WACO, INC. HEALTH AND WELFARE PLAN

WRAP SUMMARY PLAN DESCRIPTION

WACO, Inc.
5450 Lewis Road
Sandston, VA 23150

V06222020

WACO, INC. HEALTH AND WELFARE PLAN

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WRAP SUMMARY PLAN DESCRIPTION

This document, along with the benefits booklets and certificates, and provider contracts, policies and descriptions, is the summary plan description ("SPD") for the WACO, Inc. Health and Welfare Plan (the "Plan"). These documents describe the Plan as in effect on February 01, 2024. The Plan may be changed from time to time.

Because the benefits you receive through the Plan will be of importance to you and your family, you should retain this SPD as part of your permanent records. However, remember that it is only a summary. The SPD summarizes who is eligible for benefits and the nature of the benefits available. The SPD does not change the provisions of any benefit plan documents or any legal instrument related to the creation, operation, funding, or benefit payment obligations of the benefit plans.

For additional information regarding the Plan, you should contact the Employee Benefits Coordinator at (804) 226-3206 or refer to the Welfare Program documents and the full insurance contracts. Copies of the documents are available from the Employer on request. If the terms of this SPD conflict with the Plan documents, the Plan documents shall govern.

GENERAL PLAN INFORMATION

Type of Plan:	Welfare, including the following Welfare Programs: Group Medical Plan, Group Dental Plan, Group Basic Life and AD&D Plan, Group Long Term Disability as enumerated in Appendix A
Plan Name:	WACO, Inc. Health and Welfare Plan (the "Plan")
Plan Number:	501
Plan Year:	The Plan Year is the twelve month period ending January 31.
Plan Sponsor:	WACO, Inc. (the "Employer") 5450 Lewis Road Sandston, VA 23150 (804) 226-3206 For a list of Participating Employers, please refer to Appendix B.
Plan Sponsor's Employer Identification Number:	54-0720555
Plan Administrator:	WACO, Inc. 5450 Lewis Road Sandston, VA 23150 (804) 226-3206

Agent for Service of Legal Process:	WACO, Inc. 5450 Lewis Road Sandston, VA 23150 (804) 226-3206 Service of legal process may also be made upon the Plan Administrator.
Plan Administration:	Welfare Programs available under the Plan are administered by providers/insurers from which services or benefits are purchased. Unless otherwise indicated, all benefit plans are administered by the respective insurers or providers who provide and guarantee the benefits. Self-insured or unfunded benefits, if any, are paid from the Employer's general assets.
Claims Administrators:	See chart below and/or the separate summary that may apply to a particular type of coverage.

For Claims On	Claims Administrator Name	Contact
Group Medical Plan	Anthem and Its Affiliate Healthkeepers, Inc.	(804) 354-7000
Group Dental Plan	Anthem Blue Cross and Blue Shield	(800) 928-6459
Group Basic Life and AD&D Plan	Anthem Blue Cross and Blue Shield	(800) 928-6459
Group Long Term Disability	Life Insurance Company of North America	(800) 732-1603

ELIGIBILITY AND BENEFITS

An Employee (and his or her Spouse and Dependents, if applicable) is eligible to participate in the Plan only if and to the extent the Participant is eligible with respect to a particular type of coverage under the Plan and the Participant makes the required employee contribution for the coverage selected. The Plan Administrator will inform you of the amount of required employee contributions, if any, for each type of coverage.

In general, the eligibility requirements for each type of coverage include the following:

Group Medical Plan	
Provider or Program Administrator Information	Anthem and Its Affiliate Healthkeepers, Inc. P.O. Box 27401 Richmond, Virginia 27401 (804) 354-7000 www.anthem.com
Funding Medium	**Self-Insured** – The benefit is self-insured

Eligibility	Generally, employees who work an average of 30 hour(s) per week. Spouse Dependent/Child
Employees Excluded from Coverage	Employees working fewer than 30 hours per week
Waiting Period	An Employee who has completed 60 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month after the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Group Dental Plan	
Provider or Program Administrator Information	Anthem Blue Cross and Blue Shield 005937 (Contract Number) P.O. Box 1193 Minneapolis, Minnesota 55440 (800) 928-6459
Funding Medium	**Fully Insured** – The benefit is fully insured by the above named Provider
Eligibility	Generally, employees who work an average of 30 hour(s) per week. Spouse Dependent/Child
Employees Excluded from Coverage	Employees working fewer than 30 hours per week
Waiting Period	An Employee who has completed 60 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month after the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Group Basic Life and AD&D Plan	
Provider or Program Administrator Information	Anthem Blue Cross and Blue Shield CM10002690 (Contract Number) P.O. Box 1193 Minneapolis, Minnesota 55440 (800) 928-6459
Funding Medium	**Fully Insured** – The benefit is fully insured by the above named Provider

Eligibility	Generally, employees who work an average of 32 hour(s) per week.
Employees Excluded from Coverage	Temporary, Seasonal and Union employees; and all other employees working fewer than 32 hours per week
Waiting Period	An Employee who has completed 90 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month after the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate the day the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

Group Long Term Disability	
Provider or Program Administrator Information	Life Insurance Company of North America VDT-600838 (Contract Number) 1601 Chestnut Street Philadelphia, Pennsylvania 19192 (800) 732-1603 www.cigna.com
Funding Medium	**Fully Insured** – The benefit is fully insured by the above named Provider
Eligibility	Generally, Salaried employees with of annual income of $15,000 or greater who work an average of 32 hour(s) per week.
Employees Excluded from Coverage	Employees working fewer than 32 hour per week; and Salaried employees earning less than $15,000 annually
Waiting Period	An Employee who has completed 180 consecutive calendar days of service with the Employer (the "Waiting Period") is eligible to participate.
Effective Date of Coverage	Plan coverage begins on the first day of the calendar month after the end of the Waiting Period.
Coverage Termination	Plan coverage will terminate the day the Employee terminates employment or is no longer an eligible Employee under the Plan's provisions.

To the extent required by applicable law under the Patient Protection and Affordable Care Act ("ACA"), for certain companies with 50 or more full-time Employees, the number of hours worked to obtain full-time status for group health plan coverage purposes will be determined in accordance with certain measurement rules adopted by the Employer for all Employees (including variable hour and seasonal employees, if such classes exist within the Employer). A temporary Employee is not eligible for coverage if he or she is eligible for health coverage through a leasing company, unless otherwise required by the ACA and the Employer. Determination of full-time Employee status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the applicable Employer Shared Responsibility provisions of the ACA and its accompanying regulations. This eligibility information is available upon request to the Plan Administrator.

If the Employer utilizes the measurement rules under the "look-back" method as permitted by the ACA and its accompanying regulations, each Employee's hours of service in a prior period (called the "measurement period") will be calculated to determine the status of the Employee during a future period (called the "stability period"). The Employer may also utilize an additional time period (called the "administrative period"), between the measurement period and the stability period, to complete administrative functions such as determining which Employees are eligible for coverage and enrolling Employees in coverage. Employees whose hours are variable or otherwise uncertain at their start dates (e.g., "variable hour" or "seasonal" Employees) will not initially be eligible for coverage during the applicable measurement period—if it is determined during the measurement period (and any associated administrative period, if applicable) that such Employees are considered to be full-time, they will be offered coverage during their subsequent stability period.

Under ERISA, the Plan Administrator of the group health plan may have fiduciary responsibilities regarding distribution of dividends, demutualization and use of the Medical Loss Ratio rebates from group health insurers. Some or all of any rebate may be an asset of the plan, which must be used for the benefit of the participants covered by the policy. Participants should contact the Plan Administrator directly for information on how the rebate will be used.

ENROLLING IN THE PLAN

The Plan Administrator will establish procedures in accordance with each type of coverage for the enrollment of eligible Employees, their Spouses or Dependents, if any, and will communicate these procedures to eligible Employees. The Plan Administrator will prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

DISCRIMINATION BASED ON HEALTH-RELATED FACTORS PROHIBITED

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibits health plans from discriminating against any participant or dependent in terms of eligibility to participate in the Plan based on a health-related factor. Accordingly, benefits provided under your Plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The Plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

HIPAA PRIVACY ISSUES

HIPAA also requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice or, if appropriate, in the privacy notice provided by the insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

Neither this Plan nor the Employer will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of

its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself, your Spouse or Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Spouse and Dependents in this plan if you or your Spouse or Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Spouse's or Dependents' other coverage). However, you must request enrollment within 30 days after your or your Spouse's or Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Spouse and Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your Spouse or Dependents are eligible, but not enrolled, in the Group Medical Plan listed in Appendix A you may enroll when:

- Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and you request coverage under the Group Medical Plan listed in Appendix A within 60 days after the termination, or
- You or your Spouse or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP and you request coverage under the Group Medical Plan listed in Appendix A within 60 days after eligibility is determined.

The special enrollment rules do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (*e.g.*, spending accounts that limit benefits to employee salary reduction amounts).

To request special enrollment or obtain more information, contact the Plan Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A qualified medical child support order ("QMCSO") is an order made pursuant to state domestic relations law by a court or a state agency authorized under state law to issue child support orders which requires a group health plan to provide coverage to a child or children of an Employee. The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

(a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO (these procedures are available, free of charge, to Participants and Beneficiaries upon request to the Plan Administrator);

(b) Promptly notify the Employee and the child (or child's guardian) of the receipt of any medical child support order, and the group medical plan's procedures for determining whether a medical child support order is a QMCSO; and

(c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Employee and the child of such determination.

STATE MEDICAID PROGRAMS

Eligibility for coverage or enrollment in a State Medicaid Program will not impact your eligibility or a Spouse's or Dependent's in this Plan. Payment of benefits shall be in accordance with any assignment of rights as required by any State Medicaid Program.

If a Welfare Program available under this Plan contains provisions regarding coordination of benefits with State Medicaid Programs, the language in the written materials for such Welfare Program will govern unless the language fails to comply with applicable laws and regulations.

SPECIAL RULES FOR MATERNITY AND INFANT COVERAGE

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

SPECIAL RULE FOR WOMEN'S HEALTH COVERAGE

The Women's Health and Cancer Rights Act of 1998 requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the plan or coverage. For answers to specific questions regarding your particular health plan's policy, contact the Plan Administrator.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

MENTAL HEALTH PARITY

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

HEALTH COVERAGE DURING UNPAID FMLA LEAVE

If your Employer has at least 50 employees employed within 75 miles of your worksite and you take an approved unpaid leave of absence that qualifies as family and medical leave under the Family and Medical Leave Act of 1993 (FMLA), you may generally continue to receive group health coverage for yourself and your covered Spouse and Dependents. Coverage will terminate at the end of your FMLA leave period if you do not return from leave, or on the date you give notice that you will not be returning from FMLA leave, and you may then be eligible for COBRA continuation coverage (as described below). To receive group health plan coverage during unpaid FMLA leave, you must continue to pay your share of the premium. You should contact the Plan Administrator to make arrangements for premium payments during unpaid FMLA leave. If you do not continue your group health plan coverage or other types of coverage during unpaid FMLA leave, your coverages will be reinstated when you return from FMLA leave. For additional information about Plan coverage during FMLA leave, contact the Plan Administrator.

Additional family and medical leave or sick leave rights may apply under state law. Please contact the Plan Administrator for further information.

UNIFORMED SERVICES REEMPLOYMENT RIGHTS

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue your group health plan coverage. If you are absent for less than 31 days, you will pay the regular employee share of the cost of the health coverage. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.

Continuation coverage will terminate on the earlier of:

- The last day of the 24 month period beginning on the first day of military leave, or
- The date you fail to apply for reemployment, as required under USERRA, after returning from military leave.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Benefits during a period of military leave must be as generous as benefits available to similarly situated employees on other employer-approved leaves of absence (*e.g.*, family and medical leave).

COBRA CONTINUATION COVERAGE

Under a federal law called COBRA ("Consolidated Omnibus Budget Reconciliation Act"), group health plans of most employers with 20 or more employees are generally required to offer covered Employees, their covered Spouses and Dependents the opportunity to make separate elections to extend group health coverage temporarily at group rates after coverage under the Plan would otherwise cease. This extension is called COBRA continuation coverage. Evidence of your good health is not required for this extension. Domestic partners should contact the Plan Administrator to discuss eligibility for continuation coverage.

As an Employee covered under the Plan, you may have the right to elect COBRA continuation coverage if you lose health coverage (or premium payments or contributions for health coverage increase) because:

- Your hours of employment are reduced;
- Your employment is terminated for reasons other than gross misconduct; or
- The Employer starts bankruptcy proceedings under Title XI, if you are a retired employee.

Your Spouse may elect continuation health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You divorce or become legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

Your dependent child may continue health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- He or she loses Dependent status under the Plan;
- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You and your Spouse divorce or become legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

A child born to, adopted by, or placed for adoption with the covered Employee during the continuation coverage period may also be entitled to elect COBRA continuation coverage. Such child's coverage period will be determined according to the date of the qualifying event that gave rise to the covered Employee's COBRA coverage. You must notify the Plan Administrator within 30 days and provide supporting documentation.

Under COBRA, you (or your Spouse or dependent child, if applicable) must notify the Plan Administrator by filing a Change of Status notice with the Plan Administrator within 60 days after:

- You and your Spouse are divorced or legally separated; or
- One of your children loses Dependent status under the Plan.

You (or your Spouse or dependent child, if applicable) will then be notified of the right to elect continuation health coverage and the cost to do so. The deadline for electing continuation health coverage is 60 days after the date the Plan ceases to cover you or your Spouse or dependent child, or 60 days from the date you, your Spouse, or dependent child are notified of your COBRA election rights, whichever is later.

If you (or your Spouse or dependent children, if applicable) do not elect continuation coverage, your health coverage will stop. If you (or your Spouse or dependent children, if applicable) choose continuation health coverage, the Plan will provide health coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period. However, you (or your Spouse or dependent child, if applicable) must pay for this coverage. The COBRA premium will not exceed 102% of the total premium paid by you and your Employer for that level of coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

If the original qualifying event causing the loss of health coverage was the death of the Employee, divorce, legal separation, Medicare entitlement, or loss of "dependent status" of a dependent child under the Plan, then each qualified beneficiary will have the opportunity to elect 36 months of continuation coverage from the date of the qualifying event. If you (or your Spouse or dependent child, if applicable) lose health coverage under the Plan because your employment was terminated or your hours of employment were reduced (and not immediately followed by termination of employment), then the maximum continuation period will be 18 months from the date of the qualifying event. (If coverage is lost at a date later than the date of the qualifying event and the Plan measures the maximum coverage period and notice period from the date of health coverage loss, then the maximum continuation period will be 18 months from the date of health coverage loss.) If during those 18 months, another qualifying event takes place that entitles your Spouse (or dependent child, if applicable) to continuation health coverage, your Spouse's continuation coverage (or dependent child's continuation coverage, if applicable) may be extended by another 18 months. You must make sure that the Plan Administrator/COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. In no event will your Spouse's health continuation coverage (or your dependent child's health continuation coverage, if applicable) extend for more than a total of 36 months from the date of the initial event. If your covered Spouse and/or dependent child lose coverage due to your termination of employment (for reasons other than gross misconduct) or reduction in hours and such loss occurs within 18 months after you enroll in Medicare, then the maximum continuation coverage period for your Spouse and dependent child shall be 36 months from the date you enrolled in Medicare.

Disability is a special issue. If the Social Security Administration determines that you (or your Spouse or dependent child, if applicable) are disabled at any time during the first 60 days of the continuation health coverage period, or in the case of a child born to, adopted by or placed for adoption with a covered Employee during a COBRA coverage period, during the first 60 days after a child's birth, adoption or placement for adoption, then your continuation coverage period as well as your Spouse's and any Dependent's continuation periods may be extended from 18 months to 29 months. The Employer may charge up to 150% of the total premium paid by you and the Employer during this extended period. To qualify, you (or your Spouse or dependent child, if applicable) must notify the Plan Administrator in

writing within 60 days of the date of the Social Security Administration determination and during the initial 18 month continuation coverage period. Your written notice must include your name, Social Security Number, and indicate you have continuation coverage under the Plan. If there is a final determination that the qualified beneficiary is no longer disabled, the Plan Administrator must be notified within 30 days of the determination by the qualified beneficiary, and any health coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

In certain circumstances, bankruptcy under Title XI of the Employer will entitle you to continuation health coverage. If the qualifying event causing the loss of health coverage was the bankruptcy of the Employer under Title XI, then each covered retired employee will have the opportunity to receive continuation health coverage until the death of the covered retired employee. Covered spouses, surviving spouses and dependents of the covered retired employee will have the opportunity to elect continuation health coverage for a period that will terminate 36 months following the death of the retired employee or upon the death of the qualified beneficiary, whichever is earlier.

Your right to continuation health coverage (or your Spouse's or dependent child's right, if applicable) under COBRA ends if:

- The Employer ceases to provide group health coverage to any of its employees;
- You (or your Spouse or dependent child, if applicable) fail to pay the premium within 30 days after its monthly due date;
- You (or your Spouse or dependent child, if applicable) become covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such qualified beneficiary (other than an exclusion or limitation that may be disregarded under the law);
- You (or your Spouse or dependent child, if applicable) become entitled to Medicare after the date of the COBRA election;
- You (or your Spouse or dependent child, if applicable) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For such cause, such as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

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

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Additional continuation rights may apply under state law. Please contact the Plan Administrator for further information.

CLAIMS PROCEDURES FOR THE PLAN

Except as provided below, claims for benefits under each Plan that is either insured or self-insured will be reviewed in accordance with procedures contained in the policies, contracts, summary plan descriptions or other written materials for such Plan benefits. All other general claims or requests should be directed to the Claims Administrator. If a claim under the Plan is denied in whole or in part, the Claims Administrator will notify you or your beneficiary in writing of such denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Claims Administrator are final, conclusive and binding.

CLAIMS PROCEDURE FOR BENEFITS BASED ON DETERMINATION OF DISABILITY

The following claims procedure shall apply specifically to claims made under the Plan for benefits based on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for such plans, the claims procedure in the other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulations.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification regarding the claim denial. This claim denial will include the reasons for the denial, reference to the Plan provision supporting the denial, and a description of the Plan's appeals procedures. The discussion of the claim denial will also include:

- if applicable, an explanation for disagreeing with or not following the views of health care professionals or vocational experts, or with a disability benefit determination made by the Social Security Administration;
- the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim (or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist); and
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and, if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances (or a statement that such explanation will be provided free of charge upon request).

You will receive a benefit denial notice within a reasonable period of time, but no later than 45 days after the Claims Administrator's receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

You have 180 days to appeal an adverse benefit determination. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits. You will be notified of the Claims Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Administrator receives your appeal request.

The 45-day period may be extended for an additional 45-day period if the Claims Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

CLAIMS PROCEDURES FOR GROUP HEALTH PLANS

The following claims procedures shall apply specifically to claims made under any group health plan under this Plan. To the extent that these procedures are inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for the group health plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials shall supersede these procedures as long as such other claims procedures comply with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, as applicable to the Plan.

BENEFIT DETERMINATIONS

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the group health plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days. After reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the Claims Administrator will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Claim Denial Notices

If your claim for benefits is denied in whole or in part, you or your beneficiary will receive notification regarding the claim denial within the applicable time period described above. This denial notice will include the reasons for the denial, reference to the Plan provision supporting the denial, a description of the Plan's appeals procedures and other relevant information regarding the claim decision.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name.
- The plan identification number.
- The date(s) of health care service(s).
- The provider's name.
- The reason(s) you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts

as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

APPEALS DETERMINATIONS

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Care Claims, see "Urgent Care Claim Appeals" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

External Review

If you exhaust all internal appeals procedures, have been denied continued coverage for an ongoing course of treatment or have an urgent care claim, you may be entitled to an external review of your claim. Please consult the Plan Administrator or Claims Administrator for further details.

SUBROGATION/REIMBURSEMENT

If you file a claim for benefits for medical expenses you have incurred which may be the responsibility of a third party, you may be required to reimburse the Plan from any recovery you receive. For example, if you are injured in an automobile accident which is not your fault, you may have to repay the Plan for the health benefits you collect from the third party responsible for the accident, or from his or her insurance company, or anyone else from which you receive payment for the accident. You must notify the Plan of any claim you may have against any third party as soon as you become aware of the claim, you must sign any subrogation/reimbursement agreement requested by the Plan, and you must cooperate with the Plan in all attempts to collect from the third party. This means that the Plan has the right to act on your behalf in pursuing payment from the third party.

For additional information about subrogation/reimbursement, contact the Plan Administrator.

PLAN AMENDMENT OR TERMINATION

The Employer expects to maintain the Plan indefinitely but reserves the right to amend or terminate the Plan if the Employer believes the situation so requires. If you have elected to participate in the Plan, you will be notified in writing if there is any significant amendment or if the Plan is terminated. If the Plan is terminated, the Employer will cease deducting contributions from your salary to pay for Welfare Programs. However, all previous salary deductions will be used to pay for Welfare Programs that you have elected.

CIRCUMSTANCES THAT MAY CAUSE LOSS OF BENEFITS

The Plan contains numerous restrictions on the type and amount of benefits payable and the circumstances when paid. You should review the benefits booklets and other relevant materials for further information. You may lose coverage under the Plan if the Employer terminates the Plan or amends it to reduce or eliminate your coverage. You may forfeit the right to benefits if, among other things:

- You revoke your election to participate;
- You terminate employment with the Employer;
- You fail to make required contributions;
- You fail to file benefits claims on a timely basis;
- You make fraudulent benefit claims;
- You cease to be an eligible Employee; or
- The Plan terminates.

RESPONSIBILITY FOR GOODS/SERVICES

The Employer does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program because these goods and services are provided by personnel and agencies outside of the control of the Employer.

NO GUARANTEE OF EMPLOYMENT

The Plan is not an employment contract. Nothing contained in this document nor the benefits booklet gives you the right to be retained in the service of the Employer or interferes with the right of the Employer to discharge you or to terminate your service at any time.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- ⇒ Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- ⇒ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan 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 Plan Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, and your Spouse and Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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 should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

APPENDIX A
WACO, INC. HEALTH AND WELFARE PLAN

WELFARE PROGRAMS

The following Welfare Programs shall be treated as comprising the Plan:
Group Medical Plan
Group Dental Plan
Group Basic Life and AD&D Plan
Group Long Term Disability

APPENDIX B
WACO, INC. HEALTH AND WELFARE PLAN

PARTICIPATING EMPLOYERS

In addition to WACO, Inc. , the following Participating Employers have adopted the Plan:

There are no other employers participating in the Plan.