Watco Companies

Employee Assistance Program

Administered by New Directions Behavioral Health

Summary Plan Description

For the following eligible employees:

- Full-time or part-time non-represented salaried or hourly employee.

Effective January 1, 2017

What You Should Know About This Plan

This plan does not pay for every "cost" that you believe should be covered. This plan only pays for those costs or benefits that are described in this Summary Plan Description ("SPD"). As such, it is incumbent on you to carefully consider whether you should utilize the plan benefits automatically bestowed upon you. In some cases, this plan may not provide you with any financial benefit or may not pay for an expense that is important to you. Only you can determine whether the coverage this plan provides will actually be beneficial for you and your family. Again, this plan only pays for those expenses that are described in this SPD or other official plan documents. It will not pay for any expenses that are not covered. In addition, if for any reason a benefit is paid in error or is larger than the amount allowed by the plan, the plan has the right to recover that payment.

To ensure that you and your dependents (if applicable) receive the appropriate coverage, please review this SPD carefully.

Intentionally providing false information, enrolling a dependent you know to be ineligible or willfully falsifying the documentation needed to prove a relationship with your dependent constitutes fraud and may be considered grounds for rescission of coverage, termination of employment or other legal action.

The Company has the right to designate which Company-sponsored plan you and your eligible dependents (see the section titled *Who Is Eligible: Dependents*) can participate in based on your eligibility for Medicare. You and/or your covered dependents may not be eligible to participate in the same plan, and you and/or your covered dependents may be covered under different plans if any of you become eligible for Medicare either due to age or disability.

This SPD is updated from time-to-time. This SPD replaces all prior versions. If you are not certain that you have the most recent SPD, please call the EAP at 800-624-5544 to confirm whether you have the most up-to-date version.

Terms You Need to Know

Here are important terms you need to know. These terms have the specified meaning when capitalized throughout this summary plan description.

- **Company:** This term refers to Watco Companies, and in any employment context, and elsewhere as appropriate, the subsidiary or affiliate of Watco that is the employing unit of those eligible to participate in the plan.
- **ERISA:** Employee Retirement Income Security Act of 1974.
- **FMLA:** Family and Medical Leave Act of 1993.
- **HIPAA:** Health Insurance Portability and Accountability Act of 1996.
- **In-Network** or **In-Network Provider:** Providers who have a contract with the Claims Administrator to provide services to plan participants.
- **Out-of-Network** or **Out-of-Network Provider:** Any provider who does *not* have a contract with the Claims Administrator to provide services to plan participants.
- **USERRA:** The Uniformed Services Employment and Reemployment Rights Act of 1994.

Who Is Eligible: Employees

You are eligible to participate in this plan if you are:

- A full-time or part-time non-represented salaried or hourly employee.

For the purposes of benefits eligibility, you are considered a full-time employee if you are regularly scheduled to work 30 or more hours per week. For the purposes of benefits eligibility, you are considered a part-time employee if you are regularly scheduled to work at least 20 but less than 30 hours per week.

If you are in a location that offers this plan to other categories of employees, your Benefits Office will provide you with details.

Who Is Eligible: Dependents

For purposes of the plan, your spouse and children are eligible for coverage under the plan, so long as that person meets the defined requirements set out in this section. You may be required to prove that your spouse and children are eligible for coverage under the plan as described in the *Dependent Verification* section below.

- **Your legal spouse:**
  - The person to whom you are legally married (including as a result of common-law marriage) under applicable law.
- **Your natural-born child, legally adopted child, stepchild or legal guardian child:**
  - The child is your natural-born child, legally adopted child (or the child has been placed in your home for adoption), stepchild or the court has appointed your legal guardian, **and**
  - The child is under age 26.
- **Your disabled adult child:**
  - The child is your natural-born child, legally adopted child (or the child has been placed in your home for adoption), or legal guardian child, or the child is your stepchild,
  - The child is age 26 or older,
  - The child is unmarried,
  - The child is dependent on you for a majority of his or her financial support,
  - The child was covered under a Watco sponsored EAP plan immediately prior to turning age 26,
  - The child became disabled prior to turning age 26,
  - The child was your dependent at the time he or she first became disabled and continues to be your dependent,
  - The child is incapable of self-sustaining employment, **and**
  - The child continuously meets all of the plan's requirements for a disabled child.

  To enroll a disabled adult child, you must provide satisfactory evidence of disability (i.e., proof that the disabled adult child meets **all** of the above requirements) no later than the

date of the child's 26th birthday. If you provide evidence of disability after this date, the disabled adult child will be ineligible for coverage.

- **Qualified Medical Child Support Order (QMCSO) child:**
  - The child is your natural-born child or legally adopted child (or the child has been placed in your home for adoption), or your stepchild,
  - You have a current QMCSO order that is in effect, **and**
  - The child is under age 26.

Your dependents must have a Social Security Number or other Taxpayer Identification Number in order to be covered by this plan. A Social Security Number or other Taxpayer Identification Number is not required for newborns during the Social Security application period. If you have never provided a Social Security Number or other Taxpayer Identification Number for your covered dependents, the Company may make a solicitation for such numbers as needed.

Dependent Verification

From time to time, you may be asked to verify the eligibility of your dependents under the plan. Failure to comply with this request may lead to a loss of coverage for your dependents.

In order to verify the eligibility of covered dependents, the Plan Administrator or its designee may perform routine eligibility verification checks. The Plan Administrator performs these eligibility verifications for your protection to ensure that benefits are reserved for eligible participants and their eligible dependents.

If you are asked to verify your dependents, the Plan Administrator or its designee will send you an inquiry specifying the documents needed for dependent verification. The following is a list of the information that may be required in verifying dependent status.

- Your spouse.
  - Proof of marital status.
  - Proof of joint ownership.
- Your natural-born child, legally adopted child, stepchild or legal guardian child.
  - Proof of relationship.
- Your disabled adult child.
  - Proof of relationship.
  - Proof of financial support.
  - Proof of disability.
- QMCSO child.
  - Proof of relationship.

The Company may update or revise this list from time to time in its sole discretion without any prior notification to employees, participants and any dependents.

If you do not submit adequate documentation to confirm eligibility of your dependent(s) when

the Plan Administrator or its designee requests it, your dependent(s) will be deemed ineligible and will be removed from coverage. The Plan Administrator or its designee will provide you with notice of termination of such coverage. Intentionally providing false information, enrolling a dependent you know to be ineligible or willfully falsifying the documentation required to enroll a dependent constitutes fraud and may be considered grounds for rescission of coverage, termination of employment or other legal action. In the event the Plan Administrator determines that the plan has covered an ineligible person as a result of fraud, you will be responsible for paying back to the plan any costs for services provided to that ineligible person.

Who Is Not Eligible

- Any individual classified by the Company as an independent contractor.
- Any individual who is classified by the Company as an intern and who is employed by the Company for less than 90 days.
- Any individual whose compensation for services to the Company is reported on IRS Form 1099.
- Any individual whose compensation for services to the Company is paid from a payroll or other account of another employer under contract with the Company.
- Any individual who is not paid from the Company's payroll account or with respect to whom the Company does not issue an IRS Form W-2 (or any replacement form).
- The above exclusions shall not be affected by the Company's misclassification of the individual's employment status, or a determination by a court, government agency, arbitrator, or other authority that the individual is or was a common-law employee of the Company, or that the Company is or was a common-law employer, joint employer, single employer, or co-employer of the individual.
- Any employee represented by a collective bargaining agent, unless the applicable collective bargaining agreement specifically allows for participation.

Cost of the Plan

The Company pays the full cost of coverage.

When Coverage Begins

You do not enroll in this plan; you automatically are eligible to participate.

Coverage begins for you and your eligible dependents (see the section titled *Who Is Eligible: Dependents*) on your date of hire or the day after you complete your waiting period, if applicable.

How the Plan Works

The EAP offers the following benefits:

- Assessment, consultation, and problem solving.

- Risk screening and crisis intervention.
- Advocacy to help you address your situation.
- Referral to a licensed network practitioner for up to a specified number of counseling sessions (based on clinical necessity) at no charge per member or eligible dependent (see the section titled *Who Is Eligible: Dependents*) per unique problem per calendar year.
- Referral to community resources.
- Educational materials specific to issue.
- Legal consultation from a licensed attorney (does not include consultation related to any dispute involving Watco or any of its divisions, operating or business units, affiliates, employees, agents or directors, or any dispute against the EAP or any other employee benefit plan, or any employment-related matter).
- Mediation services.
- Financial counseling from a credentialed financial professional.

In order to receive EAP benefits, all services must be pre-certified by the EAP Administrator and provided by the Administrator's network practitioners. When you call Member Services, you will speak with a licensed behavioral health professional who will refer you to a licensed practitioner in your area.

The EAP provides both clinical and non-clinical services.

Your EAP benefit for up to the specified number of clinical care visits per unique problem, per calendar year is used to assess your treatment needs, and when clinically appropriate, provide for the resolution of short-term issues within the number of EAP visits available under the plan. For treatment beyond the number of clinical care visits allowed by this plan benefit and for higher levels of care, contact your medical plan.

Benefits Chart

	Plan Summary
Plan Identifying Information	
Plan Year	2017
Active Plan Code(s)	Watco
Retiree Plan Code(s)	Not applicable
Plan Facts	
Member Services	800-624-5544
Web Site	www.ndbh.com
Claims Administrator	New Directions
Claims Fiduciary	New Directions
Claims Payer	New Directions
Insurer	New Directions
Benefit Structure	
Clinical Care	100% up to 6 visits per unique problem per covered member or eligible dependent per calendar year
Non-Clinical Services	**Services**: Child/elder care referral; adult/elder support services; child/parenting support services; chronic condition support; financial services; legal assistance; life learning. **Benefit**: You will be referred to verified resources that specialize in these services, and any fees are your responsibility
Administrative Information	
Plan Records	Plan records are kept on a calendar-year basis: January 1 - December 31
Administration Type (Contract or Insured)	Insured
Funding Type (Self-Funded or	Insured

	Plan Summary
Insured)Plan Type	Welfare plan providing employee assistance benefits
Insurer Administration Type (Contract or Insured)	New Directions Insured
Funding Type (Self-Funded or Insured)	Insured
Claims Fiduciary Insurer	New Directions New Directions
Claims Filing Address Claims Fiduciary	Not applicable. EAP provider files claims with Administrator on behalf of the covered member or eligible dependent. New Directions
Appeals Filing Address **Important Addresses**	NDBH P.O. Box 6729 Leawood, KS 66206-0729
Corporate Address: Claims Administrator Claims Filing Address	New Directions Behavioral Health, L.L.C. 8140 Ward Pkwy #500 Kansas City, MO 64114 Not applicable. EAP provider files claims with Administrator on behalf of the covered member or eligible dependent.
Appeals Filing Address	NDBH P.O. Box 6729 Leawood, KS 66206-0729
Corporate Address: Claims Administrator	New Directions Behavioral Health, L.L.C. 8140 Ward Pkwy #500 Kansas City, MO 64114

What Is Covered

Getting Help Through the EAP

It's easy to get help through the EAP. Simply call Member Services toll-free, 24 hours a day, seven days a week, 365 days a year. See the section titled *Benefits Chart*.

When you call, you'll speak to an EAP specialist (an experienced behavioral health professional) who can answer your questions about EAP benefits and listen to your needs. The EAP specialist can help you find the right assistance and resources for your situation.

If necessary, the EAP specialist will locate a credentialed EAP provider so that you can schedule a convenient appointment. Typically, the EAP provider can meet with you within three to five days, in the privacy of his or her office. In emergencies, appointments are available in less than 24 hours.

EAP Benefits

EAP benefits include help with:

- Work-related problems, such as job stress, overwork, burnout, and interpersonal conflicts.
- Marital issues, including parenting issues and couples' communications problems.
- Family problems, such as parent/child conflicts, single parenting issues, child and adolescent problems, spousal abuse, and incest.
- Emotional problems and personal issues, including anxiety, depression, personal crises, and life transitions.
- Addictions, including alcohol and drug abuse, problem gaming/gambling, and co-dependency.
- Disease-related issues, such as coping with chronic and terminal illness, and grief and loss.

EAP Specialists

Qualifications for the **EAP specialists** include:

- A master's or doctoral degree in psychology, counseling, social work, or a related field.
- Licensed graduate of accredited programs.
- Training in crisis counseling.
- Demonstrated skills in listening and directing callers to appropriate services.

EAP In-Network Providers

When you call Member Services, the EAP specialist will refer you to an EAP provider. The EAP has an extensive network of qualified providers. The nationwide network includes psychologists, social workers, and marriage, family, and child counselors.

Qualifications for **EAP In-Network Providers** may include:

- A master's or doctoral degree in psychology, counseling, social work, or a related field.
- Licensed graduate of accredited programs.
- Rigorous credentialing by the Claims Administrator.
- Specialty EAP certifications.

What Is Not Covered

The EAP does **not** cover the following services or supplies:

- Services given by a pastoral counselor.
- Private-duty nursing services while confined in a facility.
- Weight reduction or control supplies, special foods, food supplements, liquid diets, diet plans, or any related products.
- Services given by volunteers or individuals who do not normally charge for their services.
- Psychological testing.
- Electroconvulsive therapy (ECT).
- Treatment for chronic pain except for psychotherapy, biofeedback, hypnotherapy rendered in connection with a DSM-IV diagnosis, pre-certified by the Claims Administrator.
- Treatment provided by an MD or DO.
- Services not pre-certified by the EAP Claims Administrator.

Filing a Claim

Under the EAP, you do not have to file claim forms. Your EAP provider handles that for you.

Limits

No interest is payable on any benefits that are delayed or paid late.

Before you can bring a lawsuit against the plan in state or federal court, you must timely use and exhaust the plan's claims and appeals procedures. If, however, the Claims Administrator and Plan Administrator fail to meet certain claims and appeals requirements, your claim will be deemed "exhausted," and you may be able to bring a lawsuit without completing the claims and appeals procedures.

During the internal appeals process you must raise all issues and legal theories you wish to have considered at any time during the internal or external administrative claims review process or any subsequent lawsuit.

No legal action, including a lawsuit, may be brought more than one year after a final decision is rendered on a claim. In addition to the one-year deadline that applies to filing a lawsuit after the claims and appeals procedures are exhausted, there is a general time limitation that applies to all lawsuits involving all types of plan issues. You must commence any such lawsuit involving

plan claims no later than two years after you first receive information that constitutes a clear repudiation of the rights you are seeking to assert (i.e., the underlying event or issue that should have triggered your awareness that your rights under the plan may have been violated). Although any period of time when your claim is in the claims procedure described above (i.e., the time between when you file a claim for benefits and the time you receive a final determination letter) does not count against the two-year period, once the claims procedure process is completed, the two-year period will continue running where it left off.

The Claims Administrator and the Plan Administrator have absolute authority and sole discretion to interpret and apply plan provisions and determine facts, benefits, and eligibility. All interpretations, decisions, and determinations of the Claims Administrator and the Plan Administrator are intended to be final, conclusive, and binding on all parties having an interest in the plan. For purposes of determining the amount of, and the entitlement to, benefits, the Plan Administrator has delegated to the Claims Administrator (the Insurer) its discretionary authority, and the Claims Administrator is the named fiduciary with the full power to interpret and apply the terms of the plan with respect to the benefits provided under the insurance contract.

Plan Administration

The plan shall be administered by New Directions EAP, which shall have the absolute and sole discretionary authority to:

- Construe and interpret the provisions of the plan, plan documents, summary plan description, as well as any communications related to the plan,
- Make factual determinations thereunder, including determining the rights or eligibility of employees or participants and any other persons, and the amounts of their benefits under the plan, and
- Remedy ambiguities, inconsistencies, or omissions.

Such determinations shall be binding on all parties. Benefits will only be paid if New Directions, in its sole discretion, determines that the participant or beneficiary is entitled to them.

When Coverage Ends for You

Your coverage under the plan will end as of the **last day of the month** in which one of the following occurs:

- You no longer meet the eligibility requirements. This includes any occurrence when you voluntarily decline to be covered or discontinue your coverage under the Company's plans.
- In the case of annual enrollment, your coverage under the plan ends the day before your newly elected plan coverage begins (generally December 31).
- You fail to make the required contributions, if applicable.
- You retire.
- You cease active employment with the Company.
- The plan ends.

If you lose eligibility under this plan and become eligible for a different Company-sponsored plan (because of certain employment transfers within the Company), your coverage under this plan may end sooner than the last day of the month.

Coverage may continue while you are not actively at work.

When Coverage Ends for Your Dependents

Coverage for your eligible dependents (see the section titled *Who Is Eligible: Dependents*) will end as of the **last day of the month** in which one of the following occurs:

- You are no longer covered under the plan (see above). This includes any occurrence when you voluntarily decline to be covered or discontinue your coverage under the Company's plans.
- Your eligible dependents (see the section titled *Who Is Eligible: Dependents*) are no longer covered under the plan, but instead covered under a different Company-sponsored medical plan, due to the plan's coverage requirements and exclusions for covered dependents who become eligible for Medicare either due to age or disability.
- In the case of annual enrollment, your eligible dependent's coverage under the plan (see the section titled *Who Is Eligible: Dependents*) ends the day before the newly elected plan coverage begins (generally December 31). Your dependents cannot be covered under the Company's plans if you voluntarily decline coverage under the Company's plans.
- They are no longer eligible for coverage, as determined by the plan, including as a result of divorce or age.
- The plan ends.

Coverage for your children will end as of the **last day of the year** in which the child reaches the age of 26.

If You Have Questions

For more information about your rights under ERISA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site.)

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible individuals who enter military service. Generally, if you are on a military leave covered under USERRA, you are entitled to the same rights and benefits that Watco provides to similarly situated employees on other types of leave.

- If your military leave is for less than 31 days, you may continue your plan coverage by paying the same amount charged to active employees for the same coverage. If your leave

is for a longer period of time, you will be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of continuation coverage available to you, your spouse, and your eligible children is the lesser of 24 months after the leave begins or the day the leave ends.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full regularly scheduled work day following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days;
- Return to or reapply for reemployment within 14 days of completion of such period of duty if your absence from employment is from 31 to 180 days; or
- Return to or reapply for reemployment within 90 days of completion of your period of duty if your military service is for over 180 days.

While you are on military leave, certain coverage may end (e.g., disability). For more information, call the EAP.

If You Are Called Up Due to a National Emergency

The Company reserves the right to issue a more generous military leave policy for employees who are called up in times of national emergency. This more generous policy applies only to employees who are *involuntarily* called up. Contact your Human Resources/Benefits Office to request information about the military leave policy for called-up employees and to find out whether that policy applies to you.

Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), if you meet the eligibility requirements, you are legally allowed to take up to 12 weeks of **unpaid** leave in a 12-month period (either rolling 12 months or calendar 12 months depending on internal Human Resources policy), for any of the following reasons:

- Because of a serious health condition that hinders your ability to perform your job.
- To care for your child (or a child with whom you stand *in loco parentis*) after birth, after placement with you for adoption, or after placement with you for foster care.
- To care for your spouse, child under age 18 (can be *in loco parentis*), child 18 and over if incapable of self-care because of a mental or physical disability, or parent (but not parent-in-law) who has a serious health condition.

Under FMLA, you are also legally allowed to take **unpaid** leave for military family leave purposes (Military Family Leave Entitlements), as described below:

- **Qualifying Exigency Leave:** You are permitted to take up to 12 weeks of **unpaid** leave for any qualifying exigency arising out of the fact that your spouse, your son or daughter (including step-children), or your parent (but not parent in-law) is on a covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces. A qualifying exigency includes the following: issues related to short-notice

deployments; military events and related activities; child care and related activities; financial and legal activities; counseling; rest and recuperation (up to five days of leave to spend time with a military family member on short-term leave from deployment); post-deployment activities for a period of 90 days following termination of military family member's active duty status; and additional activities that the employee and the Company agree are qualifying exigencies.

- **Military Caregiver Leave:** An eligible employee is entitled to up to 26 weeks of **unpaid** leave in a single 12-month period to care for a covered service member who is a spouse, son or daughter (including step-children), parent or next of kin (i.e., nearest blood relative). A covered service member is a current member of the Armed Forces (including National Guard or Reserves), who is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status' or is otherwise on the temporary disability retiree list for a serious injury or illness that was incurred in the line of duty on active duty (or existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty) and that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating. A covered service member also includes a veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces (including the National Guard or Reserves) at any time during the period of five years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy. A serious injury or illness for a veteran is a qualifying injury or illness that was incurred by the service member in the line of duty on active duty in the Armed Forces (or existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty) and that manifested itself before or after the service member became a veteran. This military caregiver leave is available during a single 12-month period during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave. Only 12 of the **combined** 26 weeks may be for FMLA-qualifying reasons other than to care for a covered service member.

In order to be eligible for FMLA leave, including Military Family Leave Entitlements, you must have worked for the Company for at least one year (in the last seven years) and for 1,250 hours over the previous 12-month period.

As long as you continue your contributions, your coverage under the plan will continue while you are on approved FMLA leave. If for some reason, during your FMLA leave, you cancel your coverage or payment lapses, you have the right to reinstate your coverage when you return to active work.

Leave of Absence

Your coverage under the plan may continue while you are on a leave of absence, depending on the type of leave. For more information, call the EAP.

Your Rights Under ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations,

such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You, your spouse, or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court, **but only after you have exhausted the plan's claims and appeals procedure**. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the party you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if the court finds that

your claim is frivolous).

Assistance With Your Questions

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor. The EBSA can be reached at:

Employee Benefits Security Administration
U.S. Department of Labor
Public Disclosure Room,
Suite N-1513
200 Constitution Avenue N.W.
Washington, D.C. 20210
1-202-693-8673

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA publications hotline.

Plan Financing

Benefits under the plan are funded by (and paid from) the Company's general assets.

Plan Expenses

To the extent a Company-sponsored plan is funded by a trust, the Company reserves the right, according to applicable law, to pay for all reasonable and proper expenses incurred in the administration of the plan from any funds held in trust; provided, however, that the Company may pay any such expenses or reimburse the trust for any payment, or the trust may reimburse the Company for any such expenses the Company has paid.

HIPAA Privacy Regulations

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law enacted by Congress. The law has provisions designed to improve people’s access to health care, as well as requirements for health care providers and health plans to more efficiently and securely share health care data and information. The HIPAA privacy regulations establish standards for protecting individuals’ medical records and other personal health information.

Protecting the Privacy of Health Information

The federal law, enacted by Congress, created national standards for the handling of protected health information (PHI) by setting boundaries on how individually identifiable health information may be used and disclosed. It also enables individuals to be informed about how their PHI may be used.

PHI is confidential, personal, identifiable health information about individuals that is created or received by a health plan, provider or health care clearinghouse and is transmitted or maintained in any form (including electronically). “Identifiable” means that a person reading this

information could reasonably use it to identify an individual. PHI includes information of persons living or deceased.

Elements that make health-related information PHI include name, address, e-mail address, birth date (except year), Social Security number, and claim number. Examples of PHI include completed health care claim forms, detailed claim reports, and explanation of benefits.

Participants' Rights Under These New Regulations

All plan participants will receive a Notice of Privacy Practices and are encouraged to read it. It describes how the plan is permitted to use PHI and the rights of individuals. These include the rights to:

- Access their personal PHI and request amendments or corrections;
- Request an accounting of certain disclosures of PHI; and
- Submit a complaint regarding any violation of the privacy rights protected by HIPAA.

The notice also explains the procedures for exercising these rights.

Permitted Use and Disclosure of Protected Health Information

New Directions may only use and disclose PHI it receives from the plan as permitted and/or required by and consistent with HIPAA and its accompanying Privacy and Security regulations found at 45 CFR Part 164. This includes, but is not limited to, the right to use and disclose participants' PHI (including electronic PHI) in connection with payment, treatment and health care operations.

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New Directions agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law;
- Ensure that any agent, including a subcontractor, to whom it gives PHI received from the plan, agrees to the same restrictions and conditions that apply to New Directions with respect to such information;
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the plan;
- Ensure that any agent, including a subcontractor, to whom it gives electronic PHI, agrees to implement reasonable and appropriate security measures to protect such information;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Watco;
- Report to the plan, at such times and in such manner as agreed upon, any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which New Directions becomes aware;

- Make available PHI in accordance with individuals' rights to access and review their PHI;
- Make available PHI for amendment and incorporate any amendments to PHI consistent with the HIPAA Privacy rules;
- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA Privacy rules;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy rules;

Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a legal judgment, decree, or order issued under a state domestic relations law that satisfies certain statutory requirements. It creates or recognizes the rights of a child to be covered under a company's health care plan.

Under a valid order, the state can require the Company to provide coverage to a child who might otherwise not be eligible for coverage under the plan.

The Company will cover children, as required in accordance with a valid QMCSO, upon receipt of appropriate documentation. Such coverage will end on the date specified in the QMCSO (or as otherwise provided for in a valid court order, decree or judgment).

The Company's Right to Change (Amend) or Terminate This Plan

You should know that the Company reserves to itself the absolute and unfettered right to terminate this plan (and the benefits it provides) at any time (including at any time during the plan year) without any prior notice to you or your beneficiaries. The Company also reserves to itself the absolute and unfettered right to amend this plan in any manner whatsoever (including in a manner that is financially adverse to you and your beneficiaries) at any time (including at any time during the plan year) and for any reason at all without prior notice to you or your beneficiaries. Participation in this plan confers no rights (legal, equitable, or otherwise) on you or your beneficiaries that are not otherwise conferred by law or applicable collective bargaining agreement. No one has a vested right to benefits under this plan; you may not rely on any statement or promise to the contrary.

If the plan is terminated, you and/or your beneficiaries will not be vested in any plan benefits or have any rights (other than payment of claims incurred before the plan's termination), subject to applicable law.

Limitation on Assignment

Your rights and benefits under the plan cannot be assigned, sold, transferred, or pledged by you or reached by your creditors or anyone else, subject to applicable law.

Your Employment

Eligibility for a benefit or the right to a benefit from the plan is not considered a contract or guarantee of employment with the Company. Nothing in the plan, this summary plan description, or any benefit communication shall be deemed to give any person any right to remain in the employ of the Company or to affect the Company's right to terminate the employment of any person at any time without cause. The Company reserves the right to terminate your employment at any time for any reason.

Collective Bargaining Agreement

If you are represented by a collective bargaining agent, the benefits described in this summary plan description reflect the provisions of the plan as outlined in applicable collective bargaining agreements between the Company and the agent representing employees of the Company. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator. A reasonable duplication charge may be made for copies furnished in response to such written request.

Disclaimer

As a matter of prudent business planning, the Company is continually reviewing and evaluating various proposals for changes to this plan. When the Company is acting in this manner, it is not acting in its capacity as fiduciary or the Plan Administrator, but as the settlor of the plan. When acting in its capacity as the settlor of the plan, the Company has no fiduciary obligations to the plan or to any participant or beneficiary of the plan. You should understand that in some cases while performing its settlor responsibilities, the Company's interests and actions will be adverse to the continuation of this plan and to the financial interests of you (as well as to any beneficiary). In acting as settlor of the plan, the Company will indemnify its officers and employees from any and all personal liability arising out of any actions taken by them in good faith and in the course and scope of their employment and responsibilities with respect to the plan.

Because of the need for confidentiality, decisions regarding changes in the plan are not discussed or evaluated below the highest levels of management. Until a plan amendment is actually adopted by the Company, lower-level managers and other employees of the Company (as well as third-party service providers) do not know whether the Company will change the plan and are not in any position to advise any employee about possible changes. Any such speculation or statements about future changes should be disregarded and may not be relied upon by you. Unless and until changes in the plan are formally announced by the Company, no one is authorized to give you assurance that a change will or will not occur.

In the event of a discrepancy between any statements (written or oral) given to you and the legal documents comprising the plan, the plan documents as interpreted within the sole discretion of the Plan Administrator will control.