Summary Plan Description

For

Dodson Bros.
Exterminating Company

Dental Care Benefits Plan

Revision and Re-Statement Date:

January 1, 2006
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ADOPTION AGREEMENT

The Dodson Bros. Exterminating Company Dental Care Benefits Plan (the "Plan") is established and continued in this document, adopted effective as of January 1, 2006, by Dodson Bros. Exterminating Company (the "Employer"). On this date, the Employer hereby re-states the health benefits plan providing dental benefits for eligible board members, employees, and their dependents in accordance with the terms and conditions of this summary plan description ("Summary Plan Description"). The Employer has duly authorized the adoption of this amended and restated Summary Plan Description 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.

Under this Plan, the Employer is the Plan Sponsor, and shall also function as the Plan Administrator and Plan Fiduciary under ERISA unless another individual or entity is appointed by the Employer. 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.
## SCHEDULE OF BENEFITS

### DENTAL COVERAGE

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>January 1st through December 31st</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Class 1 Services</th>
<th>Class 2 Services</th>
<th>Class 3 Services</th>
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<tbody>
<tr>
<td>Preventive Services</td>
<td>Basic Restorative Services</td>
<td>Major Restorative Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible</th>
<th>None</th>
<th>$25 per Covered Person</th>
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<tbody>
<tr>
<td>Coinsurance</td>
<td>None, Plan pays 100%</td>
<td>Plan pays 80%</td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td>$1,500 per Covered Person per Calendar Year</td>
<td></td>
</tr>
</tbody>
</table>

| Note | Services related to accidental injury to natural teeth are subject to pre-determination within 60 days of the onset of injury. Refer to the section entitled “Pre-Determination of Benefits” under the Dental Benefits section of this Plan for the procedure for pre-determination. |
DENTAL BENEFITS

This section describes the Covered Person’s Dental Benefits. The Plan will provide Dental Benefits when services:

1. Are authorized by a Dentist;
2. Are rendered by a Dentist or Dental Hygienist;
3. Are billed by or on behalf of a Dentist;
4. Qualify as a Covered Service; and
5. Are based on accepted standards of dental practice as determined by the American Dental Association.

Payment of the Customary and Reasonable Charge or the actual charge, whichever is less, will be provided for all Covered Services. All payments will be subject to any applicable Deductible, Coinsurance, maximum benefits and other provisions and limitations in this Summary Plan Description and the Schedule of Benefits.

PRE-DETERMINATION OF BENEFITS

If the Covered Person’s Dentist plans a course of dental treatment which will cost $300 or more, the Covered Person’s Dentist is encouraged to obtain a pre-determination of benefits. This is done by submitting a claim form outlining the treatment plan the Dentist intends to follow in treating the Covered Person. This should be provided to the Employer prior to the start of the course of treatment. The claim form should include the following information:

1. A detailed description of the work to be done; and
2. An estimate of the anticipated dental charges.

In addition to the claim form, any existing diagnostic aids and x-rays should be provided. The purpose of a dental pre-determination of benefits is to assist the Dentist and Covered Person in determining what will be covered under the Plan prior to the services being rendered. Coverage must be in effect when the actual dental services are provided in order for the services to be covered under the Plan even if the Covered Person’s Dentist has obtained a pre-determination of benefits. It is important to note that pre-determination of benefits is not required and will not result in a loss of Coverage in the event that a pre-determination of benefits is not submitted to the Plan.

MULTIPLE METHODS OF DENTAL TREATMENT

The Plan may feel that there is more than one way to treat the Covered Person’s dental condition. When there are two or more methods of treatment for the same condition which meet commonly accepted standards of dental practice, the Plan will pay for the least expensive treatment. This applies even if the Covered Person and the Covered Person’s Dentist have chosen a more costly treatment.

In order to determine the benefit amounts for dental covered services, the Plan may ask for X-rays and other diagnostic and evaluative materials. If these materials are not provided, the Plan will determine the benefit amounts on the basis of the information that is available. This may reduce the amount of benefits which otherwise would have been payable.
DENTAL CARE COVERED SERVICES

Coverage will be provided for the Covered Services listed below. They must be billed by or for a Dentist.

Expenses for the following covered services are considered incurred on the date the type of dental service for which the charge is made is completed.

Preventive and Diagnostic Services

1. Routine oral examinations and comprehensive oral examinations, twice every calendar year;
2. Routine prophylaxis (cleaning of teeth), twice every calendar year;
3. Topical application of fluoride for a covered dependent child under the age of 16, twice every calendar year;
4. Dental X-rays. One set of full-mouth or panorex x-rays will be covered for any period of 36 consecutive months. Bitewing x-rays will be covered once in any 12-month period. Other dental x-rays will be covered if they are necessary to diagnose a specific condition that requires treatment;
5. Space maintainers that replace prematurely lost deciduous (primary) teeth, for Dependent Children under age 12;
6. Emergency treatment for the temporary relief of pain, but which does not effect a definite cure;
7. Sealants for Covered Persons once every calendar year.

Basic Restorative Services

1. Oral surgery, limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch, and all related pathology services;
2. Fillings to restore diseased or accidentally broken teeth. Fillings may be made of the following materials: amalgam, silicate, acrylic, synthetic porcelain, or composite materials;
3. Endodontics (root canal therapy);
4. Apicoectomy (surgical removal of the apex or tip of the tooth root);
5. Management of acute infection and oral lesions;
6. Repair or re-cementing of crowns, inlays, onlays, fixed bridgework and full or partial dentures;
7. General anesthesia when it is needed in connection with oral or dental surgery or other covered dental services;
8. Extraction of teeth. This service includes local anesthesia and routine post-operative care.
**Major Restorative Services**

1. Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold;

2. Installation of crowns, including pre-fab resin crowns;

3. The initial installation of fixed bridgework. Fixed bridgework means a false tooth/teeth fixed at each end to existing teeth;

4. The initial installation of partial or full removable dentures;

5. Installing precision attachments for removable dentures;

6. Addition of clasp or rest to existing partially removable dentures;

7. Repair of crowns, bridgework and removable dentures;

8. Rebasing or relining of removable dentures;

9. Replacement for full or partial dentures or fixed bridgework. This benefit includes the addition of new false teeth to the full or partial dentures or fixed bridgework. The Plan will pay this benefit only if one of the following conditions exists:
   a. The Covered Person’s existing full or partial denture or fixed bridgework cannot be restored to usable condition. The Covered Person’s full or partial denture or fixed bridgework must be at least 5 years old before the Plan will pay for any part of the replacement cost;
   b. The Covered Person’s existing full or partial denture is an immediate temporary denture which must be replaced with a permanent one, within one year; or
   c. The Covered Person had more teeth extracted after the existing denture or bridgework was installed, so that (s)he must have teeth added to the existing partial denture or fixed bridgework.

**EXCLUSIONS OR LIMITATIONS**

No dental benefits are provided for any of the following:

1. **Act of War, Riot, Civil Disobedience, Nuclear Explosion.** The Plan will not cover dental services or supplies for a condition resulting from a riot, civil disobedience, nuclear explosion, nuclear accident, or an act of war;

2. **Anesthesia.** The Plan will not cover local anesthesia or partial anesthesia, including intravenous sedation, except as otherwise provided;

3. **Appliances and Restoration for Vertical Dimension.** The Plan will not cover appliances or restorations to increase the vertical dimension of the mouth or to restore the occlusion. Full mouth equilibration is one example of such a service;
4. **Congenital Malformation.** The Plan will not cover services or supplies for the treatment or correction of a congenital malformation unless Medically Necessary;

5. **Cosmetic Services.** The Plan will not cover services or supplies primarily cosmetic or aesthetic. Examples include capping teeth to cover stains; charges for personalization or characterization of crowns, full or partial dentures or fixed bridgework;

6. **Dental Services For Which Normally There Is No Charge.** The Plan will not cover dental services or supplies for which the Covered Person would not have been charged if the Covered Person had not been covered by this dental insurance. For example:
   a. If the Covered Person would have been charged less if (s)he had no insurance, the Plan will base the payment on the lower charge; or
   b. If the service would have been provided free by a clinic or health service which is operated by or for the Covered Person’s employer, union or similar group, this Plan will not pay any charges;

7. **Dental Visits to Home or in Hospital.** The Plan will not cover Charges for dental visits at home or in a Hospital, unless these visits are in connection with dental surgery or emergency care;

8. **Duplicate Devices.** The Plan will not cover duplicate prosthetic devices or appliances;

9. **Effective Date and Termination Date Rules.** The Plan will not cover dental services or supplies that are provided before this Dental Coverage goes into effect or after it is terminated. In the case of prosthetic devices and crowns, charges will not be covered if the impressions were taken before Coverage goes into effect, even if the prosthetic device or crown is installed after Coverage goes into effect. If impressions are taken while Coverage is in effect, but the prosthetic device or crown is installed after Coverage terminates, then charges for the prosthetic device or crown will not be covered. In the case of the replacement of missing teeth, the Plan will not cover dental services or supplies for the replacement of a missing tooth or teeth that was missing prior to the effective date of Coverage;

10. **Excess Charges.** The Plan will not cover charges that are considered excess charges because;
   a. the Covered Person transferred from one Dentist to another during a course of treatment;
   b. the Covered Person missed an appointment;
   c. services were rendered by more than one Dentist; or
   d. services were repeated needlessly;

11. **Experimental/Investigative.** The Plan will not cover services and supplies which are Experimental and Investigative;

12. **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;
13. **Governmental Agency or Program.** The Plan will not cover any service the Covered Person could receive free or have paid for by some government agency or program, even if (s)he does not choose to apply for or to accept this assistance;

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

15. **Lost or Stolen Supplies.** The Plan will not cover dental services and supplies to replace a lost or stolen crown, bridge or full or partial denture;

16. **Medical Benefits.** The Plan will not cover dental services or supplies which are covered under any medical benefits or health care coverage;

17. **Medicare and Medicaid.** The Plan will not cover any service available under Medicare or Medicaid (Title XVIII and Title XIX of the Social Security Act of 1965);

18. **Military Benefits.** The Plan will not cover any service the Covered Person could receive free or have paid for as a military benefit. This applies if the Covered Person receives dental services or supplies while (s)he is in active military service or if the Covered Person receives services in a veterans administration hospital;

19. **Non-Dental Services.** The Plan will not cover non-dental services, such as filling out claim forms;

20. **Non-Covered Service.** The Plan will not cover any service or supply which is not specified as a Dental Covered Service;

21. **Oral Hygiene Instruction or Programs.** The Plan will not cover plaque control programs, oral hygiene or dietary instruction;

22. **Orthodontia Services.** The Plan will not cover orthodontia services;

23. **Porcelain Veneers.** The Plan will not cover porcelain or other veneers of crowns and pontics placed on the molars. If veneers are used, payment will be the same as payment for a full cast gold crown or cast gold pontic;

24. **Stabilizing Services.** The Plan will not cover services primarily to stabilize the teeth in their supporting structures. Examples include implantology and periodontal splinting;

25. **Unnecessary Services or Supplies.** The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed unnecessary or inappropriate by the ADA or is otherwise deemed unnecessary or inappropriate in accordance with accepted dental standards and practice; and

26. **Workers’ Compensation or Occupational Benefit.** The Plan will not cover any service if the Covered Person can receive dental care as an occupational benefit. This applies if care would be provided or paid for under a state or federal workers’ compensation act or an occupational disease law or similar law.
GENERAL EXCLUSIONS

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

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

2. **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;

3. **Controlled Substance.** 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 administered by a Physician;

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;

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

8. **Experimental/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 Customary and Reasonable Charge.** The Plan will not cover charges for services and supplies for treatment which are in excess of the Customary and Reasonable 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. **Hazardous Hobby.** The Plan will not cover charges for services and supplies due to an Illness or Injury that results from engaging in a hazardous hobby. A hazardous hobby is an activity which is characterized by a threat of danger or risk of bodily harm. Some examples of hazardous hobbies include, but are not limited to: any kind of organized vehicular speed or endurance contest in the air, on land or water, hang gliding, bungee jumping, stunt driving, ski jumping, snow boarding, jet skiing, scuba diving, snowmobiling without a helmet, motorcycling without a helmet and driving or riding in a motor vehicle without a seat belt, participating in any motorized speed or endurance contest in the air, on land, in or on water, any stunt driving or aerobatics contest or demonstration;

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. **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;

15. **Maximum Benefit.** The Plan will not cover charges for services and supplies which exceed the maximum benefit, as shown in the Schedule of Benefits or Eligible Expenses;

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

17. **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;

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

19. **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;

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;

21. **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;

22. **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;

23. **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;
24. **Travel Expenses.** The Plan will not cover charges for travel, whether or not recommended by a Physician, except as provided herein;

25. **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;

26. **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. The employee must regularly work at least 30 hours per week;
2. The employee cannot be a temporary employee;
3. The employee must be Actively Working;
4. If applicable, the employee must make the required contribution towards the coverage; and
5. The board members of Dodson Bros. Exterminating Company shall be considered Eligible Employees under this Plan and are entitled to all benefits and rights that an Eligible Employee is entitled to receive.

ELIGIBLE DEPENDENTS

The following persons are considered to be Eligible Dependents:

1. The spouse of the Covered Employee. As used herein, “spouse” includes individuals of the opposite sex only;

2. A child who is the Employee’s natural child, step child, legally adopted child or child who is under the Employee’s legal guardianship pursuant to an interlocutory order of adoption and who is under age 18 at time of placement, (coverage eligibility begins from time of placement in the home for adoption whether or not the adoption proceedings have been completed), and who is unmarried and under the Dependent Limiting Age. In order to qualify as a Dependent Child under this paragraph, the child must be eligible for support in accordance with the Internal Revenue Code and have the same principal place of abode as the Covered Employee for the period of time established by the Internal Revenue Code. As used herein, the Dependent Limiting Age means the date on which the Dependent Child attains the age of 25; however, eligibility shall continue until the end of the year in which the Dependent Child attains the age of 25;

3. A child who is dependent pursuant to Qualified Medical Child Support Order (“QMCSO”) as set forth under OBRA 1993. A child eligible under this provision is referred to as an “alternate recipient.” Notwithstanding any Plan provision to the contrary, the QMCSO entitles such child to Coverage under the Plan, and such entitlement applies even if: (a) such child does not reside with the Covered Employee or is not dependent on the employee for support; and (b) even if the employee has not previously enrolled for Coverage under the Plan or does not have legal custody of the child; and (c) regardless of any enrollment restrictions that may otherwise exist for dependent coverage. Such Dependent Child will be subject to the Dependent Limiting Age under this Plan; and

4. An unmarried child who is over the limiting age of the Plan and otherwise meets the definition of a Dependent Child and who is permanently disabled upon attainment of the Dependent Limiting Age. The Dependent Child must be incapable of self-sustaining employment by reason of mental retardation or mental or physical handicap and primarily dependent upon the Covered Employee for support and maintenance. The Covered Employee must make application for continuation of Coverage to the Employer within 31 days after the Dependent Child reaches the Dependent Limiting Age. Such application shall include proof satisfactory to 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.

**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.
APPLYING FOR COVERAGE AND EFFECTIVE DATES

ENROLLMENT PERIOD FOR NEW HIRES

For Eligible Employees who are newly hired or become eligible under the Plan, the Eligible Employee must complete and submit an enrollment application to the Employer within 31 days following the Eligible Employee’s date of hire or rehire. If application is submitted during this enrollment period, Coverage will become effective the 1st day of the month following 60 days after the employee’s date of hire.

If an Eligible Employee is not Actively Working on the day Coverage would otherwise become effective, the Effective Date of Coverage will be postponed to the day the Eligible Employee returns to work. This does not apply if the Eligible Employee is not Actively Working due to the existence of a health condition.

ENROLLMENT PERIOD FOR REHIRES

For Eligible Employees who are re-hired following the loss of employment with the Employer, the Eligible Employee must complete and submit an enrollment application to the plan within 31 days following the Eligible Employee’s date of rehire. When application is submitted during this enrollment period, Coverage will become effective the 1st day of the month following 60 days after the employee’s date of re-hire. However, this waiting period will not apply if, after an employee’s actual termination date, the employee has elected COBRA coverage and the employee’s re-hire date occurs while (s)he is still covered as a COBRA beneficiary. In this event, the 60-day waiting period will be waived and Coverage will be made effective the 1st of the month following the date of re-hire.

SPECIAL ENROLLMENT PERIODS

There are a number of circumstances that qualify as Special Enrollment Periods. The following events qualify as Special Enrollment Periods under the Plan:

1. **Loss of Other Coverage:** Eligible Employees who decline enrollment when initially eligible under the Plan due to existing medical benefits under another health plan and state in writing at such time that this is the reason for declining enrollment, and who subsequently lose coverage under the other plan and complete an application within 31 days and submit it within 45 days to the Employer following the termination of coverage, shall be made effective on the first day following the loss of other coverage, as set forth below. In this event, loss of 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.

   As used herein, “loss of eligibility” includes but is not limited to the following types of losses:
   a. 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;
   b. 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;
   c. 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;

d. 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;

e. 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;

f. 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;

g. 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.

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 and state in writing at such time that this is the reason for declining enrollment, provided application 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 a birth of a child or adoption or placement for adoption of a child, the newly acquired child and the Eligible Employee and spouse, if not covered, will be eligible to enroll for Coverage under this provision. In this event, application must be completed within 31 days and submitted to the Employer within 45 days following the date the dependent child becomes an Eligible Dependent. Coverage shall be made effective on the birth date of the child for a newborn, or for an adopted child or child placed for adoption, on the date the child is adopted or placed for adoption. In this instance, in addition to the newly acquired Dependent Child under this provision, the Eligible Employee and the spouse, who are otherwise eligible under the Plan, and 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.

**Note:** In addition to the Special Enrollment Period permitted for the addition of Dependent Children following birth and adoption, the Plan will allow for the following additional enrollment period in connection with the addition of a Dependent Child to an Employee’s Coverage. If 2 employees who are husband and wife are covered under this Plan (e.g., one parent has single coverage and the other employee has coverage for himself and the Dependent Children) and the parent who is covering the Dependent Child terminates coverage, the Dependent Coverage may be continued by the other parent’s Coverage immediately following termination of Coverage under other parent’s Coverage, provided: (a) there is no lapse in Coverage between the former and replacing Coverage, and (b) application under the replacing Coverage is completed within 31 days and submitted to the Employer within 45 days following termination under the former Coverage.

3. **Marriage:** In the event Covered Employee marries after his or her Coverage has become effective, the employee may add his or her spouse to the Coverage by completing an application within 31 days and submitting it to the Employer within 45 days of the date of marriage. Coverage shall be made effective on the day following the date of marriage. In this instance, the Eligible Employee who is otherwise eligible under the Plan, and who did not enroll under the Plan when initially eligible or during a subsequent open enrollment period, if applicable, and any Dependent Child(ren) who is/are acquired as a result of the marriage, are permitted to enroll during this Special Enrollment Period.
LATE ENROLLMENT

Employees or Dependents who fail to submit a registration application during the time periods set forth above will be considered Late Enrollees. Late Enrollees will be permitted to enroll for Coverage during the Plan’s Open Enrollment Period.

OPEN ENROLLMENT PERIOD

Open Enrollment Period is the period designated by the Employer during which the Employee may elect Coverage for himself and any eligible Dependents if he is not covered under the Plan and does not qualify for a Special Enrollment as described herein. During this Open Enrollment Period, an Employee and his Dependents who are not covered under this Plan must complete and submit an enrollment form for coverage.

The Open Enrollment Period under this Plan occurs during the month of November each calendar year. Coverage for Employees and Dependents who enroll during this Open Enrollment Period will be effective the first day of January immediately following the last day of the Open Enrollment Period.
TERMINATION PROVISIONS

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 first day of the month immediately following the month in which the Covered Employee ceases to be an Eligible Employee. This includes death or termination of Active Employment of the Covered Employee; and
3. 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.

The employee may be eligible for continued Coverage under COBRA or another Continued Coverage option as described in the section entitled “Continuation of Coverage.”

In the event the Covered Employee temporarily ceases to be Actively Employed due to an employer-approved leave of absence or a disability, Coverage will continue in place for a period of up to six months or until the employee’s return to Active Employment. The Covered Employee is only eligible under this provision if his or her leave of absence or disability is considered temporary, the Covered Person continues to remain in the employ of the Employer, (s)he continues to receive employee-related benefits and (s)he continues to make any contributions as may be required by the Employer. Refer to the section entitled “Continued Coverage Provisions” for additional details.

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;
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.

The Dependent may be eligible for continued Coverage under COBRA or another Continued Coverage option as described in the section entitled “Continuation of Coverage.”

HIPAA CERTIFICATE FOLLOWING TERMINATION OF 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 employer (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.
CONTINUOUS COVERAGE PROVISIONS

CONTINUOUS COVERAGE FOLLOWING EMPLOYER-APPROVED LEAVE OF ABSENCE (OTHER THAN FMLA)

In the event the Covered Employee temporarily ceases to be Actively Employed due to an employer-approved leave of absence, Coverage will continue in place for a period of up to six months or until the employee’s return to Active Employment. The Covered Employee is only eligible under this provision if his or her leave of absence or disability is considered temporary, the employee continues to remain in the employ of the Employer, (s)he continues to receive employee-related benefits and (s)he continues to make any contributions as may be required by the Employer.

If the leave of absence is a qualified leave of absence under FMLA (refer to the next section), the Employer may require that the employee use this leave of absence prior to the FMLA leave of absence benefits. The Employer may also require that the employee substitute this leave of absence for the FMLA leave of absence benefits. Contact the Employer or Plan Sponsor to determine how this FMLA provision impacts the Employer’s paid sick leave or leave of absence policy.

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

Under the Family and Medical Leave of 1993 (“FMLA”), an employer who is subject to FMLA requirements must provide to the employee unpaid leave of absence for 12 weeks during each 12-month period when:

1. the employee requests such leave of absence in order to care for a newborn or newly-adopted Dependent Child or a Dependent Child who is placed with the employee as a foster child;

2. the employee requests such leave of absence in order to care for a sick Dependent Child who is under the age of 18, or a sick Dependent Child who is age 18 or over and incapable of self-support due to a mental or physical disability, or a sick spouse or a sick parent; or

3. the employee requests such leave of absence because the employee has a serious health condition.

During an FMLA leave of absence, the Employer cannot use the taking of FMLA leave as a negative factor in employment actions, such as hiring, promotions or disciplinary actions and Health Care Coverage under the Plan will continue for the FMLA period. However, under limited circumstances, an Employer may deny reinstatement to work, but not the use of FMLA leave, to certain highly-paid, salaried employees. In addition, an Employer is not required to continue FMLA benefits or reinstate employees who would have been laid off or otherwise had their employment terminated had they continued to work during the FMLA leave period as, for example, due to a general layoff.

Employees are eligible under FMLA if they have been employed by the Employer for twelve (12) or more months and, during that period, worked twelve hundred and fifty (1,250) hours, and work at a location where at least 50 employees are employed by the Employer within 75 miles. Spouses who are employed by the same Employer may be limited to twelve (12) weeks in aggregate, except in the case of a serious health condition of either spouse. Any paid or unpaid leave of absence, including FMLA leave of absence, will not be counted toward the minimum number of hours required for eligibility.
Should an FMLA leave of absence be required, the employee should contact the Employer immediately for details. The Employer may require certification by the attending physician, which should include the date the medical condition began, the probable duration of the condition, the appropriate medical facts, and, for a serious health condition of an employee's family member, a statement that the employee is needed to care for that family member, and an estimate of the amount of time needed to care for the family member. The Employer may, from time to time, during an FMLA leave of absence also require that the employee provide periodic reports concerning the employee’s status or the employee’s intent to return to work following the FMLA leave of absence.

If the Plan Sponsor offers paid sick leave or some other form of paid leave of absence as part of his or her employer benefit package, the Employer may also require the employee to use such other paid sick leave or other paid leave of absence prior to the 12-weeks available under FMLA. 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 12-weeks available under FMLA 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 or Plan Sponsor to determine how this FMLA provision impacts the Employer’s paid sick leave or leave of absence policy.

Employees who give unequivocal notice that they do not intend to return to work lose their entitlement to FMLA leave. In addition, employees who are unable to return to work and have exhausted their 12 weeks of FMLA leave in the designated 12-month period no longer have FMLA protections.

This section is merely a general summary of the provisions of the FMLA. If the Covered Employee requires additional details concerning FMLA, the Covered Employee should contact the Employer or Plan Sponsor.

Once the Covered Employee has exhausted the 12 weeks of continued Coverage under this section, he/she may be eligible for additional continued Coverage under COBRA.

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.
Notification and Election

The Covered Employee must notify the Employer in writing and submit to the Employer the entire monthly payment, as such may be applicable, if he or she wishes to continue Coverage. The Covered Employee’s election and first month’s monthly payment is due at the earliest of the following:

1. If the Employer notifies the Covered Employee of his or her right to continue Coverage before Coverage would otherwise end, then the Covered Employee’s election and monthly payment must be submitted to the Employer no later than 31 days after the date the Covered Employee’s Coverage would have otherwise terminated.

2. If the Employer notifies the Covered Employee of his or her right to continue Coverage after Coverage has terminated, then the Covered Employee’s election and monthly payment must be submitted within 31 days following the date of notification by the Employer.

Cost of Continued Coverage

The Employer may require the Covered Employee or Dependent to pay the full cost of the continued Coverage. The monthly payment may not exceed 102% of the monthly payment being charged by the Employer for similarly situated employees. However, if the employee performs service in the Uniformed Services for less than 31 days, such employee may not be required to pay more than 100% of the monthly payment being charged by the Employer for similarly situated employees.

Termination of Continued Coverage

The continuation of Coverage ends at the earliest of the following:

1. When the Covered Person becomes covered under another group health plan without pre-existing condition limitation;
2. Upon the expiration of the continued period of Coverage as set forth herein;
3. When the required payments are not received on a timely basis;
4. When the health plan is terminated and not replaced by the Employer with another health plan.

COBRA CONTINUATION 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 benefit (“COBRA Continuation 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 Continued Coverage provisions of the law. If the Covered Person does not choose COBRA Continuation Coverage, the Coverage under the Plan will end.

COBRA Continuation 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 Continuation Coverage for the coverage(s) (s) he elects to continue during the election process as described herein.
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 Covered Employees 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.

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 Continuation 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 Continuation Coverage section.

Notification by Covered Employee or Dependent

The Covered Employee or Dependent must notify the Plan Administrator when eligibility for COBRA Continuation Coverage results from one of the following events:

1. Divorce or legal separation from the Covered Employee.

2. A Dependent child no longer meets the eligibility requirements of the Plan.
The Covered Employee or Dependent must provide this notice to the Plan Administrator within sixty (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 Continuation 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 eighteen (18) month COBRA Continuation Coverage period and no later than sixty (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 thirty (30) days of such change in status.

These notification requirements also apply to an individual who, while receiving COBRA Continuation 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 Continuation 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 Continuation Coverage under this provision.

**Notification by Employer**

The Employer is responsible for notifying the Plan Administrator when eligibility for COBRA Continuation 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 thirty (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 Continuation 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 fourteen (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 Continuation 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 Continuation Coverage that takes effect on a date earlier than the end of the maximum period of COBRA Continuation 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 sixty (60) days from the date the notice is sent to decide whether to elect COBRA Continuation Coverage. Each person who was covered under the Plan prior to the Qualifying Event has a separate right to elect COBRA Continuation Coverage on an individual basis, regardless of family enrollment. For example, the employee’s spouse may elect COBRA Continuation Coverage even if the employee does not select the coverage. COBRA Continuation Coverage may be elected for one, several or all dependent children who are Qualified Beneficiaries and a parent may elect COBRA Continuation Coverage on behalf of any dependent child.

In considering whether to elect COBRA Continuation 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 which 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 Continuation 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 sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

1. the date coverage under the Plan would otherwise end; or
2. the date the notice is sent by the Plan Administrator notifying the person of his or her rights to COBRA Continuation 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 sixty (60) day COBRA election period. TAA-eligible individuals who did not elect COBRA Continuation Coverage during the initial sixty day COBRA election period, which followed the TAA-related loss of coverage, may elect COBRA Continuation Coverage during the sixty (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 six (6) months after the date of the TAA-related loss of coverage. Any COBRA Continuation 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 Continuation Coverage be afforded the opportunity to maintain COBRA Continuation 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 Continuation 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;
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 continuation 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 Continuation 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 Continuation Coverage from eighteen (18) months to twenty-nine (29) months. Non-disabled family members may also elect to extend COBRA Continuation 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 sixty (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 eighteen (18) month COBRA Continuation Coverage period and no later than sixty (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 thirty (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 Continuation 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 Continued 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 eleven (11) months of COBRA Continuation 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 continued Coverage. The initial payment must be made within forty-five (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 continued 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 thirty (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 above.

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 payment 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 Continuation 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 Continuation Coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during COBRA Continuation 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 Continuation Coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of Coverage.

**End Of COBRA Continuation Coverage**

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

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

2. Thirty-six (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 Continuation 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.

8. Thirty-six (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 Continuation Coverage be permitted to enroll in any individual conversion health plan which 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 Continuation of Coverage rights from the Plan Administrator. If the employee has any questions concerning his or her COBRA Continuation of 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 at the following address:

Dodson Bros. Exterminating Company
3712 Campbell Avenue
Lynchburg, VA 24501
(434) 847-9051
CLAIMS INFORMATION

When the Covered Person receives Covered Services, a claim must be filed on the Covered Person’s behalf to obtain benefits. In some cases, the Provider will file the claim for the Covered Person. If the Covered Person submits the claim, (s)he should use a claim form. 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.

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 or Plan Sponsor. 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
6. The Covered Person’s signature and the Provider's signature

TIMEFRAME FOR SUBMITTING CLAIM

The claim form must be submitted within 90 days 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 90 days will not reduce any benefit if the Covered Person shows that the claim was submitted as soon as reasonably possible. No claim may be submitted later than one year after the usual 90-day filing period ends. The claim form should be submitted to the address shown on the Covered Person’s Identification Card.

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, Post-Service Claims and Urgent Care Claims.
Pre-Service Claims - Pre-Service Claims are those claims that require 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 as set forth in the Utilization Review section of this Summary Plan Description. 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 Administrators’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.

Post-Service Claims - Post-Service Claims are those claims for services other than Pre-Service and Urgent Care Claims that 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.

Urgent Care Claims - Urgent Care Claims are those pre-service claims in which the time periods for
making claim determinations for non-Urgent Care 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.

**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 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 or Post-Service Claim 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 claims 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 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 claims appeals within 60 days of receiving the request for appeal of a Post-Service Claim. As used in this section, a Post-Service Appeal is an appeal for any adverse claims determination in connection with a Post-Service Claim.
Note: If the Named Fiduciary is a multi-employer plan which has a committee or board of trustees designated as the appropriate Named Fiduciary which holds regular meetings (at least once a quarter), and if the appeal request is received within 30 days preceding the date of the scheduled meeting, then the Named Fiduciary will make the determination concerning the claims appeal no later than the date of second meeting following receipt of the request. If special circumstances (such as the need to hold a hearing, if the Plan’s procedures allow for such a hearing) require a further extension of time for processing an appeal request, a determination shall be rendered not later than the third meeting of the committee or board of trustees following the Plan’s receipt of the request for review. In this instance, the Plan Administrator shall provide to the covered person written notification of the extension and such notice shall describe the special circumstances and the date as of which the determination will be made, prior to the commencement of the extension. The covered person will be notified of the Named Fiduciary’s decision concerning the appeal no later than 5 days after the determination is made by the Named Fiduciary.

**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 appeals 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.

**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 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/Investigative grounds.

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

**PAYMENT OF BENEFITS**

The Covered Person may request that payments be made directly to a Provider; however, the Plan reserves the right to make payments to the Provider or directly to the Covered Person. The Covered Person cannot request that payment be directed to anyone else. Once a Provider renders a Covered Service, the Plan will not honor the Covered Person’s request to withhold payment of the claims submitted.

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.
RIGHTS TO AN ITEMIZED BILL

The Covered Person has the right to receive a copy of an itemized bill. This bill would identify the services and supplies rendered to the Covered Person. To receive a copy of the bill, send a written request to the Provider that rendered services. It is in the Covered Person’s best interest to exercise this right so that (s)he has a copy of the bill for his or her personal files.
COORDINATION OF BENEFITS
AND
ORDER OF BENEFITS DETERMINATION

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 coordination of benefits provisions ("COB") applies when the Covered Person is also covered by an Other Benefit Plan. When more than one coverage exists, one plan will pay its benefits in full according to the terms of that plan. This plan is considered the primary plan. Any Other Benefit Plan is referred to as the secondary plan and pays a reduced benefit to prevent duplication of benefits.

By coordinating benefits under this provision, the total benefits payable by all Other Benefits Plans and this Plan will not exceed 100% of Allowable Expenses, as defined herein. A common set of rules is used to determine the order of benefits determination Other Benefit Plan.

When the Plan is primary, the Plan will pay benefits without regard to any Other Benefit Plan. When this Plan is secondary, the benefits payable under this Plan will be reduced so that the sum of benefits paid by all Other Benefit Plans and this Plan do not exceed 100% of total Allowable Expenses. The actual amount payable by the Plan as the secondary plan will be the difference between the amount that has been paid by the primary plan and the amount that would have been paid by this Plan had it been the primary plan. If the amount paid by the primary plan equals or exceeds the amount that would have been payable this Plan if were the primary plan, then no further benefit payments will be made by the Plan in connection with that claim.

In no event shall the Covered Person recover under this Plan and all Other Benefit Plans more than the total Allowable Expenses under this Plan and all Other Benefit Plans. Nothing contained in this section shall entitle the Covered Person to benefits in excess of the total Maximum Benefits of this Plan. The Covered Person agrees to refund to the Employer any excess benefits the Plan may have paid.

The Plan may exchange information with any Other Benefit Plans without the consent of or notice to any person, while coordinating benefits for a Covered Person. Any person claiming benefits under this Plan must furnish to the Employer the information necessary to coordinate benefits.

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 (not including Medicare).
Allowable Expenses means any Eligible Expenses incurred while the Covered Person is covered under this Plan, except that any Eligible Expenses incurred that apply toward the Covered Person’s copayment, deductible or coinsurance requirement under this Plan or any Other Benefit Plan will not be included as an Allowable Expense.

ORDER OF BENEFITS DETERMINATION (OTHER THAN MEDICARE)

Which plan provides primary or secondary Coverages 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 have 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 not 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;
   
   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 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

If, in addition to the Plan, the Covered Person is covered by Medicare, the order of benefits payments will be determined in the following manner:

Medicare Eligibility On The Basis of Age

Under Medicare, Medicare is the secondary payor for the Working Aged. As used herein, the Working Aged include an employee age 65 or over and the employee’s spouse who is age 65 and over, who have coverage under a group health plan because of the employee’s or spouse’s employment. This provision applies to employer-sponsored health plans that have 20 or more full time or part-time employees for each working day in each of 20 more calendar weeks in the current calendar or preceding calendar year. Based on this provision, the Covered Employee’s Plan will be considered primary for the employee and his/her spouse as long as such employee remains Actively Working, and the Plan will not reduce or terminate Coverage of such employees and their spouses because of their entitlement to Medicare.

Medicare allows the Covered Employee or spouse to choose Medicare as primary. In this event, the employee and spouse will lose Coverage under the Plan for any benefits that would be considered Medicare eligible expenses. Additionally, an employee or spouse who elects Medicare as the primary payor may purchase a Medicare supplement plan from a source other than the Employer. The Employer may not purchase or subsidize an individual Medicare supplement plan for the employee or spouse.

Medicare Eligibility Due to Kidney Failure

Medicare is the secondary payer if the Covered Person has Medicare due to permanent kidney failure for a period of 30 months, beginning with the earlier of the following dates:

1. The month in which the Covered Person begins a regular course of renal dialysis; or,

2. The first month in which the Covered Person becomes entitled to Medicare, if he or she receives a kidney transplant within first beginning dialysis.

After a period of up to 30 months following this date expires, Medicare will become the primary payer. Once Medicare becomes primary, the benefits of the Plan will be applied only to any unpaid balance after the Covered Person receives Medicare benefits. In this event, Medicare benefits available to the Covered Person will be subtracted whether or not a Medicare claim is filed.

Medicare Eligibility Due to Other Disability

Medicare is the secondary payer for people under age 65 who have Medicare because of a disability (other than those with permanent kidney failure) and who are covered under a Large Group Health Plan as an employee or Dependent of such person. To be eligible under this provision, the employee must be Actively Working in spite of the disability.

Generally, a Large Group Health Plan is a health plan that has 100 or more full time, part time or seasonal employees. However, the Covered Employee or spouse should contact the Plan Sponsor to determine whether or not Coverage is being provided under a Large Group Health Plan.
Medicare Eligibility for Other Covered Persons

For all other Covered Persons eligible for Medicare, Medicare will be determined the primary payer and the Plan will be considered the secondary payer. This means that Medicare benefits will be determined first and the benefits under the Plan will be applied only to any unpaid balance after Medicare benefits are received. If the Covered Person is eligible for Medicare, but has not enrolled for Medicare or filed a Medicare claim, Plan benefits will be reduced by any benefits that would have been paid under Medicare had the person enrolled for Medicare or filed a Medicare claim.
THIRD PARTY RECOVERY AND SUBROGATION

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.

The Covered Person must cooperate fully and provide all information needed under the Plan to recover payments and execute any papers necessary for such recovery. 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 a) a tortfeasor, b) a liability insurer for a tortfeasor, or c) 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, or any other form of insurance coverage (“Recovery”), the Covered Person must repay the Plan in full for any 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.

The Plan has the right to be paid from any such Recovery any and all monies: a) paid, b) payable to, or c) 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 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. 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 Covered Person has an obligation and duty to reimburse the Plan to the extent of the Subrogated Amount and is deemed to give the Plan the first lien on the Subrogated Amount. 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.
GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through Dodson Bros. Exterminating Company. Dodson Bros. Exterminating Company 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. The Employer has retained the services of HealthSCOPE Benefits to administer the benefits described in this Summary Plan Description.

The Employer is the Plan Sponsor, and shall also function as the Plan Administrator and Plan Fiduciary under ERISA unless the Employer appoints another individual or entity to act in this capacity. Refer to the section entitled to Operation and Administration of the Plan for more details concerning the administration of the Plan.

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 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 Virginia 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 Dentist, 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 an eligible Covered Person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

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.

EFFECTIVE DATE

Except where specifically stated otherwise in this Plan, the provisions of this amended and restated Plan are effective January 1, 2006 and this Summary Plan Description shall supersede and replace all prior versions of the Plan as of that date.

EMPLOYMENT RIGHTS

The establishment of the Plan and the Covered Employee’s participation in the Plan does not affect in any way the employee’s employment rights. Nor does the establishment of or employee’s participation in such Plan confer any right upon any employee to be retained in the service of the Employer.

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 DENTIST

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 Dentist 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 Non-Preferred Provider.

INCONTESTABILITY

All statements made by the Employer or by the Covered 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 Covered Person, 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.

INTEREST IN PLAN ASSETS

Except with respect to the right of a Covered Person to receive benefits under this Plan, no employee or any other person shall have any right, title or interest in or to the assets of the Plan or in or to any contributions thereto, such contributions being made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms. Neither the board of directors nor the board of trustees, if applicable, of the Employer, the Administrative Committee, the Claims Administrator, nor the Employer in any way guarantees the Plan from loss or depreciation, nor guarantees the payment of any benefits that may be or become due to any person under the Plan. The liability of the Employer, the board of directors or board of trustees, if applicable, and the Administrative Committee of the Plan for payment of benefits under the Plan as of any date is limited solely to the then assets of the Plan. The liability of the Claims Administrator for the administration of claims under the Plan as of any date is limited solely to the funds have been provided by the Plan for the express purpose of funding claims or as of that date.

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.

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. Such contributions being made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms.

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.

**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 RIGHT TO RECOVERY**

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, according to the terms of the Plan, the Plan will have the right to recover these excess payments. Whenever payments 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 these incorrect payments. The Plan has the right to recover any such overpayment or incorrect payment from the person or entity to whom payment was made, or from any other appropriate party, whether or not such payment was made due to the Plan Administrator’s own error.

**REVERSION OF ASSETS**

No part of the Plan assets shall revert to the Employer, or be used for, or diverted to, purposes other than the provision of welfare benefits as described herein for the exclusive benefit of Covered Employees.

**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, Administrative Committee or HealthSCOPE Benefits to enforce any provision of the Plan provision shall not affect the Plan Sponsor’s, Administrative Committee’s or HealthSCOPE Benefits’ right thereafter to enforce such provision or any other provisions of the Plan.

**SOURCE OF BENEFITS**

All benefits under the Plan shall be provided solely from the Plan and applicable insurance contracts, if any, and neither the Employer nor its officers, directors, or agents (including, but not limited to, the Claims Administrator) shall have any liability or responsibility therefore. The Claims Administrator shall not be liable in any manner should there be insufficient funds in the Plan to provide for the payment of any benefit under the Plan.
TERMINATION OF THE PLAN

Right to Terminate: It is the intention of the Employer to continue this Plan indefinitely. However, the Plan Sponsor reserves the right to terminate this Plan at any time by an instrument duly executed by it.

Effect of Termination: Unless otherwise provided, upon the effective date of Plan termination, the Coverage of all Covered Persons shall cease and no person shall become entitled to any benefits hereunder for any expenses incurred after the effective date of Plan termination. The Plan shall remain liable to pay benefits for expenses incurred prior to the effective date of Plan termination, but only to the extent of the assets set aside for that purpose.

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.

WORKER’S 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.
OPERATION AND ADMINISTRATION OF THE PLAN

PLAN ADMINISTRATOR RESPONSIBILITIES

Plan Sponsor and Plan Administrator: The Plan is administered through Dodson Bros. Exterminating Company which has been established and shall be maintained for the exclusive benefit of the employees. Dodson Bros. Exterminating Company 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. The Employer has retained the services of HealthSCOPE Benefits Administrators, Inc. (“HealthSCOPE Benefits”), a subsidiary of CenBen USA, Inc., to administer the benefits described in this Summary Plan Description.

Plan Fiduciary: The Employer is the Plan Sponsor, and shall also function as the Plan Administrator and 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 dental 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 Employer and Plan Administrator 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.

Discretion: Any discretion or judgment to be exercised by the Employer, its board of directors or board of trustees, if applicable, or the Administrative Committee shall be exercised in their sole and absolute discretion. If a member of the board of directors or board of trustees, if applicable, or the Administrative Committee must exercise his discretionary authority under this Plan with respect to himself as a Covered Employee in the Plan, then such discretionary authority shall be exercised solely and exclusively by a person designated by the other members of the board of directors or board of trustees, if applicable, or the Administrative Committee.

Funding: All costs of this Plan are provided from the contributions made by the Employer and by Covered Employees in the Plan. All such contributions shall be paid to the Plan or used to pay premiums due on insurance policies held by the Plan. Benefits under this Plan shall be paid from such policies or from the contributions paid to the Plan. Contributions paid to the Plan for the payment of incurred claims shall be paid for directly by the Employer. For this reason, the Plan is considered to be self-funded, meaning an insurance company is not liable to pay benefit claims.

Administrative Committee: A committee of individuals shall be appointed by an officer or officers of the Employer (as authorized by the board of directors or board of trustees, if applicable, of the Employer) to oversee administration of the Plan on behalf of the Employer. The members of the Administrative Committee shall serve at the pleasure of the officers of the Employer that appointed them. The Employer and Administrative Committee shall perform the following responsibilities:

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;

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 and the Plan Administrator’s Plan Document;

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, HealthSCOPE Benefits, 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 by the Administrative Committee.

**Resolutions by the Administrative Committee:** All resolutions or other actions taken by the Administrative Committee of the Plan at any meeting shall be handled as set forth in the Plan Document.

**Delegation of Responsibilities:** The Employer and the Administrative Committee may delegate their 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, and only if the board of directors or board of trustees, if applicable, or the Administrative Committee specifically authorize such delegation. The board of directors or board of trustees, if applicable, and the Administrative Committee may also delegate their responsibilities to officers or employees of the Employer.

**Costs and Expenses:** The costs and expenses incurred in the administration of this Plan shall be paid from the Plan, unless paid by the Employer. A portion of contributions to the Plan may also be made by the Covered Employees. All such contributions shall be paid to the Plan or used to pay premiums due on insurance policies held by the Plan. Benefits under this Plan shall be paid from such policies or from the contributions paid to the Plan. Administrative expenses shall include claims, administration fees and costs, fees, accountants, legal counsel and consultants and advisers, bonding expenses, and other costs of administering the Plan.

**Compensation of Certain Employees:** Fiduciaries who are employees of the Employer shall not receive compensation under the Plan for services to the Plan; however, they may receive reimbursement for expenses actually incurred in the performance of such services.
CLAIMS ADMINISTRATOR RESPONSIBILITIES

Under the Plan, HealthSCOPE Benefits Administrators, Inc. (“HealthSCOPE Benefits”), a subsidiary of CenBen USA, Inc., 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 (“Administrative Agreement”) 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 and the Plan Administrator’s Plan Document.

Except as otherwise provided by law, the appeal procedures set forth in this Summary Plan Description and the Plan Administrator’s Plan Document 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 ERISA Plan Administrator or Plan fiduciary on behalf of Plan Sponsor. HealthSCOPE Benefits is merely providing assistance with the administration of this Plan by adjudicating claims in accordance with the terms of the Plan. In the event the Administrative Agreement is terminated, HealthSCOPE Benefits will cease to process claims as of the termination of the Administrative Agreement.
DEFINITIONS

**Actively Working/Actively At Work** - Means the employee is performing his/her regular duties on behalf of, and in the regular business of the Plan Sponsor for the hours as listed in the Eligibility and Effective Date of Coverage section and is reasonably being compensated by the Plan Sponsor on a regular basis for such duties.

**Administrative Agreement** - Means the contract between the Plan Sponsor and HealthSCOPE Benefits (HealthSCOPE Benefits) pursuant to which HealthSCOPE Benefits has been contracted to process claims on behalf of the Plan Sponsor.

**Administrative Committee**: A committee of individual shall be appointed by an officer or officers of the Employer (as authorized by the board of directors or board of trustees, if applicable, of the Employer) to oversee administration of the Plan on behalf of the Employer.

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

**Coinsurance** - Means a percentage of the Customary and Reasonable Charge that a Covered Person pays for Covered Services. The percentage of the Customary and Reasonable Charge that the Employer pays for Covered Services is referred to as the Plan’s Coinsurance.

**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 Employee** - Means the employee of Dodson Bros. Exterminating Company who has satisfied the eligibility requirements under the Plan and has enrolled for Coverage under the Plan. The term “Covered Employee” also includes eligible board members of Dodson Bros. Exterminating Company.

**Covered Person** - Means the Covered Employee and, under Family Coverage, the Covered Employee's spouse and any unmarried Dependent Children who are eligible for Coverage.

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

**Customary and Reasonable Charge** - Customary and Reasonable is the name for the method used by the Plan for determining the maximum amount of charges to consider in determining benefit payments for Providers under the Plan. The Customary and Reasonable fee is the fee assessed by a Dentist for a 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 fee 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.
**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, at least two family members must satisfy an amount equal to the Individual Deductible, while Eligible Expenses incurred from all remaining family members will be applied to any remaining portion of the Family Deductible. Once the Family Deductible is reached, the Deductible will be considered satisfied for all family members under that Family Coverage during the remainder of the Benefit Period.

**Dental Benefits** - Means the Covered Services for non-medical dental related treatment and the payment made by the Plan for such services as set forth in this Summary Plan Description. The Dental Benefits are described in the section entitled “Dental Benefits”.

**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 a Dependent Child or Spouse.

**Dependent Child** – Means a child who is the Employee’s natural child, step child, foster child, legally adopted child or who is the Employee’s legal guardianship pursuant to an interlocutory order of adoption (such child must be under age 18 at time of placement) who: (a) is unmarried; (b) is under the Dependent Limiting Age; (c) is eligible for support in accordance with the Internal Revenue Code; and (d) has the same principal place of abode as the Covered Employee for the period of time established by the Internal Revenue Code. Note: For the adopted child or child placed with the employee pursuant to an interlocutory order of adoption, Coverage eligibility begins from time of placement in the home for adoption whether or not the adoption proceedings have been completed.

The term Dependent Child also includes a child who is dependent pursuant to a Qualified Medical Child Support Order (“QMCSO”) as set forth under OBRA 1993 and an unmarried child who is over the Dependent Limiting Age but otherwise meets the definition of a Dependent Child. Refer to the section entitled “Eligibility Provisions” for additional details.

**Dependent Limiting Age** - Means the date on which the Dependent Child attains the age of 25; however, eligibility shall continue until the end of the year in which the Dependent Child attains the age of 25.

**Diagnostic Services** - Means tests and procedures performed when the Covered Person has specific symptoms to detect or to monitor the Covered Person’s disease or condition. Diagnostic Services include, but are not limited to, the following: X-ray and other radiology services; laboratory and pathology services; cardiographic, encephalographic and radioisotope tests.

**Effective Date** - Means the date on which Coverage begins.

**Eligible Expenses** - Means expenses for Covered Services which are incurred by a Covered Person. Eligible Expenses do not include expenses in excess of the Customary and Reasonable 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/Investigative** - Means any treatment, procedure, facility, equipment, drug, device or supply which is not recognized by the Plan as accepted medical practice or which did not have required governmental approval when the Covered Person received it.

**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.

**Health Plan (also Plan)** - Means a self funded health coverage program provided and sponsored by the Plan Sponsor.

**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.

**Individual Coverage** - Means Coverage for the Covered Employee only.

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

**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. Refer to the Schedule of Benefits for maximum benefit amounts.

**Medically Necessary (or Medical Necessity)** - Means the criteria used by the Plan to determine the Medical Necessity of dental services under this Summary Plan Description.

To be Medically Necessary, Covered Services must:

1. Be rendered in connection with a dental condition;
2. Be consistent with the diagnosis and treatment of the Covered Person’s dental condition;
3. Be in accordance with the standards of good dental 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 accordance with the most appropriate dental procedure. Only the Covered Person’s dental condition (not the financial status or family situation, the distance from a dental Provider or any other non-medical factor) is considered in determining which level of care or type dental treatment 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.
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.

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 trusted plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

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

Physician - Means for Dental Benefits, one of these professionals licensed under the applicable state laws:

1. Dental Surgeon
2. Dentist (D.D.S.)

Plan Administrator – Means the person designated to administer the Plan and whose responsibilities are set forth in the section of the Summary Plan Description entitled “Operation and Administration of the Plan.”

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 Employer to act as the Plan Fiduciary. The Plan Fiduciary is identified and designated in the section of entitled “Operation and Administration of the Plan.”

Plan Sponsor – Means the person designated to sponsor the Plan. The Plan Sponsor is identified and designated in the section of the Summary Plan Description entitled “Operation and Administration of the Plan.”

Protected Health Information - Means information that is created or received by 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 Dental Benefits, the Providers listed below which are licensed and are operating within the scope of that license:

1. Dental Surgeon or Dentist (D.D.S.)
2. Dental Hygienist

**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 Covered Person or beneficiary is eligible under a group health plan. An Eligible Employee may obtain a copy of such procedures from the Plan Sponsor.

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

**Special Enrollment Period** – Means a period during which an enrollment application may be submitted following an event that qualifies the employee or dependent for a Special Enrollment Period. The events that qualify an employee or dependent for a Special Enrollment Period and the time periods during which an Enrollment Application must be submitted during such period is addressed in the section entitled Applying for Coverage and Effective Dates.

**Spouse** – Means an individual of the opposite sex who is legally married to the Eligible Employee in accordance with the laws of the state in which they reside.

**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 Administrator and sponsored by the Plan Sponsor.
SPECIAL NOTICE

NOTICE CONCERNING THE HIPAA PRIVACY AND SECURITY REGULATION

1. Permitted and Required Uses and Disclosure of Protected Health Information. Subject to obtaining written certification pursuant to paragraph 3 (below) of the Plan, the Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Protected Health Information to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such Protected Health Information except for the following purposes:

   a. To perform Plan administrative functions which the Plan Sponsor performs for the Plan.

   b. Obtaining premium bids from insurance companies, HMOs or other health plans for providing health insurance coverage under the group health plan; or

   c. Modifying, amending, or terminating the group health plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

2. Conditions of Disclosure. The Plan or a health insurance issuer or HMO with respect to the Plan, shall not disclose Protected Health Information to the Plan Sponsor unless the Plan Sponsor agrees to:

   a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.

   b. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information, including implementing reasonable and appropriate security measures to protect Electronic Protected Health Information.

   c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

   d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

   e. Make available to a Plan participant who requests access the Plan participant's Protected Health Information in accordance with 45 CFR §164.524.

   f. Make available to a Plan participant who requests an amendment the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with 45 CFR §164.526.
g. Make available to a Plan participant who request an accounting of disclosures of the participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

h. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR §164.504(f).

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

j. Ensure that the adequate separation between Plan and Plan Sponsor required in 45 CFR §164.504(f)(2)(iii) is satisfied, including ensuring reasonable and appropriate security measures.

k. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

l. Report to the Plan any security incident relating to Electronic Protected Health Information of which it becomes aware. A security incident is defined at 45 C.F.R. §164.304 as "the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system."

3. **Certification of Plan Sponsor.** The Plan shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 2 of this section as contained in the Participant’s Summary Plan Description.

4. **Permitted Uses and Disclosure of Summary Health Information.** The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:

   a. Obtaining premium bids from health plan providers for providing health insurance coverage under the Plan; or

   b. Modifying, amending, or terminating the Plan.

5. **Permitted Uses and Disclosure of Enrollment and Disenrollment Information.** The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the Plan Sponsor, provided such enrollment and disenrollment information is only used by the Plan Sponsor for the purpose of performing administrative functions that the Plan Sponsor performs for the Plan.
6. **Adequate Separation Between Plan and Plan Sponsor.** The Plan Sponsor shall only allow certain employees or classes of employees access to the Protected Health Information. Such employees shall only have access to and use suchProtected Health Information to the extent necessary to perform the administration functions that the Plan Sponsor performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to Plan sponsors employee discipline and termination procedures.

The employees or classes of employees that will be permitted access to Protected Health Information as set forth in this paragraph are: Becky Marsh, Payroll Manager, Myra Finch, Assistant Payroll Manager, and Len Hargis, Assistant Controller.
PLAN AND ERISA INFORMATION

The Plan has been established and operates under the guidelines of ERISA (Employment Retirement Income Security Act of 1974). As an ERISA Plan, there is a requirement that certain disclosures must be made to Plan participants. This page and the following pages provide this information.

1. **NAME OF THE PLAN**
   
   Dodson Bros. Exterminating Company Dental Care Benefits Plan

2. **NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN SPONSOR**
   
   Dodson Bros. Exterminating Company  
   3712 Campbell Avenue  
   Lynchburg, VA 24501  
   (434) 847-9051

3. **PLAN SPONSOR IDENTIFICATION NUMBER**
   
   54-0624996

4. **NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR**
   
   Dodson Bros. Exterminating Company  
   3712 Campbell Avenue  
   Lynchburg, VA 24501  
   (434) 847-9051

5. **NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS**
   
   Dodson Bros. Exterminating Company  
   3712 Campbell Avenue  
   Lynchburg, VA 24501

6. **PLAN YEAR (for fiscal record keeping)**
   
   January 1 – December 31

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

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

9. **EFFECTIVE DATE OF THE PLAN**

The revised and re-stated effective date of the Plan is January 1, 2006.

10. **STATEMENT OF ERISA RIGHTS**

As a participant in this Plan, the employee is 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: (a) examine, without charge, at the Plan Sponsor's office and at other specified locations, such as work sites, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions; (b) obtain copies of all Plan documents and other Plan information upon written request of the Plan Sponsor. The administrator may make a reasonable charge for the copies; (c) receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

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 this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the employee and other Plan participants and beneficiaries. No one, including the Employer, or any other person, may fire the employee or otherwise discriminate against the employee in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If the employee’s claim for a welfare benefit is denied in whole or in part, the employee must receive a written explanation of the reason for denial. The employee has the right to have the Plan review and reconsider his or her claim.

Under ERISA, there are steps the employee can take to enforce the above rights. For instance, if the employee requests materials from the Plan and do not receive them within 30 days, the employee may file suit in a federal court. In such a case, the court may require the Plan Sponsor to provide the materials and pay the employee up to $110 a day until (s)he receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the employee has a claim for benefits which is denied or ignored, in whole or in part, (s)he may file suit in a state or federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if the employee discriminated against for asserting his or her rights, (s)he may seek assistance from the U.S. Department of Labor, or (s)he may file suit in federal court. The court will decide who should pay the court costs and legal fees. If the employee is successful, the court may order the person (s)he has sued to pay these costs and fees. If the employee loses, the court may order the employee to pay these costs and fees (e.g. if the court finds the employee’s claim is frivolous).
If the employee has any questions about the Plan, (s)he should contact the Plan Sponsor. If the employee has any questions about this statement or about his or her rights under ERISA, the employee should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor.