "Plan") is established and continued in this document, adopted effective as of January 1, 2010, by Weldon, Williams and Lick, Inc. (the "Employer"). The Plan includes the Medical Plan and the Section 125 Plan, both of which are described in this document ("Summary Plan Description"). The Employer has duly authorized the adoption of this document and the execution thereof.

The benefits provided under this Plan and the general terms and conditions governing the same are contained in this Summary Plan Description, a copy of which is provided to participants in the Plan, and may also be governed by the provisions of certain insurance contracts purchased on behalf of the Plan. The Summary Plan Description, Plan Document and all such insurance contracts, if any, as the same may be amended from time to time, are hereby incorporated herein by this reference and made a part of this Plan.

This Summary Plan Description contains a summary in English of the Covered Person's rights and benefits under the Plan. If the Covered Person has difficulty understanding any part of this Summary Plan Description because (s)he requires assistance in understanding English, contact the Plan Administrator at:

711 North Street
Ft. Smith, AR 72901
(479)783-4113.

By affixing his signature and date to this document, the Plan Sponsor does hereby certify that the Plan Sponsor has reviewed the Summary Plan Description and that it represents the terms and conditions of the Plan adopted by the Plan Sponsor.

Mary S. Green

Authorized Signature of Health Plan

7/2/10

Date

PART 1

MEDICAL PLAN

SCHEDULES OF BENEFITS FOR MEDICAL PLAN

SCHEDULE OF BENEFITS MEDICAL BENEFITS		
Note: The Covered Person is entitled to Medical Benefits only if (s)he has made application for such benefits and been enrolled for Coverage by the Plan Administrator under the Plan.		
COVERED SERVICE/PLAN CATEGORY	**IN-NETWORK**	**OUT-OF-NETWORK**
GENERAL INFORMATION		
Deductible	Individual: $400 Family: $800	Individual: $400 Family; $800
	Eligible Expenses applied toward the In-Network Deductible are also applied toward the Out-of-Network Deductible, and vice versa.	
Coinsurance	Plan will pay 80% of Provider's Allowable Charge* *Except as specified	Plan will pay 60% of Provider's Allowable Charge* *Except as specified
Out-of-Pocket Limit (Only Includes the Coinsurance Expense)	Individual: $3,000 Family: $6,000	Individual: No Maximum Family: No Maximum
Maximum Benefits	All Maximum Benefits, aside from the Lifetime Maximum Benefit, are set forth in the Schedule of Benefits.	
Restoration of Benefits	$50,000	
Lifetime Maximum Benefit	$1,000,000 per Covered Person	
COVERED SERVICES		
This listing of Covered Services appears in alphabetical order to better assist the Covered Person in locating the different benefit allowances for the specific Covered Services.		
Allergy Testing	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Allergy Treatment & Serum	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Ambulance Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 80%
	Note: $500 Calendar Year Maximum Benefit for ground ambulance services.	
Ambulatory Surgical Facility Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Anesthesia Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Cardiac Rehabilitation Therapy (Phases I, II & III)	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Chemotherapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Dental Services* **Accidental Injury Only*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Diagnostic Tests	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Durable Medical Equipment	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Note: $4,000 Calendar Year Maximum Benefit	

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK	OUT-OF-NETWORK
Emergency Care in Emergency Department of Hospital	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Home Health Care Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 80%
Hospital Services During Inpatient Confinement	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Infertility Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Maternity Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Medical and Surgical Supplies	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Mental and Nervous Care/Serious Mental Illness	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Newborn Infant Care Routine Nursery Care for Well Newborn	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Note: Routine nursery charges are considered part of mother's Hospital charges.	
Care for Premature Infant	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Note: Expenses incurred for a premature newborn baby during the baby's first year of life will be the same as any other condition provided the mother has received 6 pre-natal visits or, pursuant to medical records, the mother has completed scheduled pre-natal visits and additional visits are planned at the time of premature delivery, with the 1st one having been obtained during the mother's 1st trimester, or within the 1st 3 months after a positive test is obtained. The mother must be able to document that the pre-natal visits and examinations occurred. The infant's expenses will be subject to a $25,000 maximum benefit during the 1st year of the infant's life if the mother: 1. Has not satisfied this pre-natal visit requirement; 2. Uses illegal drugs during the pre-natal period; or 3. Does not, in other manner, follow her physician's recommended medical advice.	
Occupational Therapy Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Patient Education Program Diabetic Education	Plan pays 100%, no Deductible **Diabetic education is mandatory for all diabetics in the "Diabetes Self-Management Outpatient Program at Sparks Hospital."*	Not Covered
Ostomy Education	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Other Patient Education	Not Covered	Not Covered
Physical Therapy Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK	OUT-OF-NETWORK
Physician Office Visits for Non-Routine Care	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Physician Visits During Inpatient Hospital Confinement	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Podiatry Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Pre-admission Testing Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Preventive Care for All Covered Persons	Plan pays 100% of 1st $300; thereafter, Plan pays 80% after Deductible	After Deductible, Plan pays 60%
	Preventive care includes: cancer screenings, mammograms, physical exams, gynecological exams, dexa scans, and immunizations (for Dependent Children under the age of 18 months).	
Private Duty Nursing Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Note: $4,000 Calendar Year Maximum Benefit	
Prosthetic Appliances	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Radiation Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Respiratory Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Second & Third Surgical Opinion	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Note: If second opinion is required by the assigned Case Manager or medical management company, Plan pays 100%. Refer to the Employer for additional details.	
Skilled Nursing Facility	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Note: After each period of 30 days, an updated Medical Necessity Review must be performed by the medical management company.	
Specialty Drugs	After Deductible, Plan pays 80%	
Speech Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Note: $500 Calendar Year Maximum Benefit	
Sterilization	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Substance Abuse Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Note: $3,000 Maximum Benefit per Inpatient admissions; limited to 2 admissions per lifetime	
Supplemental Accident Services	Plan pays 100% up to 1st $300 per accident; thereafter, Plan pays 80% after Deductible	Plan pays 100% up to 1st $300 of accident; thereafter, Plan pays 60% after Deductible
	Note: 1. Services must be incurred within 90 days of accident. Initial treatment must be begin within 7 days; and 2. $5,000 Maximum Benefit per accident for injuries related to alcohol or drugs.	
Surgical Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
TMJ Treatment	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Note: $2,500 Calendar Year Maximum Benefit	

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK	OUT-OF-NETWORK
Transplant Services	Plan pays 100%	Plan pays 100% *See limitations below.*
	For Out-of-Network transplant services: 1. $10,000 Maximum Benefit per Transplant Period for lodging and transportation; 2. $10,000 Maximum Benefit per Transplant Period for donor expenses when the donor is not covered by the Plan; 3. $20,000 Maximum Benefit for Physician services per Transplant Period; 4. $110,000 Maximum Benefit for heart transplants, including Physician services; 5. $155,000 Maximum Benefit for lung transplants, including Physician services; 6. $130,000 Maximum Benefit for bone marrow transplants, including Physician services; 7. $130,000 Maximum Benefit for liver transplants, including Physician services; 8. $150,000 Maximum Benefit for heart/lung transplants, including Physician services; 9. $70,000 Maximum Benefit for pancreas transplants, including Physician services; 10. $55,000 Maximum Benefit for kidney transplant, including Physician services; and 11. $95,000 Maximum Benefit for kidney/pancreas transplant, including Physician services.	
Urgent Care Services in Urgent Care Facility	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Vision Exams* **Eye exams for diabetes and eye diseases only*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%

PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
Note: The Covered Person is entitled to Prescription Drug Benefits only if (s)he has made application for such benefits and been enrolled for Coverage by the Plan Administrator under the Plan.		
	Retail Pharmacy 30 Day Supply	**Mail Order Pharmacy 90 Day Supply**
$4 Generic Drugs at Walmart	$0 Copayment	N/A
Generic Drug at Walmart	$2 Copayment	N/A
Generic Drug at Any Other Pharmacy	$7 Copayment	$14 Copayment
Preferred Brand Name Drug	$25 Copayment	$50 Copayment
Non-Preferred Brand Name Drug	$50 Copayment	$100 Copayment
Calendar Year Maximum Benefit	$12,000	
Over-the-Counter Drugs (Alavert, Alavert D, Claritin, Claritin D, Prevacid 24-Hour, Prilosec, Zegerid, Zyrtec, and Zyrtec D)	Plan will pay 100%* **Prescription required* *Note: All Proton Pump Inhibitors (PPI), including Nexium, are not covered without prior authorization.*	
Diabetic Supplies *Including needles, syringes, lancets, test strips and machines, such as Glucometer or insulin pump, as well as any other supplies associated with diabetes*	$14 Copayment for 90 Day Supply* **In order to obtain diabetic supplies, it is **mandatory** for members to be enrolled in the Diabetic Sense Program through CatalystRx. Diabetic supplies may not be obtained outside of this mandatory program.* *Contact CatalystRx or visit www.catalystrx.com for additional information.*	
Note: Drug quantity limits will be in place for certain prescriptions, including but not limited to: migraines, sleep aids, pain management, sexual dysfunction drugs, etc. based on FDA and manufacturer dosing recommendations.		

PRE-CERTIFICATION PROVISIONS AND CASE MANAGEMENT

Under the Plan, there are a number of certification requirements in connection with certain services. The purpose of these requirements is to assist the Plan in determining the Medical Necessity of the services or procedures and the appropriateness of the planned course of treatment (e.g., appropriate length of stay or the appropriate number of visits or treatments). Compliance with the certification requirements is not a guarantee of benefit payment.

Under the Plan, a medical management company will conduct and manage the certification process. This means that the Covered Person should contact the medical management company at the telephone number appearing on the identification card to facilitate this process. In each instance, the Covered Person may satisfy this requirement by having the Hospital, Physician or a family member contact the medical management company to provide the required pre-certification or notification.

This section also describes the case management program under the Plan.

PRE-CERTIFICATION REQUIREMENTS FOR SCHEDULED ADMISSION

Pre-certification is required for the following services, supplies or procedures:

1. All scheduled Inpatient Hospital admissions;
2. Skilled Nursing Facility (after each 30-day period of treatment)/rehabilitation facility admissions; and
3. All non-scheduled Hospital admissions.

In order to obtain pre-certification, the medical management company should be notified of the admission at least 72 hours prior to the admission date or other applicable date of service (e.g. date procedure performed). Failure to comply the pre-certification requirements will result in a $500 penalty. This penalty will be applied prior to any applicable Copayment, Deductible or Coinsurance. If services are not Medically Necessary, no benefits are payable at all.

If a Covered Person is admitted to a Hospital for a non-scheduled admission, notice of the admission must be provided to the medical management company no later than 48 hours after the admission. The admission will be reviewed within 1 working day of the date the notification of the admission has been provided. The review will be performed with the Covered Person's Physician to determine if a continued Hospital stay is medically necessary. Failure to provide notice of a Covered Person's non-scheduled admission will result in a $500 reduction in the payment for Eligible Expenses.

A non-scheduled admission is an emergency or unplanned admission to a Hospital. Non-scheduled admissions frequently occur through the emergency department of a Hospital.

Special Note About Confinements for Maternity Services: Pre-certification of Hospital admissions for an obstetrical delivery is not required for any Hospital Confinement for such services unless the Confinement exceeds 48 hours for a routine vaginal delivery and 96 hours for a cesarean section delivery.

PRE-CERTIFICATION FOR TRANSPLANT PROCEDURES

Pre-certification is also required for all Inpatient and Outpatient Services related to a Transplant Services for a heart, heart/lung, lung, liver, bone marrow, kidney/pancreas, kidney or pancreas transplant. Under this provision, all Inpatient and Outpatient Services related to Transplant Services must be pre-certified no later than 10 days after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant. The attending Physician should contact the Plan Administrator for referral to the medical management company for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this Plan's medical review and must include such information as diagnosis, the nature of the transplant, the setting of the procedure (i.e. name and address of the Hospital), any secondary medical complications, a five year prognosis, 2 qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. Additional attending Physician's statements may also be required. The Covered Person may provide a comprehensive treatment plan independent of the PPO Network, but this will be subject to review by the medical management company, and may result in Out-of-Network benefit Coverage. Failure to obtain pre-certification for a Transplant Procedure, will result in an additional $5,000 Deductible.

CONTINUED STAY REVIEW AND DISCHARGE PLANNING

During a Covered Person's Hospital stay, a continued stay review will be conducted. This review applies to all Hospital admissions. The purpose of continued stay review is to re-evaluate the Medical Necessity of a continued Hospital stay. It may be necessary to obtain additional information concerning the Covered Person's Hospital stay in order to conduct a continued stay review. During this process and prior to the Covered Person being discharged, the medical management company will also review the Covered Person's progress for purposes of discharge planning. The purpose of discharge planning is to identify patients requiring extended care following discharge and to determine the most appropriate setting for continued care.

TRANSPLANT MANAGEMENT

Although a Covered Person is free to choose the Hospital that will perform a covered transplant procedure, the Plan will pay a higher benefit when the Covered Person uses a Hospital that is a "Center of Excellence" to receive Transplant Services. This higher benefit level, which is set forth in the Schedule of Benefits, applies to all Eligible Expenses received in connection with the covered transplant procedure when a Center of Excellence performs the actual transplant surgery. To determine which Hospitals are considered a Center of Excellence, the Covered Person or the Covered Person's Physician should contact the medical management company as soon as the Covered Person becomes a candidate for a transplant procedure. The medical management company will be able to direct the Covered Person or the Covered Person's Physician to a list of Hospitals that qualify as a Center of Excellence.

If the transplant is performed Out-of-Network, but the Covered Person has received approval from the medical management company for Out-of-Network services, then In-Network benefits will apply to the transplant and related expenses. If services are provided Out-of-Network without approval from the medical management company, then Out-of-Network benefits will apply.

CASE MANAGEMENT

Case management is a voluntary program and it is designed to inform patients of more cost effective settings for treatment. Case management typically applies when an individual has a chronic or ongoing condition, or a catastrophic condition, that is expected to result in significant claim costs for the Plan. In this event, on an exception basis, benefits may be provided for settings and/or procedures not expressly covered under the Plan if the setting and/or procedure will assist the Plan Sponsor in managing the Plan's medical costs. All requests for case management will be individually reviewed by the Plan.

If a Covered Person requests an alternative setting or procedure under case management, the Plan Sponsor has the right to deny Coverage for such setting or procedure and to apply benefits pursuant to the terms of the Plan, exclusive of this provision.

MEDICAL BENEFITS

This section describes the Covered Person's Medical Benefits. All payments will be subject to any applicable Copayments, Deductible, Coinsurance, Maximum Benefits and other provisions and limitations in this Summary Plan Description.

PREFERRED PROVIDER (PPO) ARRANGEMENT

Covered Services Rendered by Preferred Provider

The Plan offers a broad network of providers within the network(s) selected by the Plan Sponsor. Preferred Providers are those who/that are contracted with the network(s) indicated on the identification card. For all Covered Services (other than Outpatient dialysis related services and products), Preferred Providers must accept a reduced rate ("Negotiated Rate") as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate[1]. The Covered Person may obtain a directory of Preferred Providers by accessing the PPO Network's website. If, for some reason, the Covered Person is unable to obtain information concerning the Network's Preferred Providers via the website, (s)he may obtain information about the Preferred Providers by contacting the Plan Administrator.

Covered Services Rendered by a Non-Preferred Provider

Payment for Covered Services (other than Outpatient dialysis related services and products) rendered by a Non-Preferred Provider will be based on the Provider's Reasonable and Customary Charge. The Non-Preferred Provider may bill for charges in excess of such charge. Covered Services provided by Non-Preferred Providers will generally be covered at a lower benefit level than services received from a Preferred Provider, except for the exceptions listed below:

1. Hospital services received in the emergency department of an Out-of-Network Hospital;
2. Professional services rendered by a Physician in the emergency department of an In-Network Hospital;
3. Professional reading of a Radiologist, if the X-ray was performed in an In-Network facility;
4. Professional reading of a Pathologist, if the laboratory test was performed in an In-Network facility or Laboratory;
5. Anesthesia services by an Anesthesiologist, if the surgery was performed in an In-Network facility;
6. Services rendered by a Non-Preferred Provider to a Covered Person, including a Dependent Child, who lives outside of the PPO Network Service Area (e.g. Dependent Child who is a full-time student and lives outside the PPO Network Service Area or a Dependent Child of divorced parents living outside the PPO area);
7. Services rendered by a Non-Preferred Provider to a Covered Person who is traveling outside of the PPO Network Service Area; and
8. Services rendered by a Non-Preferred Provider to a Covered Person, including a Dependent Child, because the Covered Person does not have access to a Preferred Provider.

Outpatient Dialysis Covered Services

With respect to covered dialysis-related services and products provided on an Outpatient basis ("Outpatient Dialysis"), the Plan applies an alternative basis of payment in connection with Outpatient Dialysis claims.

[1] Note: When this Plan is secondary, however, payment will be based on the primary plan's PPO negotiated rate. Refer to the section entitled "Coordination of Benefits, Subrogation and Third Party Recovery."

This alternative basis may be applied to claims by any Provider, regardless of the Provider's participation in a network. This alternative basis is based on the Outpatient Dialysis Usual and Reasonable Charge, as defined herein. The Plan shall pay no more than the Outpatient Dialysis Usual and Reasonable Charge, after deduction of all amounts subject to Deductible, Coinsurance, or applicable Copayments. Refer to the benefit description of Kidney Dialysis for further details.

COVERED SERVICES

The following is a list of those Covered Services under the Plan. The list of services appears in alphabetical order.

Allergy Treatment and Tests

The Plan will cover allergy injections and allergy testing when such services are performed by a Physician. This benefit also includes Coverage for the serum used in connection with allergy injections.

Ambulance Service

The Plan will cover air and ground ambulance service transportation by a vehicle designed, equipped and used only to transport the sick and injured.

Surface trips must be to the closest local facility that is able to render Covered Services appropriate for the Covered Person's condition. If there is no local facility able to render Covered Services appropriate for the Covered Person's condition, the Covered Person is covered for trips to the closest such facility outside his or her local area.

Air transportation is only covered when ground transportation cannot be utilized due to terrain, distance or severity of the Covered Person's condition.

Ambulatory Surgical Facility Services

The Plan will cover services rendered and billed by an Ambulatory Surgical Facility in connection with the performance of a covered surgical procedure performed in such facility.

Anesthesia Services

The Plan will cover the administration of anesthesia by a Physician or Other Medical Professional who is not the surgeon or assistant at surgery.

Birthing Care Center Services

The Plan will cover the following services in connection with normal pregnancy, complications of a pregnancy or miscarriage when such services are provided to a Covered Person and rendered and billed by a Birthing Care Center:

1. Operating and delivery room and equipment used therein;
2. Prescribed drugs;
3. Anesthesia, anesthesia supplies and services of an anesthesiologist;
4. Medical and surgical dressings, and supplies; and
5. Blood, blood transfusions and other blood-related services.

Cardiac Rehabilitation Therapy

The Plan will cover Cardiac Rehabilitation Therapy in connection with the rehabilitation of a Covered Person following a myocardial infarction or coronary occlusion or coronary bypass surgery when such rehabilitation services are rendered under the supervision of a Physician. Therapy must be initiated within 12 weeks after the initial treatment for the medical condition ends and must be rendered in a facility covered by the Plan.

Chemotherapy

The Plan will cover chemotherapy treatment rendered by a Physician or Other Medical Professional.

Dental Services

The Plan will cover the following dental services when rendered and billed by a Physician or Other Medical Professional for emergency treatment due to Injury to sound natural teeth provided such treatment is performed within 7 days of the onset of the Injury and treatment ends within 3 months of the Injury.

Diagnostic Services

The Plan will cover Outpatient diagnostic services when the Covered Person has specific symptoms and such tests and procedures are needed to detect and diagnose an Illness or Injury. Specific services covered under this benefit include:

1. Laboratory examinations;
2. X-rays;
3. EKGs;
4. EEGs; and
5. MRIs, MRAs, and CAT Scans.

Durable Medical Equipment

The Plan will cover the rental (or, if the charges would be less than the rental cost, the purchase), repair and routine maintenance of durable medical equipment prescribed by a Physician. Rental costs must not be more than the purchase price. The durable medical equipment must serve only a medical purpose and be able to withstand repeated use. Replacement of durable medical equipment will be covered if it is necessary due to the growth and development of the Covered Person.

The Plan will also cover orthotic devices under the durable medical equipment benefit. This includes palliative treatments, such as but not limited to, heel lifts, arch supports, and foot pads. Under the Plan, orthotic devices are rigid or semi-rigid supportive devices which limit or stop motion of a weak or diseased body part. In addition, orthotic devices include orthopedic shoes or corrective shoes provided such shoes are an integral part of a leg brace, and other supportive devices.

Emergency Room Services

The Plan will cover treatment of an Illness or Injury when such services are rendered in the emergency department of a Hospital. Covered Services include those Medically Necessary services and supplies provided by the Hospital following the Covered Person's admission to the emergency department for an Illness or Injury and include the services provided by the emergency room Physician and the Hospital's other emergency room staff (e.g. emergency room nursing staff, technicians, etc.).

Home Health Care Services

The Plan will cover home health care services rendered by a Home Health Care Agency when such services are provided to a Covered Person on a part-time basis in the Covered Person's home as a Medically Necessary alternative to Inpatient care. Covered Services include the following:

1. Continual skilled nursing services;
2. Medical social services;
3. Nutritional guidance;
4. Home health aide services;
5. Home infusion;
6. Laboratory services;
7. Diagnostic services; and
8. Therapy services.

Hospital Services During an Inpatient Confinement

The Plan will cover certain Hospital services when the Covered Person is hospitalized as an Inpatient in a Hospital. The following room and board expenses and ancillary services are considered covered Inpatient Hospital services:

1. **Room and Board**. Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services, unless the private duty nursing services are determined to be of such nature or degree of complexity that the Hospital's regular nursing staff cannot perform them. Refer to the private duty nursing services benefit for details. The Plan will cover charges in connection with private rooms at the semi-private room rate.

2. **Ancillary Services**. Ancillary Services received during a Hospital Confinement include, but are not limited to:

    a. Operating room and equipment;
    b. Delivery room and equipment;
    c. Other treatment rooms and equipment;
    d. Prescribed drugs;
    e. Anesthesia, anesthesia supplies and services provided by an employee of the Hospital;
    f. Medical and surgical dressings, supplies, casts and splints;
    g. Blood, blood transfusions and other blood-related services;
    h. Diagnostic Services;
    i. Radiation therapy;
    j. Intravenous chemotherapy;
    k. Kidney dialysis;
    l. Inhalation therapy;
    m. Physical therapy;
    n. Occupational therapy; and
    o. Speech therapy.

Kidney Dialysis

The Plan will cover Outpatient Dialysis treatment when such services are rendered and billed by a Preferred or Non-Preferred Provider. All Covered Persons receiving Outpatient Dialysis treatment will be subject to the Plan's case management provisions, negotiations and other Plan services which the Plan Sponsor may elect to apply in the exercise of its discretion.

Payment for Outpatient Dialysis Treatment will be based on the Outpatient Dialysis Usual and Reasonable Charge, as defined herein. The Plan shall pay no more than the Outpatient Dialysis Usual and Reasonable Charge in connection with Outpatient Dialysis claims, after deduction of all amounts subject to Deductible, Coinsurance, or applicable Copayments.

Maternity Coverage

The Plan will cover services in connection with a normal pregnancy, complications of a pregnancy or miscarriage for the Covered Employee or Covered Spouse when such services are rendered by a Physician or Physician Assistant. Coverage will be provided for office visits in connection with pre-natal and post-natal care and treatment of the mother, including but not limited to routine examination of the mother and the infant, weight checks, blood pressure checks and routine ultrasounds. Pre and post-natal office visits will be covered as part of the overall obstetrical bill.

The Plan will also cover services rendered by a Hospital or Birthing Care Center in connection with a pregnancy, complications thereof or a miscarriage. The Plan may not restrict benefits for any length of stay in connection with childbirth for the mother or newborn Dependent Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Provider (e.g. the Covered Person's Physician or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, the Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not require that a Physician or other Provider obtain authorization for prescribing a length of stay unless the length of stay will exceed 48 hours for a vaginal delivery or 96 hours for a cesarean section.

Medical and Surgical Supplies

The Plan will cover medical and surgical supplies that serve a specific medical purpose and are purchased by the Covered Person for use in the home. Covered medical and surgical supplies include, but are not limited to, the following:

1. Syringes and needles;
2. Oxygen;
3. Surgical dressings;
4. Casts and splints;
5. Braces;
6. Catheters;
7. Colostomy and ileostomy bags and supplies required for their use; and
8. Soft lenses and sclera shells intended for use in the treatment of an Illness or Injury of the eye.

Covered Services do not include items usually stocked in the home for general use like adhesive bandages, thermometers and petroleum jelly.

Mental and Nervous Care/ Serious Illness

The Plan will cover services for the treatment of a psychiatric condition while the individual is being treated as an Inpatient (including during a Partial Hospitalization) or Outpatient. A psychiatric condition will be treated the same as any other Illness for purposes of determining available Covered Services. In addition, the following additional services are covered:

1. Individual and group psychotherapy;
2. Behavioral and learning disorders, including Attention Deficit Disorder (ADD);and
3. Convulsive therapy - Convulsive therapy treatment is limited to Inpatient care. It includes electroshock treatment or convulsive drug therapy.

Psychiatric services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, or Community Mental Health Facility.

Morbid Obesity

Medically Necessary Charges for treatment of obesity are excluded, unless the Covered Person has been diagnosed by a Plan approved Physician as having Morbid Obesity.

Surgical Treatment - If surgical intervention of Morbid Obesity is recommended by a Plan approved Physician (via an approved Center of Excellence), the Plan will cover the surgical procedure, if the Covered Person has been covered under the Plan for a period 12 consecutive months.

For surgical intervention of Morbid Obesity that result from such surgery, the Coinsurance for services rendered by the Plan approved Physician will be 80% and will be subject to the Covered Person's current calendar year Deductible as set forth in the Plan's Summary Plan Description. The Covered Person will pay the remaining 20% of Eligible Expenses, up to the Covered Person's calendar year In-Network Out-of-Pocket maximum.

The Plan will only consider the following surgeries:

1. Gastric Bypass
2. Lap-Band

There is a separate Lifetime Maximum Limit of $50,000.00 for surgical intervention of Morbid Obesity and the treatment of complications related to such surgery, and is limited to one Morbid Obesity related surgery per lifetime. The Coinsurance for the surgical intervention of Morbid Obesity and any complications in connection therewith will apply to the Covered Person's calendar year In-Network Out-of-Pocket maximum.

The plan will not consider:

1. Charges related to additional procedures which may be needed as a result of physical changes associated with the subsequent weight-loss, including (but not limited to), panniculectomy, abdominoplasty, thighplasty, brachiplasty, and mastopexy are not covered, unless deemed medically necessary;
2. Non-surgical treatments such as a Physician-supervised diet and/or exercise programs, and;
3. Reversal on gastric bypass (Duodenal-Switch surgery) and lap-band procedures.

Newborn Care

1. **Routine Nursery Care**: The Plan will cover the routine nursery care of the newborn infant and the first Inpatient visit to examine the infant. The nursery charges of the newborn infant will be considered as part of the mother's hospital charges associated with the delivery of the newborn. When the mother is discharged from the Hospital, continued Coverage for the infant will only be provided if the infant has been enrolled for Coverage under the Plan pursuant to the enrollment requirements described in this Summary Plan Description.

2. **Pre-natal Care**: Expenses incurred for a premature newborn baby during the baby's first year of life will be the same as any other condition provided the mother has received 6 pre-natal visits or, pursuant to medical records, the mother has completed scheduled pre-natal visits and additional visits are planned at the time of premature delivery, with the 1st one having been obtained during the mother's 1st trimester, or within the 1st 3 months after a positive test is obtained. The mother must be able to document that the pre-natal visits and examinations occurred. The infant's expenses will be subject to a $25,000 maximum benefit during the 1st year of the infant's life if the mother:

    a. Has not satisfied this pre-natal visit requirement;
    b. Used illegal drugs during the pre-natal period; or
    c. Did not, in other manner, follow her physician's recommended medical advice.

Occupational Therapy Services

The Plan will cover occupational therapy when rendered and billed by a Physician, Occupational Therapist or Physical Therapist. As used herein, occupational therapy means treatment rendered on an Inpatient or Outpatient basis as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, maintenance, and vocational therapies (such as hobbies, arts and crafts).

Patient Education Programs

The Plan will cover patient education programs for:

1. Diabetic education programs (home blood sugar management, diabetes management, meal planning, insulin preparation and injection counseling). Diabetic education is mandatory for all diabetics in the Diabetes Self-Management Outpatient Program at Sparks Hospital; and
2. Ostomy care (care of the ostomy bag and the skin).

No other patient education programs are covered.

Physical Therapy Services

The Plan will cover physical therapy when rendered by a Physician or Physical Therapist in a covered Outpatient setting. As used herein, physical therapy means treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Physical Therapist are required.

Physician's Office Visit for Non-Routine Care

The Plan will cover charges incurred during a visit to the Covered Person's Physician for non-routine care in connection with a specific Injury or Illness. Covered Services include screening examinations, evaluation procedures, medical care, treatment or services directly related to assist in the diagnosis or treatment of a specific Injury or Illness which is known or reasonably suspected.

Physician Services During Inpatient Hospital Confinement

The Plan will cover Physician visits and certain other consultation services for a Covered Person who is hospitalized as an Inpatient in a Hospital. Services under this benefit include services such as Physician visits from the treating Physician and Physician consultations with other Physicians. Staff consultations required by Hospital rules are excluded from Coverage.

Podiatry Services

The Plan will cover podiatry services rendered by a Podiatrist or a Physician. Covered Services include capsular or bone surgery for treatment of bunions, or complete or partial removal of the nail or nail matrix affected by disease, infection or fungus.

Pre-admission Testing Services

The Plan will cover diagnostic services in connection with a scheduled surgical procedure.

Preventive Care

The Plan will cover preventive care for the Covered Employee, Covered Spouse and Covered Dependent Child. Coverage will include charges for routine periodic examinations, screening examinations, medical assessments, and preventive medical treatment not directly related to a specific Injury, Illness or pregnancy-related condition that is known or reasonably suspected. Specific services covered under this benefit include:

1. Routine physical examinations;
2. Routine gynecological exams;
3. Routine pap smear screenings;
4. Routine PSA screenings;
5. Routine colo-rectal screenings;
6. Routine mammogram screenings;
7. Dexa scan screenings;
8. Diagnostic laboratory examinations; and
9. Immunizations, for Dependent Children under the age of 18 months.

Private Duty Nursing Services

The Plan will cover the services of a Registered Nurse, Licensed Vocational Nurse or Licensed Practical Nurse when ordered by a Physician. These services include skilled nursing services received in a patient's home. The Physician must certify all services initially and continue to certify that the Covered Person is receiving skilled care and not custodial care.

Covered Services do not include care which is primarily non-medical or custodial in nature such as bathing, exercising or feeding. Also, the Plan will not cover services provided by a nurse who usually lives in the Covered Person's home or is a Family Member.

Prosthetic Appliances

The Plan will cover the purchase, fitting, needed adjustment, repairs, and replacements of prosthetic appliances and supplies that replace all or part of a missing body part and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body organ. Covered prosthetic appliances include prostheses in connection with breast reconstruction following a covered mastectomy procedure.

Radiation Therapy

The Plan will cover the treatment of disease by x-ray, radium or radioactive isotopes.

Reconstructive Surgery

The Plan will cover reconstructive surgery to restore bodily functions or correct deformity. Such surgical procedure will be treated the same as any other surgical procedure. Coverage is limited to problems caused by disease, Injury, birth or growth defects, or previous treatments.

In addition, Coverage will be provided for the following services in connection with a mastectomy:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Respiratory Therapy

The Plan will cover respiratory therapy when such services are rendered and billed by a Physician or Other Medical Professional who is qualified and licensed to render such services. Respiratory therapy is a type of therapy that involves the introduction of oxygen and other dry or moist gases into the lungs in order to maintain the breathing capacity of individuals with impaired lung function.

Second and Third Surgical Opinion

When the Covered Person's Physician recommends that a surgical procedure be performed, the Plan will cover a consultation with a Physician in order to obtain a second option in connection with the recommended surgery. The Physician providing the second opinion must be a Physician who is qualified to perform the surgery that has been recommended by the first Physician and cannot be a Physician whose practice is associated with the first Physician. Charges incurred for a second surgical opinion must be billed as a second surgical opinion. Otherwise, the consultation with the Physician will be treated the same as any other Physician consultation in connection with an Illness. If the second opinion differs from the first opinion obtained, the Plan will cover a consultation with a third Physician.

Skilled Nursing Facility Services

The Plan will cover a Confinement in a Skilled Nursing Facility. The condition being treated in the Skilled Nursing Facility must be the same as that which was being treated during the previous Hospital Confinement. The following services will be covered during the Skilled Nursing Facility Confinement:

1. **Room and Board.** Room and board in a semi-private room, including meals, special diets and nursing services. Coverage includes a bed in a special care unit approved by the Plan.

2. **Ancillary Services.** Ancillary services received during a Confinement include, but are not limited to:
   a. Treatment rooms and equipment used therein;
   b. Prescribed drugs;
   c. Medical and surgical dressings, supplies, casts and splints;
   d. Diagnostic services; and
   e. Certain therapy services such as inhalation therapy, physical therapy, occupational therapy and speech therapy.

The Plan will also pay for Confinements in a Rehabilitation Facility, subject to the same conditions and limitations described above.

Sleep Disorders

The Plan will cover the diagnosis and treatment of a sleep disorder when services are rendered and billed by a Physician or Other Medical Professional.

Specialty Drugs

The Plan will cover specialty drugs when obtained from the Plan's selected specialty pharmacy provider. Specialty drugs are high-cost drugs used to treat complex or rare conditions including multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. The drugs are often self-injected or administered in a physician's office or through home health services.

Unlike other prescription drugs obtained from a retail Pharmacy or mail order Pharmacy (and administered by the Plan's pharmacy benefits manager, CatalystRx), a HCFA claim form must submitted (typically by the specialty drug pharmacy) in order to receive payment for specialty drugs.

Speech Therapy

The Plan will cover speech therapy when rendered and billed by a Physician or Speech Therapist. As used herein, speech therapy means active treatment for improvement of an organic medical condition causing speech impairment. Treatment must be either post-operative or for the convalescent stage of an active Illness or disease.

Substance Abuse Services

The Plan will cover expenses for the care and treatment of alcoholism and drug addiction. Substance Abuse Services will be covered on an Inpatient and Outpatient basis. In addition, Partial Hospitalization is also covered. Covered Services include those services that would be covered for any other Illness, as set forth in this Summary Plan Description, and also include the following services:

1. Individual and group psychotherapy;
2. Psychological testing; and
3. Family counseling - Counseling with family members to assist in the Covered Person's diagnosis and treatment, except marriage counseling.

Substance abuse services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, Alcoholism Treatment Facility, Substance Abuse Treatment Facility or Community Mental Health Facility.

Sterilization Services

The Plan will cover surgical services in connection with a voluntary sterilization procedure, for the Covered Employee and Covered Spouse, when such services are rendered and billed by a Physician.

Supplemental Accident

The Plan will provide Coverage in connection with an accidental injury. The accident will be treated the same as any other Injury for purposes of determining the specific Covered Services available. If treatment is received within seven (7) days of the injury, then additional services rendered within 3 months following the injury will be paid at 100% of the Provider's Allowable Charge up to the first $300 of Eligible Expenses. Thereafter, accidental injury expenses will be covered in the same manner as any other Injury. Refer to the Schedule of Benefits for additional details concerning this benefit.

Surgical Services

Surgery performed by a Physician is covered on an Inpatient or Outpatient basis (e.g. in a Physician's office or

Ambulatory Surgical Facility). Surgical services also include:

1. **Surgical Assistance**. Services of a Physician who helps the Covered Person's surgeon in performing covered major surgery when a house staff member, intern or resident cannot be present. In this instance, the Provider's Allowable Charge for services of a Physician who assists the surgeon in performing a covered surgery will be determined as 20% of the surgeon's charge for the surgery; and

2. **Multiple Surgical Procedures**. When more than one surgical procedure is performed through the same body opening during one operation, the Covered Person is covered only for the most complex procedure. If more than one body system is involved or the procedures are needed for the handling of multiple traumas, then the Plan will base payment on 100% of the Provider's Allowable Charge for the most complex procedure and 50% of the Provider's Allowable Charge for each additional procedure performed.

   When more than one surgical procedure is performed through more than one body opening during one operation, then the Plan will base payment on 100% of the Provider's Allowable Charge for the most complex procedure and 50% of the Provider's Allowable Charge for each additional procedure performed.

TMJ Treatment

The Plan will cover the diagnosis Temporomandibular Joint (TMJ) disorders. In addition, Coverage will be provided for the therapeutic IM injection into the Temporomandibular Joint and orthodontic devices and the adjustment to such devices that are deemed to be Medically Necessary for the treatment of the TMJ disorder.

Transplant Services

The Plan will cover services in connection with the transplant procedures described in this section. Covered transplant services include all Covered Services described in this Summary Plan Description as such services would be available for the treatment of any other Illness. In addition, the Plan will cover expenses, which include:

1. Charges incurred in the evaluation, screening and candidacy determination process;

2. Charges incurred for organ procurement, including donor expenses not covered under the donor's benefit plan.

   Coverage for organ procurement from a non-living donor will be provided for the costs involved in removing, preserving and transporting the organ.

   Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for the medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care.

   If the transplant procedure is a bone marrow transplant, Coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or the donor's marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, and treatment and storage cost of the marrow, up to the time of reinfusion. The harvesting of the marrow does not need to be performed within the Transplant Benefit Period.

3. Charges incurred for follow up care, including immuno-suppressant therapy;

4. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, 2 other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the Transplant Benefit Period will be covered up to a Maximum Benefit of $10,000 per Transplant Benefit Period.

Re-transplantation: Re-transplantation will be covered for up to 2 re-transplants, for a total of 3 transplants per person, per lifetime. Each transplant will be subject to the pre-certification requirements. Each transplant and re-transplant will have a new Transplant Benefit Period and a new Maximum Benefit, subject to the Plan's overall lifetime Maximum Benefit.

Accumulation of Expenses: Expenses incurred during any Transplant Benefit Period for the recipient and the donor will accumulate towards the recipient's benefit and will be included in the Plan's overall lifetime Maximum Benefit.

Donor Expenses: Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition, Medical Benefits for a donor who is not a Covered Person under this Plan are limited to a Maximum Benefit of $10,000 per Transplant Benefit Period when the transplant services are provided Out-of-Network. This does not include the donor's transportation and lodging expenses.

Extended Benefits in the Event of Plan Termination: In the event of the termination of this Plan, or of the recipient's loss of eligibility, if a transplant treatment program had commenced while Coverage was in force and benefits had not been exhausted, then benefits will be paid for Eligible Expenses related to the same transplant which are incurred during the lesser of the remainder of that Transplant Benefit Period or one month after termination of the Plan or eligibility, as though Coverage had not ended.

Under the Plan, a covered transplant procedure includes the following human organ and tissue transplants:

1. Kidney transplant;
2. Pancreas transplant;
3. Kidney/pancreas transplant;
4. Bone Marrow transplant;
5. Heart transplant;
6. Lung transplant;
7. Heart/lung transplant; and
8. Liver transplant.

Urgent Care Facility Services

The Plan will cover services rendered by an Urgent Care Facility in connection with the treatment and diagnosis of an Illness or Injury. Covered Services include the services of the Physician on call in the Urgent Care Facility and all other medical staff of the Urgent Care Facility. Under this benefit, Coverage will be provided for screening examinations, evaluation procedures, medical and surgical care, and treatment or services directly related to a specific Injury or Illness that is known or reasonably suspected.

Vision Exams

The Plan will cover eye exams in connection with diabetes and/or eye diseases (e.g. glaucoma).

EXCLUSIONS AND LIMITATIONS FOR MEDICAL BENEFITS

1. **Abortion.** The Plan will not cover expenses or services for an abortion, except:
    a. charges incurred due to the elimination of a substantial danger to the mother's life;
    b. charges incurred if a pregnancy results from rape or incest;
    c. charges incurred as a result of medical complications arising from an abortion.

2. **Acupressure and/or Acupuncture.** The Plan will not cover charges in connection with acupressure and/or acupuncture;

3. **Admissions Primarily for Diagnostic Studies**. The Plan will not cover room, board and general nursing care for Hospital admissions mainly for diagnostic studies;

4. **Admissions Primarily for Physical Therapy**. The Plan will not cover room, board and general nursing care for Hospital admissions mainly for Physical Therapy;

5. **Braces and Artificial Limbs**. The Plan will not cover replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is a sufficient change in the Covered Person's physical condition to make the original device no longer functional;

6. **Certain Examinations and Services.** The Plan will not cover examinations or medical services the Covered Person receives specifically for the purpose of employment, recreation, insurance, school attendance or licensure;

7. **Chiropractic Services.** The Plan will not cover charges for chiropractic services;

8. **Contraceptives.** The Plan will not cover contraceptive drugs and devices under the Medical Benefits;

9. **Cosmetic Services**. The Plan will not cover expenses in connection with treatment only to improve appearance, except as specifically set forth herein. This exclusion does not include procedures to restore body function or correct deformity from disease, trauma, birth or growth defects or prior therapeutic processes. The Plan will not cover expenses for breast implants placed for cosmetic reasons, removal of breast implants, breast reconstruction or reimplantations. However coverage will be provided for implant removal if there is documentation of silicone implant leakage and/or a positive silicone antibody finding;

10. **Custodial Services**. The Plan will not cover expenses or services for custodial care, custodial care counseling or for services not needed to diagnose or treat an Injury or Illness and will furthermore not cover Hospital Confinements for custodial care or for custodial treatment for a psychiatric or substance abuse disorder;

11. **Dental or Medical Department/Clinic**. The Plan will not cover expenses incurred or services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group;

12. **Dental Services**. The Plan will not cover expenses for dentistry or dental processes, except as specified;

13. **Drugs.** The Plan will not cover expenses for over-the-counter or prescription drugs purchased and administered on an Outpatient basis, except as specified herein. Prescription drugs administered while an Inpatient in a Hospital will be covered under the Plan;

14. **Ecological or Environmental Medicine.** The Plan will not cover ecological or environmental medicine;

15. **Educational or Training**. The Plan will not cover expenses or services or supplies primarily for educational, vocational or training purposes, except as specified herein;

16. **Exercise Program.** The Plan will not cover expenses for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by the Plan;

17. **Eye Glasses**. The Plan will not cover expenses for eye glasses, sunglasses, safety glasses, safety goggles, subnormal vision aids or contact lenses (except for aphakic patients and soft lenses or sclera shells which are intended for use as corneal bandages);

18. **Family Counseling.** The Plan will not cover family counseling or counseling with a patient's family members, except as set forth herein;

19. **Financial Counseling.** The Plan will not cover financial counseling services;

20. **Hearing Aids**. The Plan will not cover expenses for hearing aids or examinations for prescribing or fitting them;

21. **Holistic Medicine.** The Plan will not cover charges in connection with holistic treatment or therapy;

22. **Homeopathic Medicine or Drugs.** The Plan will not cover charges in connection with homeopathic treatment or drugs;

23. **Hospice.** The Plan will not cover charges in connection with hospice care;

24. **Hypnotherapy or Hypnotic Anesthesia.** The Plan will not cover charges in connection with hypnosis, hypnotherapy or hypnotic anesthesia;

25. **Impotence Treatment**. The Plan will not cover charges for the care, treatment, services, supplies or medication in connection with treatment for impotence;

26. **Infertility Services**. The Plan will not cover expenses for assisted reproductive technologies, including but not limited to, in-vitro fertilization, artificial insemination, GIFT or ZIFT, and all other services in connection with an infertility condition. The plan will cover expenses for fertility studies, sterility studies, and surgical procedures to restore or enhance fertility.

27. **Legal Counseling Services.** The Plan will not cover charges in connection with legal counseling;

28. **Legal Obligation to Pay.** The Plan will not cover expenses for which the Covered Person has no legal obligation to pay in the absence of this or like coverage;

29. **Lifestyle Improvement Services**. The Plan will not cover lifestyle improvement services or charges, including but not limited to, physical fitness programs and equipment, spas, air conditioners, humidifiers,

personal hygiene and convenience items, mineral baths, massage and dietary supplements;

30. **Marital Counseling**. The Plan will not cover services in connection with marital counseling;

31. **Massage Therapy.** The Plan will not cover charges in connection with massage or massage therapy;

32. **Megavitamin Therapy.** The Plan will not cover megavitamins or megavitamin therapy;

33. **Non-Covered Services**. The Plan will not cover services that are not specified in this Summary Plan Description as Covered Services;

34. **Pastoral Counseling.** The Plan will not cover pastoral counseling services or other faith-based counseling services;

35. **Podiatry Services.** The Plan will not cover expenses for foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular or bone surgery), calluses, toenails, and the like;

36. **Pre-Existing Conditions**. The Plan will not cover expenses for the treatment of a Pre-Existing Condition, during the Pre-Existing Condition Waiting Period;

37. **Prior to Effective Date or After Termination Date**. The Plan will not cover expenses incurred prior to the Covered Person's Effective Date or after the termination date except as specified in this Summary Plan Description;

38. **Private Room Charges**. The Plan will not cover charges for a private room while the Covered Person is an Inpatient in a Hospital or Skilled Nursing Facility unless such private room is deemed Medically Necessary;

39. **Preventive and Routine Services**. The Plan will not cover preventive services, routine office visits or routine periodical physical examinations for a Covered Person, except as specified in this Summary Plan Description;

40. **Sleep Therapy.** The Plan will not cover sleep therapy;

41. **Smoking/Tobacco Cessation Programs**. The Plan will not cover expenses for care and treatment for smoking cessation, including smoking cessation programs and smoking deterrent patches;

42. **Sterilization Reversal**. The Plan will not cover expenses for the reversal of a sterilization procedure;

43. **Telephone Consultations, Missed Appointments, Claim Form Completion**. The Plan will not cover expenses for telephone consultations, missed appointments, or completion of claim forms;

44. **TMJ Devices and Services.** The Plan will not cover services in connection with TMJ except as set forth herein;

45. **Transplant Services**. The Plan will not cover transplant procedures other than those specified herein;

46. **Transsexual Surgery**. The Plan will not cover expenses for transsexual surgery or any treatment leading to or in connection with transsexual surgery. This exclusion includes gender dysphoria or sexual

reassignment or change, medications, implants, hormone therapy, surgery, medical or psychiatric treatment in connection with such surgery or treatment;

47. **Vision Services**. The Plan will not cover expenses for eye care, including radial keratotomy or other eye surgery to correct refractive disorders, and eye examinations including lenses for the eyes and examinations for the fitting of lenses, except as specified herein. In addition, eye examinations for any occupational condition, ailment or Injury arising out of or in the course of employment will not be covered. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages;

48. **Weight Control or Related Treatments**. The Plan will not cover dietary products or supplies or treatment for controlling or reducing weight, obesity treatments, including but not limited to exercise programs, or weight loss surgery, except as noted within;

49. **Wigs.** The Plan will not cover expenses for care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

PRESCRIPTION DRUG BENEFITS

PHARMACY INFORMATION

Under the Plan, the Plan Sponsor has contracted with a pharmacy benefits manager to assist with the management and administration of the Prescription Drug Benefits under the Plan. The pharmacy benefits manager is CatalystRx.

Under this Plan, a Covered Person may obtain prescription drugs from a Retail Pharmacy or a Mail Order Pharmacy. The Retail Pharmacy is typically used when the Covered Person needs to order a prescription on a short-term basis. When purchasing covered prescription drugs from a Retail Pharmacy, the Covered Person will be required to pay the applicable Copayment and each prescription will be subject to a 30-day dispensing limit. The Covered Person is not required to file a claim form in connection with prescription drugs obtained from a Retail Pharmacy.

The Mail Order Pharmacy is typically used when the Covered Person needs to order prescription drugs in a larger supply (e.g. maintenance drugs). In order to use the Mail Order Pharmacy, the Covered Person will need to contact the pharmacy benefits manager. When purchasing prescription drugs from the Mail Order Pharmacy the Covered Person will need to submit a prescription drug request/claim form. However, in some cases the Covered Person may be able to obtain the prescription drug over the telephone (e.g. when obtaining refills). When purchasing prescription drugs from the Mail Order Pharmacy, the Covered Person will be required to pay the applicable Copayment and each prescription will be subject to a 90-day dispensing limit. For information on how to obtain prescription drugs from the Mail Order Pharmacy, go to **www.catalystrx.com**.

In addition, the Plan will cover certain over-the-counter drugs with a prescription. Please refer to the Prescription Drug Schedule of Benefits for additional information.

Prior Authorization

The Covered Person must obtain prior authorization for certain covered drugs. The Covered Person should contact the pharmacy benefits manager to determine which drugs require prior authorization. In order to obtain prior authorization, contact the pharmacy benefits manager at the phone number appearing on the identification card. The Covered Person will be asked to provide certain information to assist in the determination of drug's Medical Necessity. Failure to obtain prior authorization for the covered drugs that require prior authorization will result in a loss of Coverage for such drugs.

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

No Prescription Drug benefits are provided for the following:

1. **Administration Charges**. The Plan will not cover charges for the administration or injection of any drug;

2. **Appetite Suppressants**. The Plan will not cover appetite suppressants, unless specified otherwise;

3. **Contraceptives**. The Plan will not cover oral contraceptives, injectable contraceptives, implantable contraceptives such as Norplant, or contraceptive devices, unless deemed Medically Necessary;

4. **Cosmetic.** The Plan will not cover any prescription used for treatment only to improve appearance;

5. **Drugs without Prescriptions**. The Plan will not cover drugs that do not require a prescription by federal law;

6. **Excess Prescription Refills**. The Plan will not cover any prescription refilled in excess of the number of times specified by the Physician;

7. **Fertility Medication**. The Plan will not cover fertility medication, unless specified otherwise;

8. **Growth Hormones**. The Plan will not cover growth hormones, unless specified otherwise;

9. **Immunization Agents and Blood Expenses**. The Plan will not cover immunization agents, biological sera, blood or blood plasma;

10. **Impotence Medication.** The Plan will not cover any impotence medication, unless specified otherwise;

11. **Inappropriate Charges.** The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed inappropriate or unnecessary by the AMA or is otherwise deemed inappropriate or unnecessary in accordance with accepted medical standards and practice;

12. **Inpatient Prescription Drugs**. The Plan will not cover any medication which is to be taken by or administered, in whole or in part, while the Covered Person is a patient in a Hospital, a convalescent Hospital, rest home, sanitarium, Skilled Nursing Facility, or nursing home or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

13. **Non-Covered Medical Condition**. The Plan will not cover any prescription drug services or charges for any condition not covered under the Medical Benefits;

14. **Non-Covered Medication**. The Plan will not cover any medication that is not specifically listed as a Covered Prescription Drug under this Summary Plan Description;

15. **Physician/Provider Administered Medication**. The Plan will not cover medication that is to be administered by a physician, nurse or anyone other than the patient in a normal home setting;

16. **Refills After One Year from Order**. The Plan will not cover any refill dispensed after one year from the Physician's original order;

17. **Smoking/Tobacco Cessation**. The Plan will not cover any prescription used for the treatment of smoking cessation, unless specified otherwise;

18. **Termination Date**. The Plan will not cover any prescription filled or refilled after termination of Coverage; and

19. **Therapeutic Devices**. The Plan will not cover therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, insulin syringes or needles when prescribed alone and syringes or needles for other than diabetic use.

GENERAL PLAN EXCLUSIONS

The following exclusions and limitations are the General Exclusions under the Plan and apply to the entire Plan.

1. **Applicable Section**. The Plan will not cover expenses which are payable under one section of this Plan under any other section of this Plan;

2. **Charges Incurred Due to Non-Payment.** The Plan will not cover charges for sales tax, mailing fees and surcharges incurred due to nonpayment;

3. **Claims Time Frames.** The Plan will not cover charges for claims not received within the Plan's filing limit deadlines as specified under the section entitled Claims Information;

4. **Court Ordered Treatment.** The Plan will not cover charges for court ordered treatment not specifically mentioned as covered under this Plan;

5. **Criminal Act.** The Plan will not cover charges for services and supplies incurred as a result of an Illness or Injury caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance;

6. **Effective and Termination Date.** The Plan will not cover charges for services and supplies for which a charge was incurred before the Covered Person was covered under this Plan or after their date of termination, except as specified herein;

7. **Exclusions.** The Plan will not cover charges for services and supplies which are specifically excluded under this Plan;

8. **Experimental or Investigative.** The Plan will not cover charges for services and supplies which are either experimental or investigational or not Medically Necessary, except as provided herein;

9. **Excess of Provider's Allowable Charge.** The Plan will not cover charges for services and supplies for treatment which are in excess of the Provider's Allowable Charge (except as otherwise stated herein);

10. **Family Member**. The Plan will not cover expenses or services received from a member of the Covered Person's household or from an Immediate Family Member. For the purposes of this exclusion, Immediate Family Member means the Covered Employee, his or her spouse, brother, sister, parent or the Dependent Child. Immediate Family Member also includes the brother sister, parent or Dependent Child of the employee's spouse.

11. **Government Owned/Operated Facility**. The Plan will not cover charges for services and supplies in a hospital owned or operated by the United States government or any government outside the United States in which the Covered Person is entitled to receive benefits, except for the reasonable cost of services and supplies which are billed, pursuant to Federal Law, by the Veterans Administration or the Department of Defense of the United States for services and supplies which are eligible herein and which are not incurred during or from service in the Armed Forces of the United States or any other country;

12. **Governmental Agency or Program**: The Plan will not cover supplies and services that are furnished or rendered to a Covered Person, or for which the cost is payable, by a governmental agency or governmental program;

13. **Hospital/Facility Employee.** The Plan will not cover charges for services billed by a Provider (Physician or nurse) who is an employee of a hospital or facility and is paid by the hospital or facility for the services rendered;

14. **Injury or Illness.** The Plan will not cover charges for the care or treatment of an Illness or Injury resulting from the voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not prescribed and/or administered by a Physician. In addition, the Plan will not cover charges for the care of an alcohol-related Injury where the Covered Person's blood contained alcohol is in excess of the legal limit of the state in which the Injury occurred. This exclusion does not apply where such Injury results from a medical condition, including a medical condition resulting from domestic violence. As used herein, a medical condition includes a physical or mental condition (e.g. depression);

15. **Legal Obligation.** The Plan will not cover charges for services and supplies for which the Covered Person has no legal obligation to pay or for which no charge has been made;

16. **Maximum Benefit.** The Plan will not cover charges for services and supplies which exceed the Maximum Benefit, as shown in the Schedule of Benefits;

17. **Medicare.** The Plan will not cover charges for which benefits are payable under Medicare Part A or would have been payable if a Covered Person had applied for Part A; and for which benefits are payable under Medicare Part B or would have been payable if a Covered Person had applied for Part B, except as specified in this Plan Document;

18. **Military Related Disability**. The Plan will not cover charges for services and supplies for any military service-related disability or condition;

19. **Non-Medical Charges.** The Plan will not cover charges for: telephone consultations; failure to keep a scheduled visit; completion of a claim form; attending Physician statements; or requests for information omitted from an itemized billing;

20. **Non-Medically Necessary Services.** The Plan will not cover any services that are not deemed to be Medically Necessary except as set forth herein;

21. **Non-Prescription Drugs**. The Plan will not cover charges for non-prescription drugs, except as otherwise stated herein;

22. **Not Under Care of Physician.** The Plan will not cover charges for services and supplies not recommended and approved by a Physician; or services and supplies when the Covered Person is not under the care of a Physician;

23. **Professional Medical Standards.** The Plan will not cover charges for services and supplies which are not provided in accordance with generally accepted professional medical standards or for experimental treatment;

24. **Subrogation Failure**. The Plan will not cover charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any party if the Covered Person fails to provide information as specified under Subrogation;

25. **Suicide or Self-Inflicted Injury.** The Plan will not cover expenses for attempted suicide or an intentionally self-inflicted injury, while sane or insane, unless the injury was sustained as a result of a medical condition or domestic violence. As used herein, a medical condition includes a physical and mental health condition;

26. **Travel Outside United States.** The Plan will not cover charges for services and supplies obtained outside of the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;

27. **Travel Expenses.** The Plan will not cover charges for travel, whether or not recommended by a Physician, except as provided herein;

28. **War.** The Plan will not cover any charge for services, supplies or treatment related to Illness, Injury, or disability caused by or attributed to an act of war, act of terrorism, riot, civil disobedience, insurrection, nuclear explosion or nuclear accident. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized military forces; and

29. **Work-Related Illness or Injury**. The Plan will not cover charges for services and supplies for any condition, disease, defect, ailment, or accidental Injury arising out of and in the course of employment (for wage or profit) whether or not benefits are available under any Workers' Compensation Act or other similar law. This exclusion applies if the Covered Person receives the benefits in whole, part or even if there is no Workers' Compensation coverage in place. This exclusion also applies whether or not the Covered Person claims the benefits or compensation.

ELIGIBILITY PROVISIONS

ELIGIBLE EMPLOYEES

Employees must meet the following eligibility requirements in order to be considered an Eligible Employee:

1. Full time employees must regularly work at least 36 hours per week. Part-time employees must meet the following requirements:
   a. The employee's part-time status was obtained prior to January, 1991;
   b. The number of hours worked per week has remained unchanged since the original date of hire;
   c. The employee has had continued coverage since part-time employment status was obtained.
2. The employee cannot be a temporary employee;
3. The employee must be Actively Working[2]; and
4. If applicable, the employee must make the required contribution towards the Coverage.

Employees who begin employment while under contract through a staffing agency and who become full-time employees, are eligible once they have worked a total of 90 days. This includes days worked as a contract employee.

An employee will retain eligibility for Coverage under the Plan if absent on an approved leave of absence, with the expectation of returning to work following the approved leave of absence as determined by the Employer. The Employer's classification of an individual is conclusive and binding for purposes of determining eligibility under the Plan.

ELIGIBLE DEPENDENTS

The following persons are considered to be Eligible Dependents of a Covered Employee:

1. The Spouse of the Covered Employee (does not include common law spouses);

2. A Dependent Child of the Covered Employee. Under the Plan, a Dependent Child is defined as:

   a. A child who is the Employee's natural child, step child, legally adopted child or who is under the Employee's legal guardianship pursuant to an interlocutory order of adoption[3] and who is under age 18 at time of placement and who: (i) is unmarried; (ii) has not provided more than one-half of his or her financial support during the preceding calendar year; (iii) has the same principal place of abode as the Covered Employee for the period of time established by the Internal Revenue Code; and (iv) is under the Dependent Limiting Age.

      As used herein, the Dependent Limiting Age means the date on which the child attains the age of 19, or, if the child is a Full Time Student, the date on which the child attains the age of 23;

[2] The Actively at Work requirement, as it relates to establishing and maintaining eligibility, applies to the extent permitted under applicable HIPAA non-discrimination regulations.

[3] For a legally adopted child or one who is in the Employee's legal guardianship pursuant to an interlocutory order of adoption, the child must be under age 18 at time of placement In addition, Coverage for such child shall begin from time of placement in the home for adoption whether or not the adoption proceedings have been completed.

b. A child who is dependent pursuant to a Qualified Medical Child Support Order ("QMCSO") as set forth under OBRA 1993 will be considered a Dependent Child under this Plan. The QMCSO entitles such child to Coverage even if (i) such child does not reside with the Covered Employee or is not dependent on the employee for support and (ii) even if the employee does not enroll for Coverage under the Plan or does not have legal custody of the child. If the Eligible Employee has not satisfied the applicable Waiting Period, the Plan must cover the Dependent Child upon the Eligible Employee's completion of such Waiting Period. All other applicable enrollment provisions of the Plan (e.g., Dependent Limiting Age, benefit options, right to continued Coverage, etc.) which are available to Covered Employees or other Covered Dependents shall be made available to the Dependent Child who is eligible pursuant to a Qualified Medical Child Support Order[4];

c. A child who is the Employee's natural child, step child, legally adopted child or who is under the Employee's legal guardianship pursuant to an interlocutory order of adoption (child must be under age 18 at time of placement and who: (i) is unmarried; (ii) is eligible for support in accordance with the Internal Revenue Code; (iii) has the same principal place of abode as the Covered Employee for the period of time established by the Internal Revenue Code; (iv) is over the Dependent Limiting Age; (v) is permanently disabled prior to reaching the Dependent Limiting Age; and (vi) is covered under the Plan prior to reaching the Dependent Limiting Age. The Dependent Child must be incapable of self-sustaining employment by reason of mental or physical handicap and primarily dependent upon the Covered Employee for support and maintenance. The Covered Employee must notify the Employer of the child's handicap and continued dependence within 31 days after the Dependent Child reaches the Dependent Limiting Age. Such notification shall include proof satisfactory to the Employer of the Dependent Child's incapacity and dependence upon the Covered Employee.

The Plan Administrator has the right to request information needed to determine the patient's eligibility when a claim is filed. In addition, the Plan Administrator has the right to request that the Covered Employee provide proof of the continuance of the incapacity and dependence of any Dependent Child who is permanently disabled.

MICHELLE'S LAW NOTIFICATION

Michelle's Law Notification – Means the extension of coverage to full-time student Dependents at postsecondary educational institutions who experience a Medically Necessary Leave of Absence, for up to one year, if both of the following conditions are met:

1. The Plan receives written certification from the Dependent's treating Physician certifying that:
    a. The Dependent is suffering from a serious Illness or Injury; and
    b. The Leave of Absence from the postsecondary institution is a Medically Necessary Leave of Absence.
2. The loss of student status would cause a loss of health coverage under the terms of the Plan without the application of Michelle's Law.

The one-year period begins with the first day of the Medically Necessary Leave of Absence and may end before the year ends, if the Dependent's coverage under the Plan would terminate for any reason.

[4] Contact the Plan Administrator for information concerning the applicable procedures for enrolling a Dependent Child who is eligible in accordance with a QMCSO.

APPLYING FOR COVERAGE AND EFFECTIVE DATES

ENROLLMENT PERIOD FOR NEW HIRES, REHIRES AND CHANGE IN ELIGIBILITY

Coverage for an Eligible Employee will begin on the 3 month anniversary of the employee being Actively at Work provided the enrollment application is submitted prior to this date. Refer to the "Eligibility Provisions" section for details concerning the eligibility criteria for an Eligible Employee.

This same provision applies to an Eligible Employee who is re-hired or has a change in eligibility after his or her initial hire date which qualifies him/her for Coverage at such later date.

A contract employee who becomes a full-time and Eligible Employee will have coverage beginning on the 3 month anniversary of employment, including days worked as a contract employee.

SPECIAL ENROLLMENT PERIODS

There are a number of circumstances that qualify as Special Enrollment Periods. A Special Enrollment Period is an additional enrollment opportunity for the employee to enroll for Coverage following his or her initial eligibility date due to: (1) loss of other coverage; (2) marriage; (3) birth of a child; (4) adoption of a child; and (5) placement for adoption of a child. The specific conditions and limitations that apply to the Special Enrollment Period are described below.

1. **Loss of Other Coverage**: Eligible Employees who are covered under another health plan and subsequently lose such coverage are eligible for Coverage following the loss of the other coverage provided they submit a completed application to the Employer within 30 days following termination of the other coverage. If an employee submits the application within this 30-day enrollment period, Coverage will be effective on the date of loss of other coverage. As used herein, loss of the other coverage must be due to: (a) exhaustion of COBRA benefits; (b) Loss of Eligibility under the prior coverage; or (c) termination of contributions by the employer under the prior plan of coverage.

   This Special Enrollment Period also applies to Dependents of Eligible Employees who decline enrollment when initially eligible under the Plan due to existing medical benefits under another health plan, provided the application for coverage is submitted within the time frame set forth above and loss coverage under the other plan was for one of the reasons set forth above.

2. **Birth or Adoption:** In the event of the birth of a child or adoption or placement for adoption of a child, the child will be eligible to enroll for Coverage under this provision provided an enrollment application is submitted to the Employer within 30 days following the child's birth date, adoption or placement for adoption. In the event the application is submitted within this enrollment period, Coverage shall be made effective on the birth date of the child, or on the date of adoption or the date the child has been placed for adoption. In addition, the Eligible Employee and Spouse, if not already covered, will also be eligible to enroll for Coverage.

3. **Marriage:** In the event a Covered Employee marries after his or her Coverage has become effective, the employee may add his or her spouse to the Coverage by submitting to the Employer a completed application within 30 days of the event. In this event, Coverage will be effective on the date of the marriage. In this instance, the Eligible Employee, the Spouse and any Dependent Children who are newly acquired as the result of the marriage, who did not enroll under the Plan when initially eligible or

during a subsequent open enrollment period, if applicable, are permitted to enroll during this special enrollment period.

Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Covered Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Covered Employee requests coverage under the Plan within 60 days after eligibility is determined.

ENROLLMENT PERIOD FOR OTHER MID-YEAR ELECTION CHANGES

This provision applies if the Employer offers a Section 125 plan, including but not limited to a Section 125 Premium Only Plan, in which the employee is participating.

When the Covered Employee experiences an event that would allow him to make a mid-year election change to his current premium payment elections under his Section 125 Plan, the employee is also permitted to make a corresponding change under this medical Plan provided such change is permitted in accordance with the IRS regulations governing Section 125 Plans. For example, if the Covered Employee experiences an event that would permit him to revoke or change his election under the Section 125 Plan, he will be permitted to change his current elections under this Plan or cancel his Coverage under this Plan.

The events that would allow such a revocation or change include, but are not limited to the following types of events: change in residence that effects an employee's or dependent's eligibility; change in family status; increase in the employer's contributions; significant change in employee-cost for a benefit package; significant curtailment of benefits; addition or significant improvement in a benefit option; change in dependent eligibility as the result of a court order or decree; becoming eligible for Medicare or Medicaid; and going on FMLA leave of absence. Any change or revocation must be consistent with the events permitted as a mid-year change under the Section 125 Plan (as regulated by the IRS) to the extent that it is necessary or appropriate as the result of such change.

All requests for changes under this paragraph must be submitted as a written request to the Employer no later than 30 days prior to making such change. If the request for change is submitted within this 30-day enrollment period, the change will be effective on the date of the event.

PRE-EXISTING CONDITION WAITING PERIOD

The Plan has a 12-month Pre-Existing Condition Waiting Period for all Covered Persons. Coverage will not be provided for a Pre-Existing Condition until the waiting period has elapsed. Except as set forth below, the Pre-Existing Condition Waiting Period applies to all persons covered under the Plan and begins on the Covered Person's Enrollment Date.

The Pre-Existing Condition Waiting Period will be reduced by the number of days the individual was covered under any Creditable Coverage in effect prior to his or her Enrollment Date, provided there is not a Significant Break between the Enrollment Date and the termination date of the Creditable Coverage. In addition, a newborn child, or child who is adopted or placed for adoption prior to the age of 18 will not be subject to the

Pre-Existing Condition Waiting Period provided the child was covered **at any time** within the first 30 days of birth, adoption or placement for adoption. Also, the Pre-Existing Condition Waiting Period will not apply if the child was covered under **other** Creditable Coverage at any time during the 1st 30 days following the birth, adoption or placement for adoption, and then later enrolls for Coverage under this Plan provided there is no Significant Break between Coverage under this Plan and the other Creditable Coverage.

As used in the Summary Plan Description, a Pre-Existing Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the Covered Person's Enrollment Date. A pregnancy is not considered a Pre-Existing Condition.

OTHER EXCEPTIONS TO PRE-EXISTING CONDITIONS

With respect to a Qualified Beneficiary who elects COBRA Continuation Coverage pursuant to the American Recovery and Reinvestment Act of 2009, the following periods shall be disregarded for purposes of determining the 63-day break in coverage period, as referred to in Section 701(c)(2) of ERISA:

1. The period beginning on the date of the Qualifying Event; and
2. The period ending with the start of COBRA Continuation Coverage.

TERMINATION PROVISIONS UNDER THE MEDICAL PLAN

TERMINATION OF EMPLOYEE COVERAGE

Coverage will terminate for the Covered Employee and his/her Covered Dependents on the earliest of the following:

1. The date the Plan terminates;
2. The date the Covered Employee ceases to be an Eligible Employee;
3. The date the Covered Employee dies;
4. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees have not been submitted when due;
5. For an employee who is on a leave of absence as defined under the Family and Medical Leave Act ("FMLA"), at the end of the FMLA leave of absence provided the employee does not return to work as an Actively Working employee at the end of the such leave of absence;[5]
6. For an employee who is on other Employer-approved leave of absence, at the beginning of the approved leave of absence.

NOTE:
Coverage may also be terminated for an employee who is participating in a Section 125 Plan, and as a result of a qualifying event which allows for a mid-year election change in accordance with IRS regulations allowing for a revocation of a Section 125 election and a termination of medical Plan Coverage. In this event, Coverage under the medical Plan will terminate on the same date as the revocation of the Section 125 election.

The employee may be eligible for COBRA Coverage as described in the section entitled "Continued Coverage."

TERMINATION OF DEPENDENT COVERAGE

Coverage will terminate for the following Covered Person(s) on the earliest of the following:

1. The date the Plan terminates;
2. The date the Employee's Coverage terminates;
3. The date of the Employee's death;
4. The date a Dependent loses dependency status under the Plan; or
5. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees have not been submitted when due.

[5] The Employer may also require the employee to use such other paid sick leave or other paid leave of absence as may be available under the Plan prior to the FMLA period. In addition, the Employer may require that the employee substitute accrued paid time under the Employer's sick leave or other paid leave of absence policy for the FMLA period, provided the Employer has notified the employee in writing that such leave of absence is being counted as an FMLA leave of absence. Contact the Employer for details concerning any applicable company policies concerning time off and FMLA.

NOTE:
Coverage may also be terminated for a Dependent who is participating in a Section 125 Plan, and as a result of a qualifying event which allows for a mid-year election change in accordance with IRS regulations allowing for a revocation of a Section 125 election and a termination of medical Plan Coverage. In this event, Coverage under the medical Plan Coverage will terminate on the same date as the revocation of the Section 125 election.

The Dependent may be eligible for COBRA Coverage as described in the section entitled "COBRA Coverage."

CONTINUED COVERAGE PROVISIONS

COBRA COVERAGE

FEDERAL COBRA COVERAGE

A federal law commonly referred to as COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of benefits ("COBRA Coverage") at group rates in certain instances where Coverage under the Plan would otherwise end. This notice is intended to inform the Covered Person, in a summary fashion, of the rights and obligations under the COBRA Coverage provisions of the law. If the Covered Person does not choose COBRA Coverage, the Coverage under the Plan will end.

COBRA Coverage applies to the medical benefits under the Plan and also applies to any dental and/or vision coverage if covered under the Plan prior to the Qualifying Event. The Covered Person will only be entitled to receive COBRA Coverage for the coverage(s) (s)he elects to continue during the election process as described herein.

NOTE:
The Employer offers an extended COBRA provisions for certain Covered Employees whose Coverage ends as the result of retirement. This extended COBRA provision will be offered to such retirees and their Dependents in lieu of the COBRA provision described in this section. Refer to the section entitled "Extended COBRA Coverage for Retirees" for details.

Qualified Beneficiaries

As used herein, a Qualified Beneficiary is a Covered Person who loses Coverage under the Plan as the result of a Qualifying Event.

Qualifying Events

Qualifying Events are any one of the following events, which would normally result in termination of Coverage. These events will qualify a Covered Person to continue coverage as a Qualified Beneficiary beyond the termination date described in the Summary Plan Description. The Qualifying Events are listed below.

1. Death of the Covered Employee;

2. The Covered Employee's termination of employment (other than termination for gross misconduct) or reduction in work hours to less than the minimum required for Coverage under the Plan. This includes a Covered Employee whose employment has been adversely affected by international trade and who is eligible for trade adjustment assistance (TAA) or an individual whose employment has terminated following the last day of leave under the Family Medical Leave Act;

3. Divorce or legal separation from the Covered Employee;

4. The Covered Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan;

5. A Dependent child no longer meets the eligibility requirements of the Plan; and

6. A covered Retiree and their covered Dependents whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.

Notification Requirements

There are a number of notification requirements under COBRA. First, the Plan Administrator must be alerted to a Qualifying Event in order to offer COBRA Coverage to Qualified Beneficiaries. This notice must be submitted in writing to the Plan Administrator, either by the Employer, or by the Covered Employee or a Dependent. The nature of the Qualifying Event determines which party must notify the Plan Administrator. Second, once the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will provide notices to the COBRA Beneficiary. The notification requirements established under COBRA are described in this COBRA Coverage section.

Notification by Covered Employee or Dependent

The Covered Employee or Dependent must notify the Plan Administrator when eligibility for COBRA Coverage results from divorce or legal separation from the Covered Employee or a Dependent Child loss of eligibility under the Plan.

The Covered Employee or Dependent must provide this notice to the Plan Administrator within 60 days of either the Qualifying Event or date of loss of Coverage, as applicable to the Plan.

For individuals who are requesting an extension of COBRA Coverage due to a disability, the individual person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial 18 month COBRA Coverage period and no later than 60 days after the Social Security Administration's determination. When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within 30 days of such change in status.

These notification requirements also apply to an individual who, while receiving COBRA Coverage, has a second or subsequent Qualifying Event. Refer to the section entitled Period of Continued Coverage for additional information.

The Covered Employee or Dependent, or their representative, must deliver this notice **in writing** to the Plan Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted. If the requested information is not provided within the time limit set forth above, the Plan Administrator reserves the right to reject the deficient notice, which means that the individual has forfeited their rights to COBRA Coverage.

To protect their rights, it is very important that Covered Employees and Dependents keep the Plan Administrator informed of their current mailing address. Any notices will be sent to individuals at their last known address. It is the responsibility of Covered Employees and Dependents to advise the Plan Administrator of any address changes in a timely manner in order to ensure that notices, such as those regarding their rights under COBRA, are deliverable.

Failure to provide notice to the Plan Administrator in accordance with the provisions of this notice requirement will result in the person forfeiting their rights to COBRA Coverage under this provision.

Notification by Employer

The Employer is responsible for notifying the Plan Administrator when eligibility for COBRA Coverage results from any events other than divorce or legal separation, or a Dependent becoming ineligible.

The Employer shall provide this notice to the Plan Administrator within 30 days of either the Qualifying Event or date of loss of coverage, as applicable to the Plan. The Employer must include information that is sufficient to enable the Plan Administrator to determine the Plan, the Covered Employee, the Qualifying Event, and the date of the Qualifying Event.

The Employer must deliver this notice **in writing** to the Plan Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted.

Notification by Plan Administrator

Election Notice: Once the Plan Administrator receives proper notification that a Qualifying Event has occurred, COBRA Coverage shall be offered to each of the Qualified Beneficiaries by means of a COBRA Election Notice. The time period for providing the COBRA Election Notice shall generally be 14 days following receipt of notice of the Qualifying Event. This time period may be extended to 44 days under certain circumstances where the Employer is also acting as the Plan Administrator.

Notice of Ineligibility: In the event that the Plan Administrator determines that the Covered Employee and/or Dependent(s) are not entitled to COBRA coverage, the Plan Administrator shall notify the Covered Employee and/or Dependent(s). This notice shall include an explanation of why the individual(s) may not elect COBRA Coverage. A notice of ineligibility shall be sent within the same time frame as described for a COBRA Election Notice.

Notice of Early Termination: The Plan Administrator shall provide notice to a Qualified Beneficiary of a termination of COBRA Coverage that takes effect on a date earlier than the end of the maximum period of COBRA Coverage that is applicable to the Qualifying Event. The Plan Administrator shall notify the Qualified Beneficiary as soon as possible after determining that coverage is to be terminated. This notice shall contain the reason coverage is being terminated, the date of termination, and any rights that the individual may have under the Plan, or under applicable law, to elect alternative group or individual coverage.

Election of Coverage

Upon receipt of Election Notice from Plan Administrator, a Qualified Beneficiary has 60 days from the date the notice is sent to decide whether to elect COBRA Coverage. Each person who was covered under the Plan prior to the Qualifying Event has a separate right to elect COBRA Coverage on an individual basis, regardless of family enrollment. For example, the employee's spouse may elect COBRA Coverage even if the employee does not select the coverage. COBRA Coverage may be elected for one, several or all dependent children

who are Qualified Beneficiaries and a parent may elect COBRA Coverage on behalf of any dependent child.

In considering whether to elect COBRA Coverage, the Qualified Beneficiary should take into account that a failure to continue coverage may affect future rights under federal law. For example, the Covered Person may lose the right to be provided with a reduction in a pre-existing condition limitation if the gap in coverage is greater than 63 days. The Covered Person also has special enrollment rights under HIPAA that allow him or her to enroll in another group health plan for which (s)he is otherwise eligible when Coverage under this Plan terminates due to a Qualifying Event. The Covered Person also has the same special enrollment rights at the end of the COBRA Coverage if (s)he receives continued coverage for the maximum period available under COBRA.

If the Qualified Beneficiary chooses to have continued coverage, (s)he must advise the Plan Administrator in writing of this choice. This is done by submitting a written COBRA Election Notice to the Plan Administrator. The Plan Administrator must receive this written notice no later than the last day of the 60-day period. If the election is mailed, the election must be postmarked on or before the last day of the 60-day period. This 60-day period begins on the later of the date coverage under the Plan would otherwise end, or the date the notice is sent by the Plan Administrator notifying the person of his or her rights to COBRA Coverage.

Second Election Period for TAA-Eligible Covered Employees

Covered Employees, whose employment is terminated and who become entitled to receive trade adjustment assistance (TAA) in accordance with the Trade Act of 1974 are provided a second 60 day COBRA election period. TAA-eligible individuals who did not elect COBRA Coverage during the initial sixty day COBRA election period, which followed the TAA-related loss of coverage, may elect COBRA Coverage during the 60 day period that begins on the first day of the month in which the individual is determined to be eligible for TAA, provided this election is made no later than 6 months after the date of the TAA-related loss of coverage. Any COBRA Coverage elected during the second election period shall be effective on the first day of the second election period, and not on the date on which Coverage originally lapsed. The time between the loss of Coverage and the start of the second election period shall not be counted for purposes of determining whether the individual has had a 63-day break in Creditable Coverage with regard to application of any Pre-existing Condition limitation.

Period of Continued Coverage

The law requires that a Qualified Beneficiary who elects COBRA Coverage be afforded the opportunity to maintain COBRA Coverage for 36 months unless (s)he loses Coverage under the Plan because of a termination of employment or reduction in hours. In that case, the required COBRA Coverage period is 18 months.

This 18-month period may be extended if a subsequent or second Qualifying Event (for example, divorce, legal separation, an employee becoming entitled to Medicare or death) occurs during that 18-month period. A second event may be a valid Qualifying Event only if it would have been a valid first Qualifying Event. That is, a second Qualifying Event shall qualify only if it would have caused a Covered Person to lose Coverage under the Plan if the first Qualifying Event had not occurred. A second or subsequent Qualifying Event is therefore limited to the following Qualifying Events:

1. Death of a Covered Employee;

2. Divorce or legal separation between the spouse and the Covered Employee; and

3. Dependent Child's loss of Dependent status under the Plan.

The Covered Employee's Medicare entitlement may also be considered a subsequent or second Qualifying Event for any Dependents who are Qualified Beneficiaries following the first Qualifying Event, but only if the Medicare entitlement would have resulted in loss of Coverage under the Plan had the first Qualifying Event not occurred.

Under no circumstances, however, will Coverage last beyond 36 months from the date of the event that originally made the Covered Person eligible to elect Coverage. Only a person covered prior to the original Qualifying Event or a child born to or Placed for Adoption with a Covered Employee during a period of COBRA Coverage is eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event. Any other Dependent acquired during COBRA Coverage is not eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event.

Period of Continued Coverage for Disabled Person

A person who is totally disabled may extend COBRA Coverage from 18 months to 29 months. Non-disabled family members may also elect to extend COBRA Coverage even if the disabled individual does not elect to extend his coverage.

The disabled person must be disabled for Social Security purposes at the time of the Qualifying Event or within 60 days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial 18-month COBRA Coverage period and no later than 60 days after the latest of the following:

1. The date of the Social Security Administration's determination;

2. The date of the Qualifying Event;

3. The date the Qualified Beneficiary would lose Coverage under the plan; or

4. The date the Qualified Beneficiary is informed of the obligation to provide the disability notice, either through this Summary Plan Description or the initial COBRA Notice provided by the Employer.

Refer to the guidelines set forth in the subsection Notification Requirements.

When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within 30 days of such change in status.

Cost of Coverage and Payments

The Employer requires that Qualified Beneficiaries pay the entire costs of their COBRA Coverage, plus a two percent administrative fee. This must be remitted to the Employer or the Employer's designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

The premium for an extended COBRA Coverage period due to a total disability may also be higher than the premium due for the first 18 months. If the disabled person elects to extend coverage the Employer may charge 150% of the contribution during the additional 11 months of COBRA Coverage. If only the non-disabled family members elect to extend coverage the Employer may charge 102% of the contribution.

For purposes of determining monthly costs for continued coverage, a person originally covered as an Employee or as a spouse will pay the rate applicable to a Covered Employee if Coverage is continued for himself alone. Each child continuing Coverage independent of the family unit will pay the rate applicable to a Covered Employee.

Timely payments must be made for the COBRA Coverage. The initial payment must be made within 45 days after the date the person notifies the Employer that he has chosen to continue Coverage. The initial payment must be the amounts needed to provide Coverage from the date continued benefits begin, through the date of election.

Thereafter, payments for COBRA Coverage are to be made monthly. These monthly payments are due on the first day of each month. If the premium is not received by the first day of the month, the Employer will consider that Coverage has been allowed to terminate until the monthly payment has been received. However, a 30-day grace period is allowed for receipt of this monthly payment before the termination becomes final. Claims will be denied until the monthly premium payment is received. There shall be no grace period for making payments, other than the grace period described in this paragraph.

If the initial payment, or any subsequent monthly payment received, is short by an insignificant amount (the lesser of $50 or 10% of the premium), the Covered Person will be sent a notice at the Covered Person's last known address stating that the remaining amount due must be sent within 30 days to continue Coverage under COBRA if the Plan Administrator requires the payment to be made in full. The Plan Administrator may also choose to accept the payment, which was short by an insignificant amount, as payment in full. Should you have any questions in regards to how payments short by an insignificant amount will be handled under this Plan, please contact the Plan Administrator.

Special Note About Tax Credit for TAA-Eligible Individuals: In accordance with the Trade Act of 2002, individuals who become eligible for TAA assistance may take a tax credit of 65% of premiums paid for qualified health coverage, which includes COBRA Coverage. The Trade Act of 2002 provides for advance payment of the tax credit to the health plan.

When Continuation Coverage Begins

When COBRA Coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the Qualifying Event or loss of coverage, as applicable to the Plan, so that no break in Coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

Dependents Acquired During Continuation

A spouse or Dependent child newly acquired during COBRA Coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during COBRA Coverage. A Dependent acquired and enrolled after the original Qualifying Event, other than a child born to or Placed for Adoption with a Covered Employee during a period of COBRA Coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of Coverage.

End of COBRA Coverage

COBRA Coverage will end on the earliest of the following dates:

1. 18 months from the date continuation began because of a reduction of hours or termination of employment of the Covered Employee;

2. 36 months from the date continuation began for Dependents whose coverage ended because of the death of the Covered Employee, divorce or legal separation from the Covered Employee, the child's loss of Dependent status, or Medicare entitlement;

3. The end of the period for which contributions are paid if the Covered Person fails to make a payment on the date specified by the Employer or by the end of the grace period;

4. The date coverage under this Plan ends and the Employer offers no other group health benefit plan;

5. The date the Covered Person first becomes entitled to Medicare after the COBRA election;

6. The date the Covered Person first becomes covered under any other group health plan without regard to a pre-existing condition after the COBRA election. If the replacing group health plan has a pre-existing condition limitation, the Covered Person may remain covered under the Plan until he or she has satisfied the pre-existing condition limitation under the new group health plan, or until he or she is no longer eligible under the COBRA Coverage, as set forth herein;

7. The date the Covered Person is terminated from the Plan for cause, provided an active Covered Employee would be terminated under the Plan for the same cause; or

8. 36 months from the date continuation began for the surviving spouse and Dependent children of a Retiree who dies, when the Retiree's Qualifying Event was the Employer's bankruptcy filing;

The Plan Administrator shall provide notice of any early termination. Refer to subsection Notification Requirements, Plan Administrator.

The COBRA law also requires that an individual who has elected COBRA Coverage be permitted to enroll in any individual conversion health plan that is provided under the Plan. Contact the Plan Administrator about the availability of a conversion policy.

The Plan Administrator and Contact Information

An employee may obtain additional information about his or her COBRA Coverage rights from the Plan Administrator. If the employee has any questions concerning his or her COBRA Coverage rights, or if (s)he wants a copy of the Summary Plan Description, (s)he should contact the Plan Administrator.

Finally, in order to protect the employee's and his or her family's rights, the Covered Person should keep the Plan Administrator informed of any changes to his or her address and the addresses of family members. The employee should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

The name, address and telephone number of the Plan Administrator is:

Weldon, Williams and Lick, Inc.
711 North A Street
Ft. Smith, AR 72901
(479)783-4113.

It is important to note that the Plan Administrator has contracted with HealthSCOPE Benefits to perform certain COBRA services on behalf of the Plan. Therefore, the employee may also contact HealthSCOPE Benefits if (s)he has questions about COBRA Coverage or wishes to inquire about his or her COBRA rights.

The address and telephone number for HealthSCOPE Benefits is:

HealthSCOPE Benefits, Inc.
27 Corporate Hill Drive
Little Rock, Arkansas 72205
501-225-1551

EXTENDED COBRA COVERAGE FOR RETIREES

The provision described in this section applies to Covered Employees who retire on or after May 1, 1992.

For Covered Employees who retire at the age of 55 or later and have a minimum of 15 years of service at time of retirement, the Employer will offer COBRA Coverage for the employee and his or her Dependents for a maximum period of 36 months. This is referred to as Extended COBRA Coverage.

A spouse or Dependent child newly acquired by the retiree during this Extended COBRA Coverage is also eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during the Extended COBRA Coverage. A Spouse or Dependent Child acquired during the Extended COBRA Coverage period will be eligible for Coverage for a period not to exceed the remaining number of months of Coverage under the retiree's Extended COBRA Coverage period.

A retiree and Dependent eligible to received this Extended COBRA Coverage is referred to as a Qualified Beneficiary.

Period of Continued Coverage

A Qualified Beneficiary who elects the Extended COBRA Coverage will be entitled to a maximum of 36 months of continued Coverage.

Notification Requirements

There are a number of notification requirements under this provision. First, the Plan Administrator must be notified of the Covered Employee's retirement in order to offer Extended COBRA Coverage to Qualified Beneficiaries. This notice must be submitted in writing to the Plan Administrator, either by the Employer, or by the Covered Employee or a Dependent. Second, once the Plan Administrator is notified of retirement, the Plan Administrator will provide notices to the COBRA Beneficiary. The notification requirements established are described in this section.

Notification by Employer

The Employer is responsible for notifying the Plan Administrator when a Covered Employee retires and becomes eligible for this Extended COBRA Coverage,

The Employer shall provide this notice to the Plan Administrator within 30 days of either the date of retirement or date of loss of coverage, as applicable to the Plan. The Employer must include

information that is sufficient to enable the Plan Administrator to determine the Plan, the Covered Employee and the date of the retirement or loss of Coverage.

The Employer must deliver this notice **in writing** to the Plan Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the event (i.e. the retirement), the date of the retirement, and include appropriate legal documentation to confirm the retirement. The Plan Administrator shall require that any additional information be provided, when necessary to validate the employee's retirement, before deeming the notice to be properly submitted.

Notification by Plan Administrator

Election Notice: Once the Plan Administrator receives proper notification that the retirement has occurred, Extended COBRA Coverage shall be offered to each of the Qualified Beneficiaries by means of a COBRA Election Notice. The time period for providing the COBRA Election Notice shall generally be 14 days following receipt of notice of the retirement date. This time period may be extended to 44 days under certain circumstances where the Employer is also acting as the Plan Administrator.

Notice of Ineligibility: In the event that the Plan Administrator determines that the Covered Employee and/or Dependent(s) are not entitled to the Extended COBRA Coverage, the Plan Administrator shall notify the Covered Employee and/or Dependent(s). This notice shall include an explanation of why the individual(s) may not elect Extended COBRA Coverage. A notice of ineligibility shall be sent within the same time frame as described for a COBRA Election Notice.

Notice of Early Termination: The Plan Administrator shall provide notice to a Qualified Beneficiary of a termination of Extended COBRA Coverage that takes effect on a date earlier than the 36 month period. The Plan Administrator shall notify the Qualified Beneficiary as soon as possible after determining that coverage is to be terminated. This notice shall contain the reason coverage is being terminated, the date of termination, and any rights that the individual may have under the Plan, or under applicable law, to elect alternative group or individual coverage.

Election of Coverage

Upon receipt of Election Notice from Plan Administrator, a Qualified Beneficiary has 60 days from the date the notice is sent to decide whether to elect the Extended COBRA Coverage. Each person who was covered under the Plan prior to the date of retirement has a separate right to elect the Extended COBRA Coverage on an individual basis, regardless of family enrollment. For example, the retiree's Spouse may elect Coverage even if the retiree does not select the coverage. The Extended COBRA Coverage may be elected for one, several or all Dependent Children who are Qualified Beneficiaries and a parent may elect the Extended COBRA Coverage on behalf of any Dependent Child.

In considering whether to elect Coverage under this provision, the Qualified Beneficiary should take into account that a failure to continue coverage may affect future rights under federal law. For example, the Covered Person may lose the right to be provided with a reduction in a pre-existing condition limitation if the gap in coverage is greater than 63 days. The Covered Person also has special enrollment rights under HIPAA that allow him or her to enroll in another group health plan for which (s)he is otherwise eligible when Coverage under this Plan terminates due to a Qualifying Event. The Covered Person also has the same special enrollment rights at the end of the 36-month period if (s)he receives continued coverage for the maximum period available under provision.

If the Qualified Beneficiary chooses to have continued coverage, (s)he must advise the Plan Administrator in writing of this choice. This is done by submitting a written COBRA Election Notice to the Plan Administrator. The Plan Administrator must receive this written notice no later than the last day of the 60-day period. If the election is mailed, the election must be postmarked on or before the last day of the 60-day period. This 60-day period begins on the later of the date coverage under the Plan would otherwise end, or the date the notice is sent by the Plan Administrator notifying the person of his or her rights to COBRA Coverage.

When Continuation Coverage Begins and Ends

Coverage Begins: When the Extended COBRA Coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the date of retirement or loss of coverage, as applicable to the Plan, so that no break in Coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

Coverage Ends: Coverage will end on the earliest of the following dates:

1. 36 months from the date continuation begins for the retiree and/or his or her Dependent;

2. The end of the period for which contributions are paid if the Covered Person fails to make a payment on the date specified by the Employer or by the end of the grace period;

3. The date coverage under this Plan ends and the Employer offers no other group health benefit plan;

4. The date the Covered Person first becomes entitled to Medicare after the COBRA election;

5. The date the Covered Person first becomes covered under any other group health plan without regard to a pre-existing condition after the COBRA election. If the replacing group health plan has a pre-existing condition limitation, the Covered Person may remain covered under the Plan until he or she has satisfied the pre-existing condition limitation under the new group health plan, or until he or she is no longer eligible under the COBRA Coverage, as set forth herein;

6. The date the Covered Person is terminated from the Plan for cause, provided an active Covered Employee would be terminated under the Plan for the same cause; or

The Plan Administrator shall provide notice of any early termination. Refer to subsection Notification Requirements, Plan Administrator.

Cost of Coverage and Payments

The Employer requires that Qualified Beneficiaries pay the entire costs of their Extended COBRA Coverage. This must be remitted to the Employer or the Employer's designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

For purposes of determining monthly costs for continued coverage, a person originally covered as an Employee or as a spouse will pay the rate applicable to a Covered Employee if Coverage is continued for himself alone. Each child continuing Coverage independent of the family unit will pay the rate applicable to a Covered Employee.

Timely payments must be made for the Extended COBRA Coverage. The initial payment must be made

within 45 days after the date the person notifies the Employer that he has chosen to continue Coverage. The initial payment must be the amounts needed to provide Coverage from the date continued benefits begin, through the date of election.

Thereafter, payments for the Coverage are to be made monthly. These monthly payments are due on the first day of each month. If the premium is not received by the first day of the month, the Employer will consider that Coverage has been allowed to terminate until the monthly payment has been received. However, a 30-day grace period is allowed for receipt of this monthly payment before the termination becomes final. Claims will be denied until the monthly premium payment is received. There shall be no grace period for making payments, other than the grace period described in this paragraph.

If the initial payment, or any subsequent monthly payment received, is short by an insignificant amount (the lesser of $50 or 10% of the premium), the Covered Person will be sent a notice at the Covered Person's last known address stating that the remaining amount due must be sent within 30 days to continue Coverage if the Plan Administrator requires the payment to be made in full. The Plan Administrator may also choose to accept the payment, which was short by an insignificant amount, as payment in full. Should you have any questions in regards to how payments short by an insignificant amount will be handled under this Plan, please contact the Plan Administrator.

Special Note About Tax Credit for TAA-Eligible Individuals: In accordance with the Trade Act of 2002, individuals who become eligible for TAA assistance may take a tax credit of 65% of premiums paid for qualified health coverage, which includes COBRA Coverage. The Trade Act of 2002 provides for advance payment of the tax credit to the health plan.

The Plan Administrator and Contact Information

An employee may obtain additional information about his or her Extended COBRA Coverage rights from the Plan Administrator. Finally, in order to protect the employee's and his or her family's rights, the Covered Person should keep the Plan Administrator informed of any changes to his or her address and the addresses of family members. The employee should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

The name, address and telephone number of the Plan Administrator is: Weldon, Williams and Lick, Inc., 711 North A Street, Ft. Smith, AR 72901, (479)783-4113.

It is important to note that the Plan Administrator has contracted with HealthSCOPE Benefits to perform certain COBRA services on behalf of the Plan. Therefore, the employee may also contact HealthSCOPE Benefits if (s)he has questions about COBRA Coverage or wishes to inquire about his or her COBRA rights. The address and telephone number for HealthSCOPE Benefits is: 27 Corporate Hill Drive, Little Rock, Arkansas 72205, 501-225-1551

CONTINUED COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

The Family and Medical Leave Act is a federal law that applies, generally, to employers with 50 or more employees, and provides that an eligible Employee may elect to continue coverage under this Plan during a period of approved FMLA Leave at the same cost as if the FMLA Leave not been taken.

If provisions under the Plan change while you are on FMLA Leave, the changes will be effective for you on the same date as they would have been had you not taken leave.

Eligible Employees
You are an eligible Employee if all of the following conditions are met:

1. You have been employed with the Participating Employer for at least 12 months;
2. You have been employed with the Participating Employer at least 1,250 hours during the 12 consecutive months prior to the request for FMLA Leave; and
3. You are employed at a worksite that employs at least 50 employees within a 75-mile radius.

Qualifying Circumstances
Coverage under FMLA Leave is limited to a total of 12 workweeks during any 12-month period that follows:

1. The birth of, and to care for, your Son or Daughter;
2. The placement of a Child with you for adoption or foster care;
3. Your taking leave to care for your Spouse, Son or Daughter, or Parent who has a Serious Health Condition; or
4. Your taking leave due to a Serious Health Condition which makes you unable to perform the functions of your position.
5. A Qualifying Exigency arising out of the fact that a Spouse, Son or Daughter, Parent, or Next of Kin of the Employee is a regular or reserve component in the Armed Forces.

Coverage under FMLA Leave is limited to a total of 26 workweeks during any 12-month period for the following situations:

1. To care for a service member following a Serious Illness or Injury to that service member, when the Employee is that service member's Spouse, Son or Daughter, Parent, or Next of Kin.
2. To care for a veteran who is undergoing medical treatment, recuperation, or therapy for a Serious Illness or Injury that occurred any time during the five years preceding the date of treatment, when the Employee is that veteran's Spouse, Son or Daughter, Parent, or Next of Kin.

This leave may be paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid. Your Participating Employer has the right to require that all paid leave be used prior to providing any unpaid leave.

You must continue to pay your portion of the Plan contribution, if any, during the FMLA Leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

Notice Requirements
You must provide at least 30 days' notice to your Participating Employer prior to beginning any leave under FMLA. If the nature of the leave does not permit such notice, you must provide notice of the leave as soon as possible. Your Participating Employer has the right to require medical certification to support your request for leave due to a Serious Health Condition for yourself or your eligible family members.

Length of FMLA Leave
During any one 12-month period, the maximum amount of FMLA Leave may not exceed 12 workweeks for most FMLA related situations. The maximum periods for an Employee who is the primary care giver of a service member with a Serious Illness or Injury that was Incurred in the line of active duty may take up to 26 weeks of FMLA Leave in a single 12-month period to care for that service member. Your Participating Employer may use any of four methods for determining this 12-month period.

If you and your Spouse are both employed by the Participating Employer, FMLA Leave may be limited to a combined period of 12 workweeks, for both Spouses, when FMLA Leave is due to:

1. The birth or placement for adoption or foster care of a Child; or
2. The need to care for a Parent who has a Serious Health Condition.

Termination of FMLA Leave
Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

1. When you inform your Participating Employer of your intent not to return from leave;
2. When your employment relationship would have terminated but for the leave (such as during a reduction in force);
3. When you fail to return from the leave; or
4. If any required Plan contribution is not paid within 30 days of its due date.

If you do not return to work when coverage under FMLA Leave ends, you will be eligible for COBRA continuation of coverage at that time.

Recovery of Plan contributions
Your Participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if you do not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles you to FMLA Leave (in which case your Participating Employer may require medical certification) or other circumstances beyond your control.

Reinstatement of Coverage
The law requires that coverage be reinstated upon your return to work following an FMLA Leave whether or not you maintained coverage under the Plan during the FMLA Leave.
On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken. The Waiting Period and the Pre-Existing Condition limitation will be credited as if you had been continually covered under the Plan.

Definitions
For this provision only, the following terms are defined as stated.

Next of Kin – Means the nearest blood relative to the service member.

Parent – Means your biological parent or someone who has acted as your parent in place of your biological parent when you were a Son or Daughter.

Qualifying Exigency – Means the following situations:

1. Short-notice deployment.

a. To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and
b. Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation;

2. Military events and related activities.
   a. To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active duty status of a covered military member; and
   b. To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member;
3. Childcare and school activities.
   a. To arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster *child*, a stepchild, or a legal ward of a covered military member, or a *child* for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that *FMLA leave* is to commence;
   b. To provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster *child*, a stepchild, or a legal ward of a covered military member, or a *child* for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that *FMLA leave* is to commence;
   c. To enroll in or transfer to a new school or daycare facility, a biological, adopted, or foster *child*, a stepchild, or a legal ward of the covered military member, or a *child* for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of selfcare because of a mental or physical disability at the time that *FMLA leave* is to commence, when enrollment or transfer is necessitated by the active duty or call to active duty status of a covered military member; and
   d. To attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors, for a biological, adopted, or foster *child*, a stepchild, or a legal ward of the covered military member, or a *child* for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that *FMLA leave* is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member;
4. Financial and legal arrangements.
   a. To make or update financial or legal arrangements to address the covered military member's absence while on active duty or call to active duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and
   b. To act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits while the covered military member is on active duty or call to active duty status, and for a period of 90 days following the termination of the covered military member's active duty status;

5. Counseling. To attend counseling provided by someone other than a health care provider for oneself, for the covered military member, or for the biological, adopted, or foster *child*, a stepchild, or a legal ward of the covered military member, or a *child* for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that *FMLA leave* is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member;
6. Rest and recuperation. To spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment. Eligible *employees* may take up to five days of leave for each instance of rest and recuperation;
7. Post-deployment activities.
    a. To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status; and
    b. To address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements; and
8. Additional activities. To address other events which arise out of the covered military member's active duty or call to active duty status provided that the *participating employer* and *employee* agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

Serious Health Condition – Means an Illness, Injury, impairment, or physical or mental condition that involves:

1. Inpatient care in a Hospital, hospice, or residential medical facility; or
2. Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or Surgery, as appropriate, by the state in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

Serious Illness or Injury – Means as an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties.

Son or Daughter – Means your biological, child, adopted child, stepchild, foster child, a child placed in your legal custody, or a child for which you are acting as the parent in place of the child's natural blood related parent. The child must be:

1. Under the age of 18; or
2. Over the age of 18, but incapable of self-care due to a mental or physical disability.

Spouse – Means your husband or wife. NOTE: For complete information regarding your rights under FMLA, contact your Participating Employer.

CONTINUED COVERAGE FOR EMPLOYEES IN UNIFORMED SERVICES

In the event the Covered Employee is required to be absent from work as the result of service in the Uniformed Services, Coverage for Medical Benefits may be continued for the Covered Employee in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

As used herein, Uniformed Services means the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Period of Continued Coverage Under the USERRA Provision

Coverage may be continued for the Covered Employee and his or her covered Dependents for a period which shall equal the lesser of the following:

1. The 24-month period beginning on the date on which the employee's absence begins; or
2. The period beginning on the date on which the employee's absence begins and ending on the day after the date on which the employee fails to apply for or return to a position of employment.

CLAIMS INFORMATION

CLAIM FORMS

When the Covered Person is submitting the claim on his or her own behalf, (s)he may obtain a claim form from the Employer. If forms are not available, send a written request for claim forms to HealthSCOPE Benefits. Written notice of services rendered may also be submitted to HealthSCOPE Benefits without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

1. Name of patient;
2. Patient's relationship to the Covered Employee;
3. Identification number;
4. Date, type and place of service;
5. Name of Provider; and
6. The Covered Person's signature and the Provider's signature.

Refer to the section entitled "Prescription Drug Benefits" for information on how to submit a claim.

TIME FRAME FOR SUBMITTING CLAIM

The claim form must be submitted within 12 months of receiving Covered Services and must have the data needed to determine benefits. An expense is considered incurred on the date the service or supply is given. Failure to submit the claim form within 12 months will not reduce any benefit if the Covered Person shows that the claim was submitted as soon as reasonably possible. The claim form should be submitted to the address shown on the Covered Person's identification card. Note: refer to the section entitled "Prescription Drug Benefits" for information on how to submit a claim.

It is important to note that if the Provider is a Preferred Provider, the Provider will likely submit the claim on behalf of the Covered Person. It is in the Covered Person's best interest to ask the Provider if the claim will be filed on his or her behalf by the Provider.

In the event of termination of the agreement between the Claims Administrator and the Plan Sponsor, all notices of claims for Covered Services received after the termination of such agreement should be provided to the Plan Sponsor.

CLAIMS REVIEW PROCEDURE

This section describes the claims review procedures under the Plan. A claim is defined as any request for a benefit made by a Covered Person or by a Provider on behalf of the Covered Person that complies with the Plan's reasonable procedure for making a claim for benefits. The times shown in this section are maximum times only. A period of time begins at the time the claim is filed. The days shown in this section are counted as calendar days.

Under the Plan, the Covered Person can check on the status of a claim at any time by contacting the Customer Service number appearing on the Covered Person's identification card.

There are different time frames for reviewing a claim and providing notification concerning the claim. The time frames are based on the category of the claim. For the purpose of this provision, there are three categories of claims: Pre-Service Claims, Urgent Care Claims and Post-Service Claims.

Pre-Service Claims - Pre-Service Claims are those claims for which the Plan requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification, pre-authorization or pre-determination. For Pre-Service Claims (other than Urgent Care Claims), the following time frames apply concerning review and notification of the benefit determination:

1. **Notification Concerning Failure to Follow Procedure -** In the event the Covered Person, or Provider on behalf of the Covered Person, fails to follow the proper procedure for providing notification of a Pre-Service Claim, the Covered Person or Provider will be notified within 5 days.

2. **Benefit Determination Period** – The Covered Person will be notified of the benefit determination within 15 days following receipt of notification concerning the Pre-Service Claim.

3. **Extension of Benefit Determination Period** - If a benefit determination cannot be made within the standard 15-day benefit determination period due to matters beyond the Plan Administrator's control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 15-day benefit determination period. Only one extension is permitted for each Pre-Service Claim.

   If a benefit determination cannot be made within the standard 15-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 15-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

Urgent Care Claims - Urgent Care Claims are those **Pre-Service Claims** in which the time periods for making claim determinations for Pre- or Post-Service Claims could seriously jeopardize the Covered Person's life, health or ability to regain maximum function or when a Physician with knowledge of the Covered Person's medical condition determines that the Covered Person would be subject to severe pain that cannot be adequately managed or controlled without the treatment that is the subject of the claim. For Urgent Care Claims, the following time frame applies concerning review and notification concerning the benefit determination:

1. **Notification Concerning Incomplete Claim -** In the event the Covered Person, or Provider on behalf of the Covered Person, fails to submit complete information in connection with an Urgent Care Claim, the Covered Person or Provider will be notified of the specific information needed to complete the claim within 24 hours.

2. **Benefit Determination Period** – The Covered Person will be notified of the benefit determination concerning an Urgent Care Claim within 72 hours following receipt of notification concerning the Urgent Care Claim.

3. **Extension of Benefit Determination Period** - In the event additional information is needed in order to make a benefit determination, the Covered Person must be notified within 24 hours following receipt of notification concerning the Urgent Care Claim. Notification of the extension will include a detailed

explanation of the information needed to make the benefit determination. Upon receipt of the notification of the required extension, the Covered Person has 48 hours to provide the requested information. The determination will be made within 48 hours following receipt of the requested information from the Covered Person. If the Covered Person fails to provide the requested information, the benefit determination will be made within 48 hours following the end of the period allowed for providing said information.

4. **Benefit Determination Period For Request of Continuation of Treatment** - Any request to continue the course of treatment that is an Urgent Care Claim shall be decided as soon as possible. The Covered Person will be notified of the benefit determination within 24 hours of the receipt of the claim, provided that such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-Service Claims - Post-Service Claims are those claims for services, other than Pre-Service and Urgent Care Claims, which have been rendered by a Provider. For Post-Service Claims, the following time frames apply concerning review and notification of the benefit determination:

1. **Benefit Determination Period** - The Covered Person will be notified of the benefit determination within 30 days following receipt of notification concerning the Post-Service Claim.

2. **Extension of Benefit Determination Period** - If a benefit determination cannot be made within the standard 30-day benefit determination period due to matters beyond its control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 30-day benefit determination period. Only one extension is permitted for each Post-Service Claim.

   If a benefit determination cannot be made within the standard 30-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 30-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

CLAIMS APPEAL PROCESS

The Plan has a claims appeal process. The claims appeal process and the time limits associated with requesting and responding to a request for Claims Appeal are described in this section. The Covered Person and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office.

Under the Plan, the Covered Person can check on the status of a claim appeal at any time by contacting the Customer Service number appearing on the reverse side of the Identification Card.

Requesting a Claims Appeal - The Plan has a claims appeals process that allows the Covered Person to submit a request for appeal to the fiduciary who has been named by the Plan Administrator to review a claims appeal ("Named Fiduciary"). Under the Plan, the Plan Administrator will serve as the Named Fiduciary, unless the Plan Administrator has specifically delegated this responsibility to another party. The Named Fiduciary has the sole responsibility for making the decision on an appeal of an adverse benefit determination.

Under the claims appeal process, the Covered Person will be provided with a full and fair review of an adverse benefit determination. This review of an adverse benefit determination must be done by an individual who is neither the individual who made the original adverse benefit determination nor the subordinate of such individual. In addition, if the adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary, the Named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In the event the Covered Person disagrees with a claims decision concerning the denial of a benefit or scope of benefits, the Covered Person or the Covered Person's authorized representative may submit a request for appeal within 180 days from receipt of the notice of denial or adverse benefit determination. Absent an express written authorization by the Covered Person providing otherwise, the authorized representative includes a medical provider only for an Urgent Care Claims Appeal.

Under the claims appeal process:

1. The Covered Person is permitted to submit written documents, comments, records and other information relating to the claim;
2. The Covered Person is allowed reasonable access to any copies of documents, records and other information relevant to the claim;
3. The Covered Person is permitted to request the name of the medical provider used in making the initial adverse benefit determination; and
4. All comments, documents, records and other information submitted without regard to whether such information was submitted or considered in the initial determination will be taken into account.

The Covered Person's request for an appeal of an adverse benefit determination for a Pre-Service and Post-Service Claims must be submitted in writing and should be submitted to:

Named Fiduciary c/o HealthSCOPE Benefits, Inc.
P.O. Box 2860
Little Rock, Arkansas 72203

For appeal of an Urgent Care Claim, the request for appeal may also be submitted verbally to the Named Fiduciary by contacting 501-218-7865.

If the Covered Person's request for appeal is not submitted to the Named Fiduciary in the manner described in this section, it will not be considered a "claims appeal" under the Plan.

Under this Plan, HealthSCOPE Benefits, Inc. is not the Named Fiduciary for purposes of reviewing claims appeals under the Plan, but is instead acting strictly at the request of the Plan Administrator to coordinate receipt of appeals on behalf of the Plan.

Time Frame for Claims Appeal Review For Pre-Service Claim - All Pre-Service Claim Appeals will be reviewed and written notification of the Named Fiduciary's decision will be prepared and mailed to the Covered Person who submitted the claim appeal within 30 days of receiving the request for appeal of a Pre-Service Claim. As used in this section, a Pre-Service Claim Appeal is an appeal for any adverse claims determination in connection with a Pre-Service Claim.

Time Frame for Claims Appeal Review for Urgent Care Claim – An Urgent Care Claim Appeal will be reviewed immediately and the Covered Person will be notified of the Named Fiduciary's decision within 72 hours of receiving the request for appeal. Because of the urgency related to Urgent Care Claim Appeals, all notifications concerning an appeal decision may be made verbally, or by fax or other electronic means. As used in this section, an Urgent Care Claim Appeal is an appeal for any adverse claims determination in connection with an Urgent Care Claim.

Time Frame for Claims Appeal Review For Post-Service Claim - All Post-Service Claim Appeals will be reviewed and written notification of the Named Fiduciary's decision will be prepared and mailed to the Covered Person who submitted the claim appeal within 60 days of receiving the request for appeal of a Post-Service Claim. As used in this section, a Post-Service Claim Appeal is an appeal for any adverse claim determination in connection with a Post-Service Claim.

Information Included in an Adverse Appeal Determination - All adverse appeal determinations will include the following information:

1. The reason for the determination;
2. The reference to the specific plan provision(s) on which the benefit determination is based;
3. A statement that the Covered Person is entitled to receive free of charge access to and copies of documents and records pertinent to the claim;
4. A statement of the Covered Person's right to bring a civil action under ERISA section 502(a), which right only applies if the Plan is an ERISA plan;
5. A statement of the Covered Person's right to obtain free of charge, internal rules, guidelines, protocols, or other similar criterion used in making the adverse determination; and
6. Either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan, or a statement that such explanation may be obtained free of charge upon request if the claim was denied on the basis of medical necessity or Experimental or Investigative grounds.

The decision of the Named Fiduciary with regard to an appeal is final.

COORDINATION OF BENEFITS, SUBROGATION AND THIRD PARTY RECOVERY

COORDINATION OF BENEFITS PROVISION

All benefits provided as described in this Summary Plan Description are subject to Coordination of Benefits ("COB"). COB determines when a benefit plan is primary or secondary when a Covered Person is covered by more than one benefit plan.

This COB provision applies when the Covered Person is also covered by this Plan and another benefit plan ("Other Benefit Plan"). When more than one coverage exists, one plan will pay its benefits in full according to the terms of that plan and the other plan(s) will pay a reduced benefit to prevent duplication of benefits. The plan that pays its benefits in full is considered to be the "primary plan." The plan that pays reduced benefits to prevent duplication is considered to be the "secondary plan." A common set of rules is used to determine the order of benefits determination.

When the Plan is primary, the Plan will pay benefits without regard to any Other Benefit Plan. When this Plan is secondary, payment will be based on the primary plan's PPO negotiated rate. In addition, when this Plan is secondary, the benefits payable under this Plan will be reduced so that the sum of benefits paid by all Other Benefits Plans and this Plan do not exceed 100% of total Allowable Expenses.

Definitions: As used in this section, the following terms are defined as:

"Other Benefit Plan" means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

"Allowable Expenses" means any Customary and Reasonable charges that would be considered Eligible Expenses incurred while the Covered Person is covered under this Plan. When this Plan is secondary, Allowable Expenses includes any expenses used to satisfy a deductible, coinsurance or copayment requirement under any Other Benefit Plan **except** for any deductible, coinsurance or copayment requirement under Personal Injury Protection, no-fault, medical payments provision, or any other category (including such benefits mandated by law) of any automobile or vehicle insurance plan.

Automobile Limitations: When medical payments coverage is available under the vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles or other out-of-pocket requirements under the vehicle plan. This Plan shall always be considered secondary regardless of the Covered Person's election under Personal Injury Protection (PIP) or any no-fault coverage with the automobile carrier.

Motor-Vehicle Related Injury: The Plan will not cover the cost of health care expenses resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent that such services or expenses are payable under any Personal Injury Protection, no-fault, medical payments provision, or any other category (including such benefits mandated by law) of any automobile or vehicle insurance plan.

ORDER OF BENEFITS DETERMINATION (OTHER THAN MEDICARE

Which plan provides primary or secondary Coverage will be determined by using the first of the following rules that applies:

1. **No COB**. If the Other Benefit Plan contains no COB provision, it will always be primary.

2. **Employee or Member**. The benefit plan covering the Covered Person as an employee, member or subscriber (other than a Dependent) is primary.

3. **Medicare Eligible**. If a Covered Person is eligible for Medicare, benefits will be coordinated with Medicare as set forth in the section entitled "Order of Benefits Determination for Medicare."

4. **Dependent Child of Parents (Not Divorced or Legally Separated)**. When a Dependent is covered by more than one plan of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary. If both parents have the same birthday, the plan that covered the parent longer will be primary. If a Dependent is covered by two benefit plans and the Other Benefit Plan does not coordinate benefits based on the birthday of the parent (e.g., benefits are coordinated based on the gender of the parents), the rule of the Other Benefit Plan will determine the primary and secondary contract.

5. **Dependent Child of Parents Divorced or Legally Separated**. When a Dependent is covered by more than one plan of different parents who are separated or divorced, the following rules apply:

    a. If the parent with custody has not remarried, his or her coverage is primary;

    b. If the parent with custody has remarried, his or her coverage is primary, the stepparent's is secondary and the coverage of the parent without custody pays last; or

    c. If a court decree specifies the parent who is financially responsible for the Child's health care expenses, the coverage of that parent is primary.

6. **Active Employees vs. Laid Off or Retired Employees**. When a plan covers the Covered Person as an active employee or a Dependent of such employee and the Other Benefit Plan covers the Covered Person as a laid-off or retired employee or as a Dependent of such person, the plan that covers the Covered Person as an active employee or Dependent of such employee is primary.

7. **Above Rules Do Not Apply**. When the rules above do not apply, the plan that has covered the Covered Person longer is primary.

8. **Special Note About Continued Coverage**. If the Covered Person is covered under an Other Benefit Plan that is primary but also has continued Coverage under this Plan (e.g., COBRA) due to the Other Benefit Plan's pre-existing condition exclusion, then this Plan will be primary for expenses incurred in connection with such pre-existing condition only.

ORDER OF BENEFITS DETERMINATION FOR MEDICARE

For individuals who are Medicare eligible (e.g. individuals who are Medicare eligible due to age or disability) Medicare will pay primary, secondary or last to the extent dictated by the Medicare Secondary Payer rules and any other applicable federal statutory or regulatory requirements. When Medicare is to be the primary payer, this Plan will base payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

SUBROGATION AND THIRD PARTY RECOVERY

What is Subrogation?

Subrogation applies to situations where the Covered Person is injured and another party is responsible for payment of health care expenses (s)he incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injury on another's property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Covered Person's injuries under the Plan may be recovered from the other party. Any payments made to the Covered Person for such injury may be recovered from the Covered Person from any judgment or settlement of his or her claims against the other party or parties.

By accepting Coverage under the Plan, the Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. Therefore, the Plan Administrator may act as the Covered Person's substitute in the event any payment made by this Plan for health care benefits, including any payment for a Pre-existing Condition, is or becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim.

The Covered Person must cooperate fully and provide all information needed under the Plan to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure such rights to the Plan. The other party may be sued in order to recover the payments made for the Covered Person under the Plan.

Right of Reimbursement and Recovery

Specifically, by accepting Coverage under the Plan the Covered Person agrees that if the Covered Person receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a tortfeasor, (2) a liability insurer for a tortfeasor, or (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers' compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage ("Recovery"), the Covered Person must repay the Plan in full for any medical, dental, vision, or disability benefits which have been paid or which will in the future be payable under the Plan for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.

Pursuant to *Sereboff v. Mid Atlantic Med. Servs.*, 126 S.Ct. 1869 (2006), the Plan has an equitable lien against the Recovery rights of the Covered Person and has the right to be paid from any such Recovery any and all

monies or properties: (1) paid; (2) payable to; or (3) for the benefit of, a Covered Person to the extent of benefits paid by the Plan ("Subrogated Amount"), whether or not the Covered Person has been "made whole" for the injuries received. This right applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the Covered Person constitute a full or partial recovery, and applies to funds paid for non-health care charges or attorney fees, or other costs and expenses. This right for first priority in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Covered Person or any person or entity responsible for paying any Recovery attempts to designate or characterize the Recovery, regardless of whether the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically linked to certain kinds of damages or payments. Payment of the Subrogated Amount to the Plan shall be without reduction, set-off or abatement for attorney's fees or costs incurred by the Covered Person in the collection of damages. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan Administrator, the Plan may reduce any future Eligible Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Subrogated Amount that is subject to the equitable lien. All rights of recovery will be limited to the amount of payments made under this Plan.

The equitable lien shall also attach to the first right of Recovery to any money or property that is obtained by anybody, including but not limited to the Covered Person, the Covered Person's attorney, and/or a trust for the direct or indirect benefit of the Insured or for his/her "special needs," as a result of an exercise of the Covered Person's rights of Recovery.

The Plan may, in its sole discretion, require the Covered Person, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist the Plan to secure the Plan's right to payment of the Subrogation Amount from the third party. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan may, in its sole discretion, bring legal action against the Covered Person or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Covered Person. If the Plan takes legal action to enforce its subrogation rights, the Plan shall be entitled to recover its attorneys' fees and costs from the Covered Person.

The following provisions apply to the Plan's right of subrogation, reimbursement, and creation of an equitable lien:

1. **"Pursue and Pay."** At its sole discretion, the Plan Administrator may elect to "pursue and pay" in connection with the subrogation, reimbursement and equitable lien rights for claims involving Eligible Expenses. Pursuant to the election of "pursue and pay," the Plan Administrator has the right to apply the subrogation, reimbursement and equitable lien rights prior to making any benefit payments under the Plan, and such payment shall be reduced by any amounts that were paid by any other party as described in this section.

2. **Scope of Subrogation, Reimbursement and Equitable Lien Rights.** The subrogation, reimbursement and equitable lien rights apply to any benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:

    a. Any no-fault insurance;
    b. Medical benefits coverage under any automobile liability plan. This includes the Covered Person's Plan or any third party's policy under which the Covered Person is entitled to benefits;
    c. Under-insured and uninsured motorist coverage;
    d. Any automobile medical payments and personal injury protection benefits;
    e. Any third party's liability insurance

f. Any premises/guest medical payments coverage;
g. Any medical malpractice recovery;
h. Workers' compensation benefits. The right of subrogation, reimbursement and equitable lien attach to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services arose out of and in the course of employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made.
i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).

4. **Excess Payments.** If the Plan erroneously makes total payments that exceed the maximum amount to which the Covered Person is entitled at any time under the Plan, the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.

5. **Reduction of Future Benefits.** The Plan provides that recovery of excess amounts may include a reduction of future benefit payments available to the Covered Person under the Plan of any amount up to the aggregate amount of Reimbursable Payments that have not been reimbursed by the Plan.

6. **"Make Whole" and "Common Fund" Rules Do Not Apply.** The provisions of the Plan concerning subrogation, reimbursement, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines and/or state laws commonly referred to as the "make whole" rule and the "common fund" rule.

7. **No Deductions for Costs or Attorneys' Fees.** The reimbursement required under the Plan shall not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator at the exercise of its sole discretion.

DEFINITIONS FOR MEDICAL PLAN

Actively Working/Actively At Work - Means the employee is performing his or her regular duties on behalf of, and in the regular business of the Plan Sponsor for the hours as set forth in this Summary Plan Description and is reasonably being compensated by the Plan Sponsor on a regular basis for such duties. An employee will retain eligibility for Coverage under the Plan if absent on an approved leave of absence, with the expectation of returning to work following the approved leave of absence as determined by the Employer. The Employer's classification of an individual is conclusive and binding for purposes of determining eligibility under the Plan.

Alcoholism Treatment Facility - Means a facility that is primarily engaged in the treatment of alcoholism. The facility must have in effect plans for utilization and peer review and programs for rehabilitation or rehabilitation and detoxification of alcoholism. The facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Health.

Ambulatory Surgical Facility - Means a facility, with an organized staff of Physicians, which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
2. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
3. Does not provide Inpatient accommodations; and
4. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other Professional.

The facility must be accredited by the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Association.

Assistance Eligible Individual – Means any Qualified Beneficiary who elects COBRA Continuation Coverage, and has satisfied all of the following conditions:

1. The qualifying event occurred at any time during the period that begins with September 1, 2008, and ends with December 31, 2009, and the Qualified Beneficiary was eligible for COBRA Continuation Coverage during this period;
2. The Covered Employee or Qualified Beneficiary must elect COBRA or applicable state continuation coverage;
3. The qualifying event with respect to the COBRA Continuation Coverage consists of the involuntary termination of the Covered Employee's employment and occurred during such period; and
4. The Covered Employee must have had a modified adjusted gross income of less than $145,000, if single, or $290,000, if married filing jointly, for each tax year in which the subsidy is received. Note that the available COBRA subsidy will be reduced for years in which the Covered Employee's gross income exceeds $125,000 (or $250,000 for joint returns).

Benefit Period – Means the period beginning on January 1st and ending on December 31st of each year.

Coinsurance - Means a percentage of the Provider's Allowable Charge that a Covered Person pays for Covered Services.

Community Mental Health Facility - Means a facility that is primarily engaged in the treatment of mental Illness, including substance abuse. The facility must have in effect utilization and peer review plans. The facility must also be approved by the Joint Commission on Accreditation of Health Care Organizations or

certified by the Department of Health.

Confinement - Means an Inpatient stay in a Hospital or other Facility. Two successive Confinements will be considered one Confinement if readmission is for the same or related condition for which the Covered Person was previously confined and the readmission occurs within 90 days.

Copayment - Means the dollar amount payable by the Covered Person for a service, treatment or procedure rendered. The Copayment is applicable on a per occurrence basis.

Coverage - Means the payment for Covered Services as specified and limited by this Summary Plan Description.

Covered Dependent Child(ren) – Means the Dependent Child(ren) who is (are) covered under this Plan.

Covered Employee - Means the employee of the Employer (also referred to as the participant) who has satisfied the eligibility requirements under the Plan and has enrolled for Coverage under the Plan.

Covered Person - Means the Covered Employee, the Covered Spouse and/or Covered Dependent Child(ren).

Covered Services - Means services or supplies that are considered eligible for payment under this Plan.

Covered Spouse – Means the Spouse who is covered under this Plan.

Creditable Coverage - Means coverage under any of the following:

1. Group health plan;
2. Health insurance coverage, group or individual;
3. Medicare;
4. Medicaid;
5. Medical and dental coverage for member and certain former members of Uniformed Services, and their dependents (Title 10 U.S.C. Chapter 55);
6. Medical care program of the Indian Health Services or a tribal organization;
7. State health benefits risk pool;
8. Public health plan;
9. Federal Employees Health Benefits Program;
10. Health benefit plan under Peace Corps Act; and
11. State Children's Health Insurance Program.

Customary and Reasonable Charge – Means the maximum amount of charges for Covered Services (other than Outpatient Dialysis Covered Services) rendered by a Non-Preferred Provider. The Customary and Reasonable Charge that applies to a given service, treatment or supply which shall not exceed the general level of charges assessed by Providers rendering the same type of service, treatment or supplies. The Customary and Reasonable Charge is established using historical data collected for charges by Providers within specific geographic areas for the same or similar services, treatment or supplies. The data may be supplemented with information provided by independent research firms who specialize in the collection of Provider charge data. Unusual circumstances that reasonably require additional time, skill or experience for a Provider's service, are taken into consideration by the Plan and may result in reimbursement of an amount above the Customary and Reasonable maximum but not exceeding the actual charge. The Customary and Reasonable charge does not apply to Preferred Providers or Outpatient Dialysis Covered Services.

Deductible - Means the amount a Covered Person must pay for Eligible Expenses incurred in a Benefit Period before benefits begin to be paid for that person under the Plan.

An Individual Deductible is the amount that each Covered Person must pay during a Benefit Period before benefits begin to be paid for that person. A Family Deductible is the maximum amount that 2 or more family members covered under the same Family Coverage must pay in Deductible expense in a Benefit Period. Under the Family Deductible, one member of the family may satisfy the Individual Deductible. Once the Individual Deductible is reached, the remaining portion of the Family Deductible may be satisfied by a combination of one or more remaining family members. At such point, the Family Deductible will be considered satisfied for all family members under that Family Coverage during the remainder of the Benefit Period.

Deductible Carry Forward - Any Eligible Expenses incurred during the last 3 months of the Benefit Period and credited to the individual Deductible for that Benefit Period will be applied toward the individual Deductible for the next Benefit Period.

Dental Hygienist - Means a person licensed to practice dental hygiene and who is working under the supervision and direction of a Dentist.

Dentist - Means a person licensed to practice dentistry as defined by the state in which the Covered Service is rendered**.**

Dependent - Means the Spouse and/or the Dependent Child(ren).

Dependent Child - Means a dependent child who satisfies the eligibility criteria set forth in the Summary Plan Description. Refer to the section entitled "Eligibility Provisions."

Dependent Limiting Age - Means the date on which the Dependent Child attains the age of 19, or if a Full Time Student, the date on which the Dependent Child attains the age of 23.

Effective Date - Means the date on which Coverage begins.

Eligible Employee - Means an employee of the Employer who satisfies the eligibility criteria set forth in this Summary Plan Description. Refer to the section entitled "Eligibility Provisions."

Eligible Expenses - Means expenses for Covered Services that are incurred by a Covered Person. Eligible Expenses do not include expenses in excess of the Provider's Allowable Charge.

Enrollment Date - Means the first day of coverage, or if there is a waiting period, the first day of the waiting period. As used in this definition, the waiting period means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the Plan can become effective.

Experimental or Investigative - Means the use of any procedure, treatment, facility, equipment, drug, device or supply which is not approved or accepted as standard medical treatment of the condition being treated or any such item requiring American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, U.S. Food and Drug Administration, National Institute of Health, American Dental Association or American Osteopathic Association or other government approval, if it is not granted at the time services are rendered. In determining whether any treatment, procedure, facility, equipment, drug, device or supply is Experimental or Investigative, the Plan Administrator may consider the views of the state

or national medical communities and the views and practices of Medicare, Medicaid and other government financed programs. Although a Physician may have prescribed treatment, such treatment may still be considered Experimental or Investigative within this definition.

Family Coverage - Means Coverage for the Covered Employee and one or more Dependents.

Family or Medical Leave of Absence - Means an unpaid leave of absence to care for a newborn, newly adopted Dependent Child, a sick Dependent Child, spouse or parent, or an unpaid leave of absence due to a serious health condition pursuant to the Family and Medical Leave Act.

Full Time Student - Means a Dependent Child who is enrolled in and regularly attending an accredited college or university for a minimum of 12 credit hours per semester or quarter, or if less than 12 hours is required by that college or university in order to maintain full-time student status, the school's definition of full time student will apply. In a proprietary school, full time attendance means a minimum of 25 hours of classroom attendance per week.

GINA - Means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes.

Therefore, this Plan will not discriminate in any manner with its Participants on the basis of such genetic information.

Home Health Care Agency - Means an agency or organization that provides skilled nursing and other services on a visiting basis in the Covered Person's home, and is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician. A Home Health Care Agency must be certified by Medicare or accredited by the Joint Commission on the Accreditation of Health Care Organizations.

Hospital - Means an institution licensed by the jurisdiction in which it is located; approved by the Joint Commission on the Accreditation of the Health Care Organizations or certified under Medicare. It must provide Inpatient medical care and treatment, a staff of physicians and nurses, facilities for diagnosis and major surgery, but cannot be mainly a place for the aged or for treatment of alcoholism or drug addiction.

Illness - Means any physical disease or mental illness. Pregnancy, premature birth, congenital anomalies and birth anomalies are considered to be Illnesses.

In-Network - Refers to Covered Services rendered by a Preferred Provider.

Individual Coverage - Means Coverage for the Covered Employee only.

Injury - Means an accidental bodily injury caused by external and violent means. Injury to the teeth as a result of biting and chewing is not considered an accidental bodily Injury.

Inpatient - Means a Covered Person who is admitted to a Hospital or Other Medical Facility as a registered Inpatient and who remains in the Hospital or Other Medical Facility for 24 or more hours.

Laboratory - Means a facility which is maintained to perform diagnostic tests and which is approved for Medicare reimbursement.

Loss of Eligibility – As it relates to the HIPAA Special Enrollment Period described herein, Loss of Eligibility includes, but is not limited to the following types of losses:

1. Loss of Eligibility under the other coverage due to divorce, dissolution, legal separation. In this instance, the Eligible Employee and any Dependent Children would be eligible to enroll;
2. Loss of Eligibility under the other coverage due to cessation of dependency status. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll;
3. Loss of Eligibility under the other coverage due to death of the employee. In this instance, the Eligible Employee (whose Spouse has died) and any Dependent Children would be eligible to enroll;
4. Loss of Eligibility under the other coverage due to termination of employment or reduction of hours. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll;
5. Loss of Eligibility under the other coverage because the individual no longer resides in the service area. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll;
6. Loss of Eligibility under the other coverage because the overall Maximum Benefit has been reached. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll; and
7. Loss of Eligibility under the other coverage because the other employer ceases to provide health care benefits to similarly situated individuals. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll.

Maximum Benefit – Means the maximum amount the Plan will pay for a given benefit. The Maximum Benefit can be stated as a dollar amount or the maximum number of days or visits for a specific benefit. In addition, Coverage is subject to a lifetime Maximum Benefit for all Covered Services combined. This is referred to as the Lifetime Maximum Benefit. Refer to the Schedule of Benefits for Maximum Benefit amounts.

Medical Benefits Means the medical Covered Services described in the section entitled "Medical Benefits" and the payment made by the Plan for such services as set forth in this Summary Plan Description.

Medically Necessary (or Medical Necessity) - Means the criteria used to determine the Medical Necessity of Covered Services under this Summary Plan Description.

To be Medically Necessary, Covered Services must:

1. Be rendered in connection with an Injury or Illness or condition;
2. Be consistent with the diagnosis and treatment of the Covered Person's condition;
3. Be in accordance with the standards of good medical practice;
4. Not be considered Experimental or Investigative; and
5. Not be for the Covered Person's convenience or the convenience of the Covered Person's Physician.

To be Medically Necessary, Covered Services must also be provided at the most appropriate level of care or in

the most appropriate type of health care facility. Only the Covered Person's medical condition (not the financial status or family situation, the distance from a Facility or any other non-medical factor) is considered in determining which level of care or type of health care facility is appropriate.

In order for Covered Services to be paid, the services must be Medically Necessary. Any service failing to meet the Medical Necessity criteria may be the Covered Employee's liability.

Medically Necessary Leave of Absence – Means a Leave of Absence by a full-time student Dependent in a postsecondary educational institution that:

1. Commences while such Dependent is suffering from a serious Illness or Injury;
2. Is Medically Necessary; and
3. Causes such Dependent to lose student status at a postsecondary educational institution for purposes of coverage under the terms of the Plan.

Medicare - Means the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Michelle's Law – Means H.R. 2851.

Morbid Obesity – Means the following:

1. Body Mass Index ("BMI") greater than 40; or
2. BMI greater than 35 if serious co-morbid conditions co-exist; or
3. Endogenous obesity (contained within the body) including, but not limited to, metabolic factors such heperinsular, hyperinterrenal, hypogonad, hypothyroidism, hypercholesterolemia, and obesity due to hypothalamic lesions; or
4. Exogenous obesity (caused by overeating).

Negotiated Rate – Means the rate established by the contract in effect between the PPO Network and the Preferred Provider. Under this contract, the Preferred Provider has agreed to accept a reduced rate ("Negotiated Rate") as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate.

Non-Preferred Provider - Means a Provider who is not participating in the PPO Network that appears on the Covered Person's identification card.

Ophthalmologist - Means a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.) legally qualified to practice medicine, including diagnosis, treatment and prescribing of medications and lenses related to conditions of the eye.

Optometrist - Means only a person licensed to practice optometry as defined by the laws of the state in which the service is rendered.

Other Benefit Plan - Refers to COB and means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

Out-of-Network - Refers to Covered Services rendered by a Non-Preferred Provider.

Out-of-Pocket Limit - Means the maximum or limit on the Covered Person's Coinsurance requirement in a

Benefit Period and acts as a cap or limit on the Coinsurance. In this event, 100% of Eligible Expenses will be paid for the remainder of the Benefit Period or until (s)he reaches the Maximum Benefits as described in this Summary Plan Description, whichever occurs first. Only the Coinsurance expense is used to meet the Out-of-Pocket Limit. The Out-of-Pocket Limit does not include the Deductible or any other expenses other than the Coinsurance expense.

An Individual Out-of-Pocket Limit is the maximum amount each Covered Person is required to pay in Coinsurance expenses in a Benefit Period.

A Family Out-of-Pocket Limit is the maximum amount 2 or more family members covered under the same Coverage are required to pay in Coinsurance expense in a Benefit Period.

Outpatient - Means a Covered Person who receives medical care or treatment when he or she is not an Inpatient.

Outpatient Dialysis Usual and Reasonable Charge – Means charge(s) for Outpatient Dialysis which is/are based upon the average payment actually made for reasonably comparable services and/or supplies to all Providers of the same services and/or supplies by all types of plans in the same market area during the preceding calendar year, adjusted for the National Consumer Price Index medical care rate of inflation. The Plan Administrator may pay or reimburse charges greater than the Outpatient Dialysis Usual and Reasonable Charge based upon factors concerning the nature and severity of the condition being treated, geographic and market considerations and provider availability, in the exercise of the Plan Administrator's discretion. All charges must be billed in accordance with generally accepted industry standards.

Partial Hospitalization - Means a psychiatric and/or substance abuse program that is accredited by the Joint Commission of Accreditation of Health Care Organizations or in compliance with equivalent standards for patients who require skilled level of care in a Hospital or Other Medical Facility but who do not need treatment for an acute or life threatening condition. A Partial Hospitalization is provided in a treatment setting that is less than a 24-hour residential setting.

Pharmacy - Means a facility that is a licensed establishment where prescription drugs are dispensed by a pharmacist under applicable state laws.

Physician - Means one of these professionals licensed under the applicable state laws:

1. Doctor of Medicine (M.D.)
2. Doctor of Osteopathy (D.O.)
3. Podiatrist (D.P.M.) or Surgical Chiropodist (D.S.C.)
4. Dental Surgeon or Dentist (D.D.S.)
5. Doctor of Optometry (O.D.)
6. Psychiatrist
7. Psychologist

8. **Plan Administrator** – Means the person designated to administer the Plan. The Plan Administrator is Weldon, Williams and Lick, Inc.

Plan Document - Means the governing document for the Health Plan, as required under ERISA, that has been adopted and sponsored by the Plan Sponsor

Plan Fiduciary – Means the Employer or person designated by the Employer to act as the Plan Fiduciary.

The Plan Fiduciary is Weldon, Williams and Lick, Inc.

Plan Sponsor – Means the person designated to sponsor the Plan. The Plan Sponsor is Weldon, Williams and Lick, Inc.

PPO Network – Means the network of Preferred Providers to which the Covered Persons will have access under this Plan.

Pre-Existing Condition - Means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the Covered Person's Enrollment Date. A pregnancy is not considered a Pre-Existing Condition.

Pre-Existing Condition Waiting Period - Means the waiting period in connection with a Pre-Existing Condition as set forth in this Plan.

Preferred Provider - Means a Provider who is a member of the PPO Network that appears on the Covered Person's identification card.

Prescription Drug Benefits - Means the Covered Services for prescription drugs obtained from a Pharmacy and/or Mail Order Drug Company as described in the section entitled "Prescription Drug Benefits" and the payment made by the Plan for such services as set forth in this Summary Plan Description.

Primary Care Physician ("PCP") – Means a Physician in Family Medicine, General Medicine, Internal Medicine, Pediatrics, and Obstetrics and Gynecology.

Protected Health Information - Means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Personal health information includes information of persons living or deceased. The following components of a member's information also are considered personal health information: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code. Protected Health Information includes Electronic Protected Health Information as defined at 45 C.F.R. §160.103 that is received from, or created or received on behalf of the Plan.

Provider - Means for Medical Benefits, the Facility Providers or Professional Providers listed below which are licensed and are operating within the scope of that license:

Facility Provider – Means a Hospital and an Other Medical Facility.

Other Medical Facility - Means a Facility Provider other than a Hospital and includes the following:

1. Ambulatory Health Facility

2. Ambulatory Surgical Facility
3. Home Health Care Agency
4. Skilled Nursing Facility
5. Community Mental Health Facility
6. Alcoholism Treatment Facility
7. Specialized Hospital

Professional Provider – Means a Physician and an Other Medical Professional**.**

Other Medical Professional - Means a Professional Provider other than a Physician and includes the following:

1. Physical Therapist
2. Speech Therapist
3. Registered Nurse Anesthetist (C.R.N.A.)
4. Registered Nurse (R.N.)
5. Licensed Practical Nurse (L.P.N.)
6. Licensed Occupational Therapist (O.T.)
7. Pharmacy
8. Certified Nurse Midwife (C.N.M.)
9. Laboratory (must be Medicare approved)
10. Professional Ambulance Service
11. Licensed Social Worker

Provider's Allowable Charge – Means the method used by the Plan for determining the maximum amount of charges to consider in determining benefit payments under the Plan. Payment will be subject to any applicable Deductible, Coinsurance and other applicable Plan provisions. The Plan will determine the Provider's Allowable Charge for all Providers. The Provider's Allowable Charge is determined as follows:

1. **Outpatient Dialysis Services**: For Outpatient Dialysis Covered Services, the Provider's Allowable Charge is the Outpatient Dialysis Usual and Reasonable Charge, as defined herein.

2. **Other Covered Services by Preferred Provider**: For all other Covered Services rendered by a Preferred Provider, not including Outpatient Dialysis Covered Services, the Provider's Allowable Charge will be based on the Negotiated Rate set forth in the PPO contract.

3. **Other Covered Services by a Non-Preferred Provider**: For all other Covered Services rendered by a Non-Preferred Providers, not including Outpatient Dialysis Covered Services, the Provider's Allowable Charge will be the Reasonable and Customary Charge, as defined herein.

Qualified Medical Dependent Child Support Order (QMCSO) – Means a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan. An Eligible Employee may obtain a copy of such procedures from the Plan Sponsor.

Rehabilitation Facility – Means a facility that is primarily engaged in the Inpatient treatment and rehabilitation of the Covered Person as the result of an acute Illness or Injury, not including the rehabilitation of a condition resulting from substance abuse. The facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Health.

Schedule of Benefits - Means a separate schedule showing vital information with respect to the Coverage under this Plan.

Significant Break - Means a period of 63 consecutive days during each of which the individual does not have Creditable Coverage**.**

Skilled Nursing Facility - Means a facility that mainly provides Inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal custodial care, ambulatory or part time care or that provides treatment for mental illness, alcoholism, drug abuse or tuberculosis. The Skilled Nursing Facility must be certified by the Medicare program.

Special Enrollment Period – Means a period following the Eligible Employee's initial eligibility under the Plan during which the employee and Eligible Dependents may enroll for Coverage following the loss of other coverage, marriage, birth or adoption of a child as set forth herein.

Specialized Hospital - Means a facility that is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must also be provided under the supervision of a registered nurse.

Spouse – Means the individual of the opposite sex who is married to the Eligible Employee in accordance with the laws of the state in which they reside. The term Spouse does not include common law spouses.

Summary Health Information - Means information, that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

Summary Plan Description – Means the document that is provided by the Plan Administrator and that describes, in understandable terms, the Covered Person's rights, benefits and responsibilities under the Health Plan. This document serves as the Summary Plan Description for the Health Plan administered by the Plan Administer and sponsored by the Plan Sponsor.

Transplant Benefit Period – Means the period beginning on the date of the initial evaluation and ending 12 consecutive months after the date of the transplant. If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.

PART 2
SECTION 125 PLAN

OVERVIEW

The Employer offers a Section 125 Flexible Benefits Plan that can help the Participating Employee offset expenses by allowing such employee to use pre-tax dollars to pay for certain expenses.

Pre-tax dollars are dollars that are set aside from the Participating Employee's earnings before taxes are assessed.

These pre-tax dollars are used to pay the Participating Employee's Premium Conversion Option contributions and the Dependent Care and Health Care Expenses under the FSA. The following flexible benefits are available to the Participating Employee each year. The Eligible Employee may elect to participate in any or all of these options:

PREMIUM CONVERSION OPTION

SPENDING ACCOUNT OPTIONS

Dependent Care
Health Care

Each option under the Section 125 Plan has separate rules governing benefits and plan administration, subject to the provisions of applicable Federal legislation, which is commonly referred to as Section 125. The benefits are described briefly in this overview and in more detail on the following pages.

PREMIUM CONVERSION OPTION – If the Eligible Employee elects the Premium Conversion Option, his or her cost will automatically be deducted from his or her earnings on a pre-tax basis – unless the employee advises his or her Employer otherwise, in writing, at the time of enrollment.

FLEXIBLE SPENDING ACCOUNTS – If the Eligible Employee wants to pay for his or her Health Care and/or Dependent Care Expenses with pre-tax dollars, the estimated expenses will be deducted and set aside from his or her earnings on a pre-tax basis. The Employer will use these contributions to establish a Flexible Spending Account specifically for the Participating Employee.

The Flexible Spending Account (FSA) is easy to use:

1. The Participating Employee contributes a set amount from each paycheck to his or her FSA;

2. No taxes will be withheld on the amount the Participating Employee contributes to the FSA; and

3. The Participating Employee submits a request for reimbursement from his or her FSA after the Participating Employee has paid a health or dependent care expense. Reimbursement will made via direct deposit. A check will not be issued for health or dependent care expenses incurred.

ADVANTAGES OF FSA

There are a number of advantages for participating in an FSA:

1. The Participating Employee takes home more of his or her earnings because the Participating Employee is setting aside money for his or her estimated expenses with pre-tax dollars. This will lower the Participating Employee's taxable income before Federal income and Social Security taxes are withheld from his or her earnings;

2. There is no charge to the Participating Employee for the tax advantages offered by this Plan;

3. The Participating Employee's reimbursement from the FSA are not taxed; and

4. The Participating Employee's tax savings for dependent care may be greater with an FSA than with the Federal income tax credit.

DISADVANTAGES OF FSA

There are a number of disadvantages to participating in an FSA:

1. The Participating Employee must use all the money set aside for his or her estimated expenses, or forfeit what is not used;

2. The Participating Employee must leave his or her elections under the Plan unchanged for one year, unless the Participating Employee experiences a change that allows for a mid-year election change as explained herein;

3. The Participating Employee's Social Security benefits may be slightly reduced because his or her taxable income is reduced. This process reduces the amount of contributions that the Participating Employee makes to the Federal Social Security system, as well as the Employer's contribution to Social Security on the Participating Employee's behalf; and

4. The Participating Employee's tax savings for dependent care may not be greater with an FSA than with the Federal income tax credit.

ELIGIBILITY AND PARTICIPATION

ELIGIBILITY

The Employee must meet the following eligibility requirements in order to be considered an Eligible Employee for the Flexible Benefits Plan:

1. The Employee must regularly work 36 hours per week, or meets the requirements of a full-time employee;

2. The Employee cannot be a temporary Employee; and

3. The Employee must be Actively Working.

The Employee may participate in the Section 125 Plan even if the Employee does not elect coverage under the Employer's Health Plan.

NEW EMPLOYEE ENROLLMENT

In order to participate in the Section 125 Plan, the Eligible Employee will be required to complete an election form within two weeks of date when his or her participation under the Plan will commence. When completing the election form, the employee will need to designate if (s)he will be participating in the Health Care FSA and/or Dependent Care FSA and, if so, will need to designate the FSA contribution amount under each option. If the election form is submitted within this two-week period, participation under the Section 125 Plan will begin on the 3 month anniversary of Active Work.

In order to provide the Employee with the tax savings advantage of the Premium Conversion Option and FSA Plan, the Federal government requires that the benefit options the Employee elects remain unchanged throughout the year, except in the case of a qualified Change In Status or other event change, as defined in this Summary Plan Description.

OPEN ENROLLMENT

Each year, the employee will be required to re-submit an Election Form indicating what his or her elections will be for the upcoming Plan Year. All employees will automatically be enrolled in the Premium Conversion Option (provided the employee is enrolled for Coverage under the Health Plan). However, an employee will be required to designate an FSA election if (s)he wishes to participate in the Health Care and/or Dependent Care FSA. This applies even if the employee was a Participant in the FSA during the preceding Plan Year. If the employee fails to make an election, or waives participation in the Health Care and/or Dependent Care FSA, the employee will not be enrolled in any FSA option. This means that (s)he will not be able to receive any reimbursement under the FSA.

The Employer will provide the employee with a written election form that will enable the employee to indicate the options the employee is choosing and the amount of pre-tax dollars that will be applied to each FSA, if elected.

The Plan's Open Enrollment Period is determined by the Employer each year. All election forms must be completed and submitted to the Employer each preceding year for the Employee's Section 125 Plan options to become effective for the following year.

MID-YEAR ELECTION CHANGE

The Employee may have the right to change the choice(s) (s)he has made for the current year for his or her Premium Conversion election, Health Care FSA or Dependent Care FSA, if the Employee experiences the specific events described below, as outlined in Treasury Regulation § 1.125-3, Treasury Regulation § 1.125-4, IRS Notice 2004-50 and 2004-33 I.R.B. 196. In addition, the Employee may have the right to revoke the Premium Conversion election, Health Care FSA election or Dependent Care FSA election entirely if (s)he experiences certain events, as outlined in Treasury Regulation § 1.125-3, Treasury Regulation § 1.125-4, IRS Notice 2004-50 and 2004-33 I.R.B. 196.

Any change or revocation must be (a) consistent with the events described in this section to the extent that it is necessary or appropriate as the result of such change and (b) submitted as a written request to the Employer no later than 30 days prior to making such change. With the exception of a change made as the result of birth, adoption or placement for adoption, retroactive change or retroactive revocation will not be permitted under the Plan.

Some group health plans are considered to be excepted benefits. HIPAA special enrollment rules do not apply if the Plan is an excepted benefit. As such, a cafeteria plan does not have to permit pre-tax changes for HIPAA special enrollment events, but must permit an individual who qualifies for the special enrollment rights to elect on an after-tax basis. (Refer to the Health Plan Summary Plan Description for detailed information regarding HIPAA special enrollment events.) Additionally, most health FSA plans are excepted benefits as defined in Code § 106(c)(2). If the health FSA plan is an excepted benefit, HIPAA Special Enrollment requirements do not apply.

MID-YEAR ELECTION TABLE

The following table provides an overview regarding when mid-year election changes or revocations may be permissible under Premium Conversion and Health and Dependent Care FSAs. Contact the Plan Administrator for specific information regarding the specific circumstances under which changes and revocations may be made.

Event	Premium Conversion Plan	Health Care FSA	Dependent Care FSA
Change in Status Special Notes Concerning "Changes in Status": 1. In the event of a divorce, annulment, legal separation, death of spouse/dependent or dependent ceasing to be eligible, the Employee may only be permitted to change or revoke the election for the affected individual. 2. In the event eligibility is gained under family member coverage through another employer health care plan as a result of a change in marital status or employment status, the Employee may be permitted to change or revoke his or her Health Care FSA election, Premium Conversion and/or Dependent Care FSA election only if the coverage under the other health care plan takes effect or is increased.	Applies	Applies	Applies
Cost Changes with Automatic Increase/Decrease in Elective Contributions This change applies whether due to action by the Employer (e.g., reduced employer contribution) or Employee (e.g., switching to part-time employment status).	Applies	Not Applicable	Applies
Significant Cost Changes This change applies when the cost charged to Employee for a benefits package option significantly increases or decreases. This change applies whether due to action by the Employer or Employee.	Applies	Not Applicable	Applies
Significant Curtailment of Coverage This change applies when coverage for the Employee, spouse or dependent is significantly curtailed with or without loss of coverage (e.g., an	Applies	Not Applicable	Applies

increase in deductible or HMO option is eliminated).			
Addition or Significant Improvement of Benefit Package Option	Applies	Not Applicable	Applies
Change in Coverage under other Employer Cafeteria Plan or Qualified Benefits Plan	Applies	Not Applicable	Applies
Loss of Coverage under Group Health Plan of Governmental or Educational Institution	Applies	Not Applicable	Not Applicable
Changes in 401(k) Contributions	Not Applicable	Not Applicable	Not Applicable
HIPAA Special Enrollment Rights	Applies	Applies	Not Applicable
COBRA Qualifying Events	Applies	Applies	Not Applicable
Judgment, Decree or Order This change applies when a dependent becomes eligible as the result of a judgment, decree or order resulting from divorce, legal separation, annulment or change in legal custody that requires accident or health coverage for a dependent child.	Applies	Applies	Not Applicable
Medicare or Medicaid Eligibility	Applies	Applies	Not Applicable
FMLA Leaves of Absence	Applies	Applies	Applies
Pre-Tax HSA Contributions	Not Applicable	Not Applicable	Not Applicable
Note: Any change or revocation must be (a) consistent with the events described in this section to the extent that it is necessary or appropriate as the result of such change and (b) submitted as a written request to the Employer no later than 30 days prior to making such change, and must be in accordance with Treasury Regulation § 1.125-3, Treasury Regulation § 1.125-4, IRS Notice 2004-50 and 2004-33 I.R.B. 196. Contact the Employer for details.			

LEAVE OF ABSENCE

Health Care FSA

1. **Paid Leave (FMLA or any other Paid Leave of Absence to which the Employee is entitled):** If the Participating Employee experiences an absence from work due to an approved paid leave in accordance with the provisions of the Family Medical Leave Act (FMLA) or any other paid leave of absence to which the employee is entitled, (s)he may continue the Health Care FSA on the same terms and conditions as though the (s)he were an active employee. If the Employer mandates that the Participating Employee continue coverage and participation in the Health Care FSA while on paid leave, the Participating Employee's contributions to the Health Care FSA will continue to be made on a pre-tax basis via payroll deductions.

   A Participating Employee who is on a paid leave of absence has the same rights during the leave as an employee who is not on leave. All provisions of this Plan will be administered as required by Federal regulations. Refer to the Employer's Health Plan Summary Plan Description for more information. The Participating Employee may also discuss his or her specific situation with a Human Resources representative.

2. **Unpaid Leave of Absence (FMLA or any other Unpaid Leave of Absence to which the Employee is entitled):** If the Participating Employee experiences an absence from work due to an approved unpaid leave in accordance with the provisions of the Family Medical Leave Act (FMLA) or any other unpaid leave of absence to which (s)he is entitled, the Employer may permit the employee the opportunity to

choose in writing between: 1) continuing participation in the Health Care FSA during the leave of absence; or 2) revoking participation in the Health Care FSA for the duration of the leave of absence.

An Employer may also require that a Participating Employee continue health care coverage (including a Health Care FSA) during an unpaid leave of absence provided that the Employer pays the Participating Employee's share of the health care premiums. The Employer may recover the Participating Employee's share of the health care premiums when the employee returns to work.

If a Participating Employee who is on an unpaid leave of absence continues participation in the Health Care FSA, (s)he will be permitted to continue participation in the Health Care FSA for the duration of the leave of absence and must continue to make the same Health Care FSA contributions that he was making immediately prior to the leave of absence.

The Participating Employee may make Health Care FSA contributions for continued participation in the Health Care FSA by:

a. Choosing to pre-pay costs in pre-tax or after-tax dollars before an anticipated leave;

b. Choosing to make monthly payments from the Participating Employee's own funds either at the time payment would have been made if by payroll deduction or on the same schedule as payments are made for COBRA continuation coverage on an after-tax basis; or

c. Opting to discontinue Health Care FSA contributions during the leave of absence, whereas the Employer will make the Participating Employee's Health Care FSA contributions during the leave of absence, but the Employer will recoup the Participating Employee's share of the Health Care FSA contributions upon the Participating Employee's return to work on a pre-tax or after-tax basis.

If the Participating Employee's participation in the Health Care FSA terminates while the Participating Employee is on a leave of absence due to revoking participation in the Health Care FSA or failure to make the Health Care FSA contributions, the Participating Employee is not entitled to receive reimbursement for any claims incurred during the period for which participation in the Health Care FSA was terminated. A Participating Employee is entitled to elect to be reinstated, or the Employer may require reinstatement, in the Health Care FSA upon the Participating Employee's return to work at the same coverage level that was in effect prior to the leave with increased contributions for the remaining period of coverage or at a coverage level that has been reduced by the period of time while the Participating Employee was on leave when Health Care FSA contributions were not made.

Contact the Plan Administrator to determine what option(s) is/are available to Participating Employees on an unpaid leave of absence to determine how payments should be made to continue participation in the Health Care FSA.

A Participating Employee who is on an unpaid leave of absence has the same rights during the leave as a Participating Employee who is not on leave. All provisions of this Plan will be administered as required by Federal regulations. Refer to the Employer's Health Plan Summary Plan Description for more information. The Participating Employee may also discuss his or her specific situation with a Human Resources representative.

Premium Conversion Option: If the Participating Employee experiences an absence from work due to an approved paid FMLA leave of absence or any other approved leave of absence to which (s)he is entitled, the employee may continue his or her participation in the Premium Conversion Option on the same terms and

conditions as though the employee were an active employee. In this instance, the employee's participation will be continued only if (s)he continues to direct his or her salary for purposes of paying his or her premium contribution under the Premium Conversion Option. The Employer will assist the Participating Employee in arranging to make contributions to his or her Premium Conversion Option. For example, the employee may make his or her premium contributions through the following methods:

1. The Participating Employee might choose to make his or her Premium Conversion contributions with after-tax dollars while (s)he is on leave;

2. The Participating Employee might choose to pre-pay his or her costs in pre-tax dollars before an anticipated leave; or

3. The Participating Employee might make another arrangement with the Plan Administrator.

Contact the Plan Administrator to determine how payments should be made to continue participating under the Premium Conversion Option.

The Employee may also discontinue participation under the Premium Conversion Option during an approved paid leave of absence by notifying the Employer within 31 days of the start of the leave of absence. If the Employee fails to notify the Employer that (s)he wishes to discontinue participation under the Premium Conversion Option during such paid leave of absence, the employee's participation will automatically be continued and (s)he will be required to pay his or her contributions with after-tax dollars.

All provisions of this Plan will be administered as required by Federal regulations. Refer to the Employer's Health Plan Summary Plan Description for more information. The Employee may also discuss his or her specific situation with the Employer.

Dependent Care FSA

If the Participating Employee experiences an absence from work due to an approved paid or unpaid leave of absence in accordance with the provisions of the Family Medical Leave Act (FMLA) or any other leave of absence to which the employee is entitled, contributions to the Dependent Care FSA will be discontinued for the duration of the leave. Expenses incurred during the leave of absence are generally not eligible for reimbursement, but claims for Eligible Expenses incurred prior to the commencement of the leave may be submitted in accordance with the Plan's provisions.

RETURN TO WORK

Premium Conversion Option: When the Participating Employee returns from an approved leave of absence, (s)he will be permitted to resume his or her Premium Conversion Option contributions on the same basis as before the leave of absence.

Health Care FSA Plan: If the Participating Employee returns from a FMLA or USERRA leave of absence within the same Plan Year, the Health Care FSA contributions that were in effect immediately prior to the leave of absence will resume automatically. This applies whether or not the Participating Employee elected to continue his or her Health Care FSA contributions during the leave of absence. If the employee does not return within the same Plan Year, (s)he will be required to make a new Health Care FSA election upon his or her return to work before Health Care FSA contributions will be continued.

Dependent Care FSA Plan: If the Participating Employee returns from a FMLA or USERRA leave of

absence within the same Plan Year, the Dependent Care FSA contributions that were in effect immediately prior to the leave of absence will resume automatically. This applies whether or not the Employee elected to continue his or her Dependent Care FSA contributions during the leave of absence. If the Employee does not return within the same Plan Year, (s)he will be required to make a new Dependent Care FSA election upon his or her return to work before Dependent Care FSA contributions will be continued.

PREMIUM CONVERSION OPTION

Under the Premium Conversion Option, any required contributions made by the Participating Employee for his or her health care coverage under the Employer's Health Benefit Plan will automatically be made on a pre-tax basis – unless the Participating Employee advises the Employer otherwise, in writing, at the time of enrollment. This arrangement is administered in accordance with the provisions of Federal regulations for a Section 125 Flexible Benefits Plan.

Participation in a Section 125 Flexible Benefits Plan requires that the Participating Employee continue his or her elections for the remainder of the Plan Year until the next Open Enrollment Period. Exceptions may be made, as outlined in the section entitled "Mid-Year Election Change."

For a specific description of the Health Benefit Plan, refer to the Employer's Summary Plan Description that describes the health care benefits (e.g., medical, prescription drug and dental coverage).

The Participating Employee's portion of the cost for his or her elections under the Premium Conversion Option is deducted from his or her earnings in equal amounts, or prorated for the Plan Year. This means that the deduction for each pay period is determined by dividing the Participating Employee's cost for the Plan Year by the number of pay periods in the Plan Year.

SPENDING ACCOUNTS

The employee may take advantage of the tax savings offered by Section 125 Accounts ("FSAs") simply by predicting certain expenses for the upcoming Plan Year, and having the money for those expenses set aside from his or her regular earnings before taxes are assessed. The deduction (or contribution) from the employee's earnings is prorated, which means that the earnings reduction for each pay period is determined by dividing the employee's contributions for the Plan Year by the number of pay periods in the Plan Year. The employee may want to make additional adjustments when the Plan Administrator has elected a Grace Period.

This arrangement is administered in accordance with the provisions of Federal regulations for a Section 125 Flexible Benefits Plan.

Participation in a Section 125 Flexible Benefits Plan requires that the Employee continue his or her elections for the remainder of the Plan Year until the next Open Enrollment Period. Exceptions may be made, as outlined in the section entitled "Mid-Year Election Change."

If the Eligible Employee chooses to participate in the Section 125 Flexible Spending Plan for Dependent Care Expenses and/or Health Care Expenses, the Employer will establish a separate bookkeeping account for each in order to manage the employee's funds. This account is referred to as a Flexible Spending Account (FSA).

Based on the Participating Employee's elections, the Employer will set aside pre-tax dollars from the Employee's regular earnings. These pre-tax dollars are referred to as contributions to the Participating Employee's FSA(s). This action reduces the Participating Employee's taxable earnings, but it will appear as a deduction on his or her earnings statement.

The Participating Employee will be reimbursed from the FSA after the employee incurs Eligible Expenses and submits a request for reimbursement. See the sections entitled "Requesting Reimbursement and Appeal Rights."

Expenses that are reimbursed from the Participating Employee's FSA may not be claimed as deductions for Federal income tax purposes. The Participating Employee may claim an expense only once – either through his or her FSA or on his or her Federal income tax return.

Each FSA is independent of any other. For example, the funds from the Employee's Health Care FSA may not be used to reimburse Dependent Care Expenses under the Dependent Care FSA, and vice versa.

ELIGIBLE EXPENSES

To be considered eligible for reimbursement under the FSA:

1. The expense must be an eligible Dependent Care and/or Health Care Expense;
2. The expense must be incurred during the Plan Year; and
3. The Employee was participating in the Plan on the date the expenses were incurred;

ESTIMATING EXPENSES

The Participating Employee must estimate his or her Health Care Expenses and Dependent Care Expenses for the upcoming Plan Year and then elect, through the enrollment process, to make salary reduction contributions in that amount. The Participating Employee's estimate should be calculated very carefully, considering all expenses that (s)he expects to encounter.

The Participating Employee may want to be conservative in his or her estimate when (s)he is uncertain about a particular expense item. Carefully consider the following facts:

1. If the Employee's actual expenses exceed the contribution (s)he made to the FSA, the Employee may still claim any such Eligible Expenses as a Federal income tax deduction;
2. If the Employee's actual expenses are less than the contribution (s)he made to the FSA, the Employee will forfeit, or lose, the amount of money (s)he over-estimated.

HEALTH CARE FSA

The use of FSA's can result in significant tax savings to the Employee. This savings will help to offset the Participating Employee's health care costs. However, the employee may want to compare these tax advantages to those available under the Federal Tax Credit for health care to be certain which better serves the employee and his or her family.

Contribution for Health Care Expenses

There is no minimum contribution that the Employee must make to a Health Care FSA per year. The contribution the Employee elects to make for anticipated Health Care Expenses for the Plan Year may not exceed the maximum contribution allowed by the program, which is $2,500.

Eligible Health Care Expenses

The Participating Employee's FSA can be used to reimburse medical and dental expenses that qualify as Federal income tax deductions.

Health Care Expenses that are eligible for reimbursement include the Employee's out-of-pocket Health Care Expenses that are not covered by his or her health care plan. This generally includes the following:

1. Deductibles;
2. Copays;
3. Coinsurance;
4. Expenses that exceed any Plan limits;
5. Expenses that exceed any usual and customary charges; and
6. Most expenses that are medically necessary or prescribed by a licensed physician.

There is a wide range of expenses that are eligible, for example: vision care; child-birth classes for an expectant mother; infertility treatment; acupuncture; medical care in a nursing home; guide dogs; and special equipment or training related to disabilities.

Non-prescription medications are also an eligible expense, provided they are used to cure, mitigate, treat or prevent disease or have the purpose of affecting a bodily function. Non-prescription medications are often referred to as "over-the-counter" because they are available for purchase without a prescription. Eligible over-

the-counter products include, for example: antiseptics; medications to treat asthma, cold, flu and allergies; diabetic supplies; ear and eye care products; health aids; pain relievers; personal test kits; and medications for skin care and stomach care.

Certain over-the-counter products can have a dual purpose, and may therefore require a physician's statement of need in order to be considered as an Eligible Expense. Other items that may also be available over-the-counter but are not considered as eligible non-prescription drug expenses include, but are not limited to: vitamins; dietary supplements; diet food and diet beverages; cosmetics; and other personal use items.

Ineligible Health Care Expenses

The following expenses will not be included as Eligible Expenses:

1. Cost of coverage under any other health plan,
2. Coverage under a spouse's plan;
3. Premiums for any long term care insurance;
4. Expenses or charges related to vitamins;
5. Expenses or charges related to dietary supplements, diet food and diet beverages;
6. Expenses or charges related to cosmetics and other personal use items;
7. Expenses or charges related to hair transplants,
8. Expenses or charges related to health clubs,
9. Expenses or charges related to hot tubs,
10. Expenses or charges related to nutritional supplements,
11. Expenses or charges related to custodial care,
12. Expenses or charges related to domestic help; and
13. Expenses or charges related to non-reconstructive cosmetic surgery.

Contact the Plan Administrator to determine the eligibility of specific expenses the Employee may anticipate for himself or herself and/or his or her dependents. The employee may also refer to IRS Publication 502 for current information regarding what expenses the employee may deduct from his or her Federal income tax.

DEPENDENT CARE FSA

The use of FSA's can result in significant tax savings to the Participating Employee. This savings will help to offset the Participating Employee's dependent care costs. However, the Participating Employee may want to compare these tax advantages to those available under the Federal Tax Credit for dependent care to be certain which better serves the employee and his or her family.

Contribution for Dependent Care Expenses

There is no minimum contribution the Employee must make to a Dependent Care FSA per year. In addition, the maximum contribution for the Plan Year may not exceed the maximum contribution allowed by the program, which is $5,000. The Participating Employee's marital status, filing of his or her income tax return (joint or separate) and spouse's participation in another FSA plan may impact the maximum contribution permitted under the Plan.

For example, if the Participating Employee is married and filing a joint federal income tax return or is single, the maximum contribution permitted is $5,000. If the Participating Employee is married and filing separate federal income tax returns, the maximum contribution for that employee is $2,500. However, in no event can the maximum contribution amount exceed the Employee's (taxpayer's) earned income or, if less, the earned

income of the Participating Employee's spouse.

Please note: A Participating Employee's spouse who is either a full-time student or incapable of self-care, has the same principal abode as the employee for more than one-half of the tax year and has no earned income is considered to be gainfully employed for purposes of Dependent Care FSA and to have an earned income of $250 per month (or $500 per month if there are two or more qualifying individuals) in each month during which the spouse is either a full-time student or incapable of self-care.

Contact the Employer for details.

Eligible Dependents

In order for Eligible Expenses to be considered eligible Dependent Care Expenses, the expenses must be incurred for an individual who qualifies as the Employee's dependent for Federal tax purposes and meets the following dependency criteria according to the Internal Revenue Code and as set forth below:

1. Is a Qualifying Child of the Participating Employee who meets all of the criteria in this paragraph. A Qualifying Child is: (a) the Employee's natural child, descendant of such child, stepchild, legally adopted child or child lawfully placed with the Participating Employee for adoption, foster child placed with the Employee by an authorized placement agency or judgment, decree or court order, sibling or stepsibling or descendent of any such person; (b) is under the age of 13; (c) has the same principal place of abode as the Employee for more than one-half of the taxable year (not including absences due to illness, education, business, vacation or military service); and (d) has not provided more than one-half of his or her support for the taxable year; or

2. Is a spouse of the Participating Employee who is: (a) physically or mentally incapable of caring for himself/herself and (b) has the same principal place of abode as the Participating Employee.

Eligible Dependent Care Expenses

The Participating Employee's FSA can be used to reimburse Dependent Care Expenses that would qualify as Federal income tax deductions, provided those expenses are incurred for an individual who qualifies as the employee's dependent for Federal tax purposes and meets the dependency criteria as set forth in the Internal Revenue Code. Refer to the section entitled "Eligible Dependents."

Dependent Care Expenses that are eligible for reimbursement include expenses the Participating Employee must pay for personal care of a child or other dependent, including related housekeeping or facility expenses if required for the qualifying individual, in order for the employee (and his or her spouse) to be gainfully employed.

Dependent care generally includes the situations listed below. Facilities that care for more than six individuals must be licensed and in compliance with any applicable state and local law.

1. A day care center, summer day camp, preschool or after school facility;

2. An adult day care facility;

3. In-home day care provided in the Employee's home or in the house of the caregiver;

4. Housekeeping services provided in the Employee's home when incidental to the care of a qualified dependent, such as those provided by a maid, babysitter, housekeeper, cook or cleaning person.

Ineligible Expenses

Expenses that are not eligible include, but are not limited to the following:

1. Overnight camp;
2. Care provided during the employee's (and his or her spouse's) non-working hours;
3. Care given by a dependent relative or child under age 19;
4. Housekeeping not related to dependent care;
5. Health Care Expenses; and
6. Child support, food, clothing, education, transportation, residential programs, nursing homes or care provided outside the employee's home for a dependent who does not regularly spend at least eight hours per day in the employee's home, such as full-time care in a nursing home for a dependent parent.

Contact the Plan Administrator to determine the eligibility of specific expenses the employee may anticipate for his or her dependents.

REQUESTING FSA REIMBURSEMENT AND APPEAL RIGHTS

REQUESTING REIMBURSEMENT FOR HEALTH CARE AND DEPENDENT CARE EXPENSES

To obtain reimbursement from the Employee's FSA, the Employee must submit a completed Flexible Spending Account (FSA) Reimbursement Request Form in accordance with the instructions the Employee receives from his or her Plan Administrator.

The Employee's request must include an attachment, such as receipts, invoices or statements, which verifies his or her expenses. The Plan may request additional documentation as necessary. In addition, the Plan has the right to refuse or recover reimbursement payments for unsubstantiated or ineligible expenses. See the section entitled "General Provisions, Plan Right to Recovery" for more information.

For non-prescription medications under the Health Care FSA, the Employee must include a receipt that identifies the product the Employee has purchased, the date of purchase and the price. If such a receipt is unavailable, the Employee must certify in writing that the purchase was for an Eligible Expense.

For Dependent Care Expenses, the Participating Employee must also include the name, address and taxpayer identification number of the caregiver.

The Participating Employee will be reimbursed for Eligible Expenses that are incurred during the Plan Year provided:

1. The Employee was participating in the Plan on the date the expenses were incurred; and
2. The required FSA Reimbursement Request Form is submitted to the Plan Administrator no later than 3 months in which expenses were incurred.

Health Care Expense reimbursements will not exceed the current balance of the Employee's Health Care FSA and Dependent Care Expense reimbursement will not exceed the current balance of the Employee's Dependent Care FSA. In addition, any funds remaining in the FSA after the reimbursement request has been submitted in accordance with this section will be forfeited. Balances in an FSA may not be combined with another FSA (e.g. Health Care FSA balances may not be combined with the Dependent Care FSA balance), carried over into the next year (except as specified) applied to expenses that occurred in a different Plan Year or converted to cash.

The Participating Employee will periodically receive statements during the Plan Year so that the (s)he will be aware of any remaining balance in the FSA. The Participating Employee must submit requests for reimbursement of Eligible Expenses that equal or exceed his or her entire contribution, or forfeit the remaining portion of his or her contribution.

APPEAL RIGHTS

A Participating Employee, or the Participating Employee's representative, may request and receive a full and fair review of an Adverse Benefit Determination by submitting a written notice of appeal to the Plan Fiduciary within 180 days of receipt of the notification of benefit determination. The written notice requesting a review should:

1. State the reasons the Participating Employee feels the claim should not have been denied; and

2. Include any additional documentation, which the Participating Employee believes supports the claim.

Any statements and additional information that is provided with the notice of appeal will become a part of the claim and will be included in the appeal review process.

The appeal review will be conducted by a Plan Fiduciary, other than and not a subordinate of the Plan Fiduciary who has previously reviewed the claim.

The appeal review will be conducted without deference to a previous Adverse Benefit Determination.

On receipt of the appeal, a Plan Fiduciary will review the claim to confirm the accuracy of the Adverse Benefit Determination. The Plan Fiduciary will notify the Participating Employee of this decision.

An Employee, or his or her authorized representative, may examine all relevant documents that the Plan Fiduciary may have, excluding any records of a confidential nature. This includes all relevant documents, whether or not that information was relied upon by the Plan in determining the claim and whether or not that information was favorable to the Plan. An Employee, or his or her authorized representative, may submit a written opinion of the issues and his comments to the Employer.

Following the Plan's receipt of the written notice of appeal, the Plan Fiduciary will provide notification of a decision on the appeal within a reasonable period of time. Notification will be provided in a period of time that is reasonable and appropriate to the circumstances, but within 60 calendar days.

If the Plan Fiduciary, on behalf of the Plan Administrator, determines that special circumstances exist that require an extension of this time period, the Participating Employee will be notified within 60 calendar days of the Plan's receipt of appeal of a post-service claim. This extension notice will identify the circumstances requiring the extension, and the date by which the Plan Fiduciary expects to render a decision. In the event of an extension, a decision will be rendered as soon as possible, but no later than 120 calendar days from the Plan's receipt of appeal of a claim.

A decision made by the Plan Fiduciary is final.

In the event a decision on review of an appeal results in an Adverse Benefit Determination, the Participating Employee will receive written notification from the Plan Fiduciary. The notification of a claim determination is presented in the same fashion as a reimbursement for a claim, in a manner designed to be understood by the Participating Employee. The notification of an Adverse Benefit Determination will include the following:

1. A claim worksheet that shows the calculation of the total amount payable, charges not payable and the specific reason or reasons why the charges are not payable;

2. Reference to the specific Plan provision or provisions upon which the determination is based;

3. If the Plan consulted with an independent reviewer in considering the request for appeal, a statement that the Participating Employee is entitled to request the Plan to provide the identity of such expert, without regard to whether the independent reviewer's advice was relied upon in making the benefit determination;

4. A statement that the Participating Employee is entitled to receive reasonable access to and copies of all documents, records and other information relevant to the claim for benefits, free of charge, upon request. A document, record or other information is considered relevant if: (a) it was relied upon in making the benefit determination; (b) it was submitted, considered or generated in the course of making the

determination; or (c) it demonstrates that the determination was made in accordance with governing Plan Documents and that Plan provisions have been applied consistently with similar claims; and

5. A statement of the Participating Employee's right to obtain a copy upon request, provided free of charge, of any specific internal rule, guideline, protocol or similar criterion, if relied upon in making the determination.

As used herein, the term "claim" means a request for reimbursement under the Plan.

TERMINATION PROVISIONS FOR SECTION 125 PLAN

TERMINATION OF PARTICIPATION

The Employee's participation in the Plan will terminate:

1. On the date the Participating Employee is no longer an Eligible Employee;

2. On the date the Participating Employee no longer satisfies the conditions for participation in the Plan;

3. On the date the Participating Employee revokes all elections under the Plan due to a status change;

4. When the Plan terminates; or

5. Upon the Participating Employee's death.

When the employee's participation in the Plan terminates for any reason, or the Employee revokes his or her election under the provisions described in the section entitled "Mid-Year Election Change," his or her salary reductions will terminate.

An employee whose participation is terminating based on the above may continue to claim reimbursement from an FSA according to the following:

1. From a Dependent Care FSA, through the 31st day of March following the end of the Plan Year in which Eligible Expenses were incurred, for any Eligible Expenses incurred on or before the date his or her participation terminated.

2. From a Health Care FSA, through the 31st day of March following the end of the Plan Year in which Eligible Expenses were incurred, for any Eligible Expenses incurred on or before the date his or her participation terminated.

The employee will not be able to receive reimbursements from an FSA for expenses that are incurred after his or her participation terminates.

COBRA CONTINUATION

1. The Participating Employee may qualify for COBRA continuation of an existing Health Care FSA; however, the cost of such continuation may not be paid or contributed to on a pre-tax basis.

2. A Health Care FSA may only be continued if the amount of the Employee's elected Plan Year contribution that is available to be reimbursed during the remainder of the Plan Year is greater than the Employee's total cost of COBRA continuation for the remainder of the Plan Year.

3. Refer to the Employer's Health Plan Document for additional information on COBRA continuation.

4. The Employee may not continue a Dependent Care FSA under the provisions of COBRA continuation.

When the employee's participation in the Health Care FSA is terminated due to his or her failure to make the

required contribution, the employee may not make a new Health Care FSA election for the remaining portion of the Plan Year.

Refer to the section entitled "Eligibility and Participation" for more details concerning the Employee's participation rights, including his or her rights to reinstate his or her Section 125 Plan options and continue his or her eligibility and contributions following a leave of absence.

PLAN COMPLIANCE

The Plan will make any necessary amendments to the Section 125 Plan that are required to maintain compliance with Federal regulations.

The Employee may be required to make changes in his or her benefit elections as a result of this action, such as reducing or discontinuing his or her contributions to an FSA. In such event, the Plan Administrator will make the necessary adjustments to the Employee's salary reduction amounts for the remainder of the Plan Year.

DEFINITIONS FOR SECTION 125 PLAN

Actively Working/Actively at Work – Means the employee is performing his or her regular duties on behalf of, and in the regular business of the Plan Sponsor for the hours as listed in the section entitled "Eligibility and Participation" and is reasonably being compensated by the Plan Sponsor on a regular basis for such duties.

Adverse Benefit Determination – Means a denial of claim under the Section 125 Plan.

Change in Status - Means any of the following:

1. Change in Employee's legal marital status;
2. Change in Employee's number of dependents;
3. Change in Employee's employment status or the employment status of the Employee's spouse or dependent;
4. Dependent satisfies or ceases to satisfy dependent eligibility requirements;
5. Change in place of residence of Employee, spouse or dependent (i.e., change in residence that impacts eligibility under the health care plan, such as moving outside of the HMO's service area); and
6. Commencement or termination of an adoption proceeding (applicable if adoption assistance is provided through the Section 125 Plan).

Dependent Care Expenses – Means those expenses that are considered eligible for reimbursement under the Dependent Care FSA, as set forth in the section entitled "Dependent Care FSA."

Dependent Care FSA – Means the Section 125 Flexible Spending Account that provides for the reimbursement of Dependent Care Expenses.

Effective Date – Means the date on which participation in the Plan begins.

Eligible Employee – Means an employee of Weldon, Williams & Lick, Inc. who satisfies the eligibility conditions as set forth in the section entitled "Eligibility."

Eligible Expense – Means any Dependent Care Expense or Health Care Expense that is considered eligible for reimbursement under the Section 125 Plan.

Flexible Benefits Plan (also Plan) – Means the plan as described in this Summary Plan Description that includes the Health Care and Dependent Care FSA.

Flexible Spending Account (FSA) – Means the separate bookkeeping account established by the Employer for each Participating Employee which is funded with pre-tax dollars that are deducted from the Employee's regular earnings in order to reimburse the Participating Employee for Dependent Care and/or Health Care Expenses incurred by the Employee.

Health Care Expenses – Means those expenses that are considered eligible for reimbursement under the Health Care FSA, as set forth in the section entitled "Health Care FSA."

Health Care FSA – Means the Section 125 Account that provides for the reimbursement of Health Care Expenses.

Medical Plan – Means the plan of benefits sponsored by the Plan Sponsor that provides for Medical Benefits

and Prescription Drug benefits as described in this Summary Plan Description.

Participating Employee – Means an employee of Weldon, Williams & Lick, Inc. who has satisfied the eligibility requirements under the Section 125 Plan and has enrolled in the Section 125 Plan.

Plan Document – Means the governing document for the Section 125 Plan and may include governing documents in connection with the Plan Sponsor's Health Plan and other benefit plans which have been adopted and sponsored by the Plan Sponsor.

Plan Sponsor – Means the person designated to sponsor the Plan. The Plan Sponsor is Weldon, Williams & Lick, Inc.

Plan Year – Means the 12-month period beginning on January 1st and ending at midnight on December 31st.

Summary Plan Description – Means the document that is provided by the Plan Administrator and that describes, in understandable terms, the Participating Employee's rights, benefits and responsibilities under the Section 125 Plan.

PART 3

GENERAL PROVISIONS OF MEDICAL & SECTION 125 PLAN

GENERAL PROVISIONS

ALTERATION OF APPLICATION

An enrollment application may not be altered by anyone other than the applicant unless the applicant has given his or her written consent allowing alterations.

AMENDMENT OF THE PLAN

Amendment: The Employer reserves the right to amend this Plan at any time by an instrument duly executed by an authorized officer. Such amendment shall be binding upon the Employer and all Covered Persons. The Employer shall furnish to each Covered Employee a summary, written in a manner calculated to be understood by the average Covered Employee, of any modification to the Plan or change in the information required to be included in the Summary Plan Description.

Retroactive Amendments: An amendment to this Plan may be made retroactively effective so long as it does not adversely affect the rights of Covered Persons to benefits under this Plan for covered health care expenses which are incurred after the effective date of the amendment but before the amendment is adopted.

Material Reduction: Amendments that are a material reduction in Covered Services or benefits must be disclosed not later than 60 days after the date of adoption of the modification or change. A "material reduction in covered services or benefits" means any modification to the plan or change in the information required to be included in the Summary Plan Description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average Covered Employee to be an important reduction in Covered Services or benefits under the Plan. A "reduction in covered services or benefits" generally would include any Plan modification or change that: eliminates benefits payable under the Plan; reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, Deductibles, Coinsurance, Copayments, or other amounts to be paid by a Covered Employee.

APPLICABLE LAW

This Plan shall be construed in accordance with the laws of the State of Arkansas and of the United States of America. Any provision of this Plan that is in conflict with applicable law is amended to conform with the minimum requirements of that law.

ASSIGNMENT OF BENEFITS

No assignment of the Plan, or any rights or benefits under the Plan, shall be valid unless permitted under the terms of the Plan or the Plan Sponsor has consented to such assignment in writing.

The Plan will pay benefits under this Plan to the Employee unless payment has been assigned to a Hospital, Physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the Claims Administrator is notified in writing of such assignment prior to payment hereunder.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than a Participating Employee is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

BONDING

Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

CLERICAL ERROR

No clerical error on the part of the Employer or Plan Administrator shall operate to defeat any of the rights, privileges, services or benefits of any Employee hereunder, nor create or continue participation which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or reimbursements will be made when the error or delay is discovered. However, if more than 90 days has elapsed after the end of a Plan Year prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the Plan that is in conflict with statutes that are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

COUNTERPARTS

This Plan may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together constitute one instrument, which may be sufficiently evidenced by any counterpart.

DEATH

Any benefit payments, or FSA reimbursements, payable to the employee under the Plan after his or her death will be paid to his or her surviving spouse. In the case of no surviving spouse, any payments will be paid to the employee's estate or designated beneficiary. Eligible requests may be submitted after the employee's death.

EFFECTIVE DATE

Except where specifically stated otherwise in this Summary Plan Description, the provisions of this amended and restated Summary Plan Description are effective January 1, 2008 and this Summary Plan Description shall supersede and replace all prior versions of the Summary Plan Description as of that date.

ELIGIBILITY DETERMINATIONS UNDER HIPAA

Federal Law, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), prohibits the Plan Sponsor from denying Coverage under the Plan based on any of the following health-related factors:

1. Health status;
2. Medical condition (including both physical and mental Illnesses);
3. Receipt of healthcare;
4. Medical history;
5. Genetic information;
6. Evidence of insurability (including conditions arising out of acts of domestic violence); and
7. Disability.

EMPLOYMENT RIGHTS

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between the Covered Employee and the Employer to the effect that (s)he will be employed for any specific period of time or retained in the service of the Employer and does not affect in any way the employee's employment rights.

ERRONEOUS INFORMATION

If any information pertaining to any Covered Person is found to have been reported erroneously to the Plan Sponsor or to HealthSCOPE Benefits, as the claims administrator, and such error affects his or her Coverage, the facts will determine to what extent, if any, the Covered Person was or is covered under the Plan.

EXEMPTION FROM ATTACHMENT

To the full extent permitted by law, all rights and benefits under the Plan are exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Covered Employee or other Covered Person.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to make a free choice to select a Hospital, Professional Provider or other Provider of health care services. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have higher out-of-pocket expenses if the Covered Person uses the services of a Non-Preferred Provider.

INCAPACITATION

If the Participating Employee is under a legal disability or, in the opinion of the Plan Administrator, the employee is incapacitated so as to be unable to submit a proper reimbursement request from his or her FSA or otherwise manage his or her financial affairs, the Plan Administrator may direct any reimbursement to the employee's legal representative, relative or friend, or in any other manner that the Plan Administrator considers appropriate on the employee's behalf.

INABILITY TO HANDLE AFFAIRS

If a benefit is owed when the Covered Person is not able to handle his or her affairs, the benefit may be paid to a relative by blood or marriage. This would happen if the Covered Employee had died or become mentally incompetent. The Plan will make payment to a relative whom it judged to be entitled in fairness to the money. Any such payment would discharge any obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the Employer or by a Participating Employee shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the Employer or by the employee, as the case may be. A statement made shall not be used in any legal contest unless such statement is made in writing and signed by such person and a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

INTERPRETATION OF PLAN PROVISIONS

All provisions of this Plan shall be interpreted and administered in accordance with the provisions of applicable law in a non-discriminatory manner and in a manner that will assure compliance of the Plan's operation therewith. All persons in similar circumstances shall receive uniform, consistent, and non-discriminatory treatment hereunder.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of 60 days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of 3 years from the date the expense was incurred.

LIABILITY AND LIMITATION OF ACTION

This Plan will not give the Covered Person any claim, right, action or cause of action against any person or entity other than the Provider rendering Covered Services to the Covered Person for acts or omissions of such Provider.

Contributions being made to and held by the Plan are made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms. Except with respect to the right of a Covered Person to receive benefits under this Plan, no Covered Person shall have any right or interest in or to the assets of the Plan or in or to any contributions to the Plan.

The Plan Sponsor and HealthSCOPE Benefits do not actually furnish health care services as described in this Summary Plan Description. Rather, Coverage will be provided for the health care services covered under the Plan when rendered by a Provider to the Covered Person.

LOST DISTRIBUTEES

Any reimbursement payable hereunder shall be deemed forfeited if the Plan Administrator is unable to locate the Employee to whom payment is due. However, if the Participating Employee submits a request for reimbursement for the forfeited funds within the time prescribed in the sections entitled “Requesting Reimbursement and Appeal Rights,” the employee is entitled to such funds and those funds shall be reinstated.

MISREPRESENTATION

If the Participating Employee or anyone acting on behalf of a Participating Employee makes a false statement on the election form or reimbursement request form and any attachments, or withholds information with the intent to deceive or affect the acceptance of the election form or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the Employee, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided.

Any material misrepresentation on the part of the Participating Employee in: making election for participation, or any election for reclassification thereof, or for service thereunder, or; establishing an FSA or seeking FSA reimbursement, shall render the benefits under this Plan null and void.

PHYSICAL EXAMINATION AND AUTOPSY

By accepting Coverage, as described in this Summary Plan Description, the Covered Person agrees that (s)he may be required to have one or more physical examinations. Performance of an autopsy may also be required in the case of death where it is not forbidden by law. These examinations and/or autopsy will help to determine what benefits will be payable, particularly when there are questions concerning services on a claim.

PLAN ADMINISTRATION

The Plan is administered through the Plan Administrator. Weldon, Williams & Lick, Inc. is the Plan Administrator. The Plan Administrator shall have full charge of the operation and management of the Plan.

Each Section 125 Flexible Spending Account (FSA) is administered by the Plan Administrator in accordance with federal regulations, with no administrative cost to the Participating Employee. Any forfeited funds may be used by the Employer, at its discretion, to pay for administration of the Plan, to offset distributions from health care accounts that exceed contribution, or for redistribution to all contributors.

PLAN CHANGES

The Employer reserves the right to amend the Plan at its sole discretion. The Employer will communicate to the Employee in writing regarding any such changes that affect the Employee.

Any amendments to the Plan will be incorporated in writing into the master copy of the Plan on file with the Employer, or a written copy will be kept with the master copy of the Plan.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not a contract between the Employer and the Employee or an inducement or condition of employment. Nothing in the Plan gives any Employee the right to retain the Employee status or to interfere with the right of the Employer to terminate the employment of any Employee at any time.

PLAN RIGHT TO RECOVERY

Whenever the payments or reimbursements have been made from the Plan in excess of the maximum amount of payment or reimbursement necessary, according to the terms of the Plan, the Plan will have the right to recover these excess reimbursements. Whenever reimbursements have been made from the Plan that should not have been made, according to the terms of the Plan, the Plan will have the right to recover any such excess reimbursement, improper or incorrect reimbursement from the person or entity to whom reimbursement was made, or from any other appropriate party, whether or not such reimbursement was made due to the Plan Administrator's own error.

The Plan reserves the right to follow certain correction procedures in order to recover improper reimbursements. First, upon identifying an improper reimbursement, the Employer shall require the Employee to pay back to the Plan an amount equal to the improper reimbursement. Second, if the Employee fails to pay back the improper reimbursement, the Employer has the right to withhold the amount of the improper reimbursement from the Employee's wages or other compensation to the extent consistent with applicable law. Third, if the improper reimbursement amount still remains outstanding, the Employer has the right to utilize a claim substitution or offset approach to resolve improper claims. This process allows the Employer to substitute, or apply, the improper reimbursement amount for a future substantiated claim incurred during the same coverage period. No reimbursement shall be made on any such future claims until the improper reimbursement amount is fully recouped by the Plan. In addition, the Employer may take other actions to ensure that further violations of the terms of reimbursement do not occur, whether through the Employee's use of a reimbursement claim for, or use of a debit card, including temporary or permanent denial of access to the debit card.

PLAN TERMINATION

The Employer reserves the right to terminate the Plan at any time, and will communicate this action to the Employee.

In the event the Plan is terminated, the Employee may continue to submit timely requests for reimbursement from his or her FSAs to recover any remaining balance, as provided in the section entitled "Requesting Reimbursement and Appeal Rights."

PRONOUNS

Any personal pronouns used in this Summary Plan Description shall include either gender unless the context clearly indicates to the contrary.

RIGHTS OF PLAN

To the full extent permitted by law, all rights and benefits under the Plan are exempt from attachment or garnishment or other legal process for the debts or liabilities of any Covered Person.

RIGHT TO ENFORCE PLAN PROVISIONS

Failure by the Plan Sponsor or HealthSCOPE Benefits to enforce any provision of the Plan provision shall not affect the Plan Sponsor's or HealthSCOPE Benefits' right thereafter to enforce such provision or any other provisions of the Plan.

SUMMARY PLAN DESCRIPTION

This document constitutes a Summary Plan Description under the ERISA regulations and Section 125 of the Internal Revenue Code ("Code"), which includes Medical Benefits and the Section 125 Flexible Spending Account. The portions of this document related to reimbursement of health expenses constitute a medical expense reimbursement plan under Section 105 of the Code. The portions of this document related to reimbursement of Dependent Care Expenses constitute a separate written plan under Section 129 of the Code. The benefits payable hereunder are intended to be excludable from the Participating Employee's gross income under Sections 105, 106 and 129 of the Code, and this Summary Plan Description shall be interpreted to the maximum extent to provide this intended effect.

TAX BENEFITS

The Employer bears no responsibility for and makes no warranties regarding any personal income tax filings, such as eligibility of any personal expenses for credits or deductions. It is the Participating Employee's responsibility to determine what expenditures are eligible under Federal, state or local income tax regulations.

TIME EFFECTIVE

The effective time with respect to any dates used in the Plan shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the Plan Administrator.

TITLES ARE FOR REFERENCE ONLY

The titles used in the Plan are for reference only. In the event of a conflict between a title and the content of a Section, the content of the Section shall control.

WORKERS' COMPENSATION COVERAGE

The Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

WORD USAGE

Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine or neuter form.

WRITTEN DIRECTIONS

Whenever a person must or may act upon the written direction of another, he shall not be required to inquire into the propriety of such direction, and he shall follow the direction unless it is clear on its face that the actions to be taken under that direction are prohibited by law or the terms of this Plan. Moreover, such person shall not be responsible for failure to act without such written direction.

PART 4

PLAN ADMINISTRATION AND PLAN OPERATION

OPERATION AND ADMINISTRATION OF THE PLAN

PLAN SPONSOR AND PLAN ADMINISTRATOR

The Plan is administered through Weldon, Williams & Lick, Inc. which has been established and shall be maintained for the exclusive benefit of the employees. Weldon, Williams & Lick, Inc. is the Employer and Plan Sponsor and also functions as the Plan Administrator, unless another individual or entity is appointed by the Employer. The Plan Administrator shall have full charge of the operation and management of the Plan.

PLAN FIDUCIARY

Weldon, Williams & Lick, Inc. shall also function as the Plan Fiduciary under ERISA unless the Employer appoints another individual or entity to act in this capacity. The Plan Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the Plan, to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary, including, but not limited to, the denial of certification of the Medical Necessity of Hospital or medical services, supplies and treatment, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Fiduciary will be final and binding on all interested parties. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

CLAIMS ADMINISTRATOR

Under the Plan, HealthSCOPE Benefits, Inc. ("HealthSCOPE Benefits") has agreed to provide certain administrative services on behalf of the Plan Sponsor according to the terms and limitations of the Plan. The responsibilities of HealthSCOPE Benefits are spelled out in an agreement between the Plan Sponsor and HealthSCOPE Benefits and include but are not limited to the administration of claims on behalf of the Plan Sponsor. Claims for benefits under the Plan shall be filed, processed, reviewed, and, if denied, appealed in accordance with the procedures set forth in this Summary Plan Description.

Except as otherwise provided by law, the appeal procedures set forth in this Summary Plan Description shall be the sole and exclusive remedy.

HealthSCOPE Benefits does not furnish health care services and is not liable for the quality of health care services received by a Covered Person. HealthSCOPE Benefits does not provide insurance coverage or benefits nor does HealthSCOPE Benefits underwrite the liability of this Plan. HealthSCOPE Benefits will not act nor assume the responsibility to act as the Plan Administrator, Plan Fiduciary or Named Fiduciary in connection with this Plan. HealthSCOPE Benefits is merely providing assistance with the administration of this Plan by adjudicating claims in accordance with the terms of the Plan.

ADMINISTRATIVE COMMITTEE

The Employer, at its option, shall appoint a committee to oversee the administration of the Plan on behalf of the Employer. The members of the Administrative Committee shall serve at the pleasure of the Employer that appointed them.

DELEGATION OF RESPONSIBILITIES & ADMINISTRATIVE DUTIES

The Employer may delegate its responsibilities hereunder to other persons or entities. Such delegation shall be effective only if the proposed delegate executes an instrument acknowledging acceptance of the delegated responsibilities.

The following responsibilities shall be performed in the administration of the Plan. These duties may be performed by the Employer or by a committee of individuals appointed by the Employer to assist in the administration of the Plan:

1. Maintaining all Plan records;

2. Filing tax returns and reports required under federal and state law and complying with all other governmental reporting and disclosure requirements;

3. Authorizing payments and resolving questions concerning the Plan and interpreting, in its discretion, the Plan's provisions related to benefits and eligibility;

4. Hiring outside professionals to assist with Plan Administration and render advice concerning the responsibility they have under the Plan, including but not limited to hiring a claims administrator, actuaries, attorneys, accountants, brokers, consultants and other specialists to render advice concerning any responsibility they have under the Plan;

5. Establishing policies, interpretations, practices and procedures of the Plan;

6. Receiving all disclosures required of fiduciaries and other service providers under any federal or state law;

7. Acting as the Plan's agent for service of legal process;

8. Administering the Plan, including but not limited to the Plan's claims procedures as set forth in the Summary Plan Description;

9. Paying benefits under the Plan, by drawing checks, or instructing others to draw checks, against the Plan established for this purpose. With respect to claims that are administered by the claims administrator, this responsibility includes instructing the claims administrator to withdraw monies from the funding account for the purpose of administering claims incurred under the Plan; and

10. Performing all other responsibilities allocated to the Plan Administrator.

PART 5

GENERAL PLAN

GENERAL PLAN INFORMATION

SUMMARY OF PLAN INFORMATION

NAME OF PLAN

Weldon, Williams and Lick, Inc. Group Hospital and Section 125 Plan

NAME, ADDRESS AND PHONE NUMBER OF EMPLOYER/PLAN SPONSOR

Weldon, Williams and Lick, Inc.
711 North A Street
Ft. Smith, AR 72901
(479) 783-4113

EMPLOYER IDENTIFICATION NUMBER

71-0188290

PLAN NUMBER

501

TYPE OF PLAN

This Summary Plan Description contains a description of the Medical Plan and Section 125 Plan for the Weldon, Williams & Lick, Inc. Employees.

TYPE OF ADMINISTRATION

Contract administration: The processing of requests for reimbursements under the terms of the Plan is provided by the Employer which is referred to as the Claims Processor.

NAME, ADDRESS AND PHONE NUMBER OF PLAN ADMINISTRATOR AND FIDUCIARY

Weldon, Williams and Lick, Inc.
711 North A Street
Ft. Smith, AR 72901
(479) 783-4113

NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS

Weldon, Williams and Lick, Inc.
711 North A Street
Ft. Smith, AR 72901
(479) 783-4113

PLAN YEAR

January 1st to December 31st

CLAIMS ADMINISTRATOR

HealthSCOPE Benefits, Inc.
27 Corporate Hill Drive
Little Rock, Arkansas 72205
501-225-1551

Send Non-PPO Medical Claims to:
HealthSCOPE Benefits
P.O. Box 619053
Dallas, TX 75261-9053

Send PPO Claims to the PPO Network appearing on the Identification Card.

Send Prescription Drug Claims to the Prescription Drug Vendor appearing on the Identification Card.

Flexible Spending Department
P.O. Box 2317
Little Rock, AR 72203
FSA Customer Service: 1-877-385-8775
FSA Fax: (501) 225-9153

ADDRESS AND TELEPHONE NUMBER OF THE OFFICE OF THE DEPARTMENT OF LABOR

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Room N-5644
Washington, D.C. 20210
(202)565-7500

SOURCE OF PLAN CONTRIBUTIONS AND FUNDING FOR THE MEDICAL PLAN

Benefits under the Plan will be paid as needed directly from the general assets of the Employer that sponsors the Plan. In addition, if the Employer has purchased insurance contract(s) in connection with the Plan, benefits will also be paid from said insurance contract(s).

Contributions for Plan expenses are obtained from the Employer and from the participating employees. The Employer evaluates the costs of the Plan based on the past three (3) years' Plan expenses and determines the amount to be contributed by the Employer and the amount to be contributed by the participating employees.

Note about COBRA: COBRA premiums will be the Qualified Beneficiaries' full responsibility and are generally 102% of the costs for non-COBRA individuals, except in special circumstances where a greater amount is permitted under COBRA. Refer to the section that addresses COBRA Coverage for additional details.

PART 6

IMPORTANT NOTICES UNDER THE PLAN

HIPAA PRIVACY STATEMENT AND OTHER IMPORTANT NOTICES

HIPAA PRIVACY STATEMENT

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
2. Modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
4. Notify Participants of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18);
5. Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18);
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
7. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
9. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
10. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
11. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which

disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

12. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
       CFO, CEO, Benefits Administrator, Benefits Assistant, IT Director, Network Administrator, IT Staff, PC Support Specialist
    b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
    c. In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

       "Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

    The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:
    a. The Plan Documents have been amended to incorporate the above provisions; and
    b. The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI;
4. Report to the Plan any security incident of which it becomes aware;
5. Notify Participants of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18); and
6. Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

PATIENT'S RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are 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 (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies 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 (if any), 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.

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 Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-existing Condition exclusion for 12 months (18 months for Late Enrollees) after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate 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 (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against 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 would 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, or if you need assistance in obtaining documents from the Plan Administration, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NOTICE REGARDING HIPAA CERTIFICATES OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all persons who lose Coverage under an employer group health Plan be automatically provided with a HIPAA Certificate of Creditable Coverage ("HIPAA Certificate"). The covered employee will need a HIPAA Certificate if (s)he enrolls in another employer group health plan that contains a Pre-Existing Condition Waiting Period.

HIPAA also requires that a HIPAA Certificate be provided upon request to the employee (1) at any time while the employee is covered under the Plan and (2) within 24 months after the date that Coverage ended, regardless of whether a HIPAA Certificate was issued automatically at the time of termination. If the covered employee requests a HIPAA Certificate before losing the Coverage, the HIPAA Certificate will describe the length of Coverage, but will indicate that no Coverage has been lost.

HIPAA Certificates must also be provided to persons who would have lost Coverage if not for the election of COBRA Continuation Coverage. In this event, the COBRA beneficiary will receive two automatic HIPAA Certificates, one upon the initial qualifying event, and another when COBRA Continuation Coverage ends.

A HIPAA Certificate must include all of the following:

1. Date that the HIPAA Certificate was issued;
2. Name of the Plan that provided Coverage;
3. Name of the covered employee and/or dependents to whom the HIPAA Certificate applies, along with any information necessary for the Plan specified in the HIPAA Certificate to identify such person(s) (name or ID number);
4. Name, address, and telephone number of the Plan Administrator required to provide the HIPAA Certificate; and
5. Telephone number to call for further information regarding the HIPAA Certificate.

The employer is required to provide the employee with written procedures on how to request a HIPAA Certificate. Therefore, the employee may contact his or her employer to obtain additional information concerning requesting a HIPAA Certificate.

NOTICE CONCERNING RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Group health plans and issuers are required to provide Coverage for the following services in connection with a mastectomy that has been performed and that is covered under the Plan:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan is required to notify the Covered Person of his or her WHCRA rights each year.

NOTICE CONCERNING RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the group health plan or issuer may pay for a shorter stay if the attending Provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or issuer may not, under federal law, require a Physician or other health care Provider to obtain authorization for prescribing a length of stay of up to 48 or 96-hours.

NOTICE CONCERNING THE AMERICAN RECOVERY AND REINVESTMENT ACT

COBRA Changes Pursuant to The American Recovery and Reinvestment Act. Effective for periods of coverage beginning on or after February 17, 2009 (in most instances March 1, 2009), the Plan reflectS the following COBRA changes in response to the requirements of the American Recovery and Reinvestment Act:

Assistance Eligible Individuals: Employees who were or are involuntarily terminated from employment between the dates of September 1, 2008 and December 31, 2009 are eligible for a 65% COBRA premium subsidy for up to nine (9) months of the COBRA coverage period. This will also apply to other Qualified Beneficiaries whose coverage ceased/ceases due to the Employee's involuntary termination. Under the Act, such individuals are referred to as assistance eligible individuals or "AEIs". An AEI is a COBRA Qualified Beneficiary: (1) who at any time during the period that begins September 1, 2008 and ends December 31, 2009, is eligible for COBRA, (2) who elects COBRA, and (3) whose Qualifying Event was/is the involuntary termination of a covered Employee's employment during such period.

AEIs include individuals entitled to comparable State or governmentally-mandated continued coverage even though such individuals are not entitled to Federal COBRA (for example, the small employer exception to Federal COBRA). However, the Act generally limits eligibility for the subsidy to the categories of individuals who are eligible for Federal COBRA.

COBRA Premium Assistance / The Subsidy: Under the Act, COBRA premium assistance is available for up to nine (9) months of the AEI's maximum coverage period. That is, the AEI pays 35% of the COBRA premium (i.e., the cost of COBRA coverage) and the Employer (or in come cases, the Plan or insurer) is then reimbursed ("subsidized") by the federal government for the other 65% of the COBRA premium through a credit or refund of an overpayment of payroll taxes.

Eligibility for the subsidy will begin during the first COBRA period beginning after the later of: (1) the Employee's involuntary termination of employment, or (2) February 16, 2009 (generally March 1, 2009). An AEI will generally be eligible for the subsidy for a period of nine (9) months but the subsidy period will be shorter under certain circumstances. First, an AEI will no longer be eligible for the subsidy when the individual becomes eligible for coverage under another group health plan (other than plans such as stand-alone dental or vision plans or health flexible spending arrangements) or Medicare. An individual's eligibility for the subsidy will end as soon as the individual becomes eligible for such other coverage, regardless of whether the individual actually enrolls in the other coverage. For example, an individual is considered to be ineligible for the subsidy if the individual is eligible to enroll in his or her spouse's group health coverage. Also the subsidy period will end on the earliest of: (1) nine months following the date the AEI is first eligible for the subsidy, or (2) the date the maximum COBRA coverage period ends (generally 18 months following the COBRA Qualifying Event).

An AEI who fails to timely notify a group health plan that he or she is no longer eligible for the subsidy, and therefore receives such subsidy while ineligible, will be subject to a penalty of 110% of the premium reduction provided after the individual was no longer eligible for the subsidy.

If an AEI has a modified adjusted gross income (AGI) which exceeds $125,000 but is not more than $145,000) (or $50,000 and $290,000, respectively, in the case of a joint return), in the year the subsidy is received, the individual will be subject to an additional tax, on a phased-in basis, equal to a portion of the premium reduction. To the extent an individual's AGI exceeds $145,000 (or $290,000 in the case of a joint return), the individual will be subject to an additional tax equal to the full amount of the premium reduction.

Extended Election Period / Second Opportunity to Elect: The Act applies to AEIs who were terminated as early as September 1, 2008 but is not retroactive. If any such AEI does not have a COBRA election in effect on February 17, 2009, then he/she may elect COBRA coverage during a special extended election period. The extended election period (or second opportunity to elect) begins on February 17, 2009 and ends sixty (60) days after the date on which notification of the election right is provided to the individual. If an AEI elects COBRA coverage during the extended election period, the coverage begins with the first period of coverage after February 17, 2009 (generally March 1, 2009), and will not extend beyond the maximum period of coverage that would have been required if COBRA had been elected when first available.

Plan Enrollment Option: If the Plan offers more than one coverage, the Plan may permit an AEI to elect to enroll in a different coverage. Following receipt of the Plan's notice of the COBRA enrollment option, the AEI has ninety (90) days to elect the different coverage. The premium (cost of coverage) for the different coverage cannot exceed the premium for the coverage in which the individual was enrolled on a non-COBRA basis and the different coverage must be coverage that is also offered to active Employees. Certain coverages, including stand-alone dental, vision, counseling or referral services, are excluded.