SUMMARY PLAN DESCRIPTION
FOR EMPLOYEES OF WACO, INC.

GENERAL INFORMATION

NAME OF PLAN - **Dental Insurance Plan for Employees of Waco, Inc.**

PLAN SPONSOR - The Plan is sponsored by:

Waco, Inc.
5450 Lewis Road
Sandston, VA 23150
Ph: 804/222-8440

EMPLOYER AND PLAN IDENTIFICATION NUMBER - Some information about the Plan is filed with the Internal Revenue Service and the Department of Labor. Should you wish to contact either agency, you must refer to both numbers:

Employer Identification Number: 54-0720555
Plan Number:

TYPE OF WELFARE PLAN - The Plan provides Dental Insurance benefits.

PLAN ADMINISTRATOR - The Plan Administrator is:

Waco, Inc.
5450 Lewis Road
Sandston, VA 23150
Ph: (804) 222-8440

PLAN TRUSTEE - If you have any questions about the Plan, you should contact the Plan Trustee, who is Daniel M. Walker at the above address and phone number of the Plan Sponsor.

Costs of the Plan are funded by contributions made by the Employee, which can be collected through payroll deduction.

SERVICE OF LEGAL PROCESS - Service of Legal Process may be made upon the Plan Trustee.

PLAN YEAR - The Plan records are kept on a fiscal year beginning January 1.

BENEFIT INFORMATION – The plan provides benefits through a group insurance contract with Anthem. Coverage is paid for entirely by the employee. The contract provides for certain benefits for any licensed dentist or specialist of the participant's choosing. Your costs for services are normally lower when you choose a dentist that is within the Anthem network. There are waiting periods for certain types of services, and there are maximum annual benefits. See the

Summary of Benefits available online or ask a Waco benefits administrator for more information.

ELIGIBILITY - An employee becomes eligible to participate in the Plan on the first day of the month following 60 days of continuous full time employment. Eligibility is on the same basis as company Health Insurance. Collection of employee-paid premiums must begin in the month prior to coverage. If the company is unable to collect the entire premium prior to the beginning of the month, coverage will be terminated. If the employee has not received an enrollment form two weeks prior to eligibility date, he or she should contact the Plan Administrator.

Coverage will terminate at the end of the month in which the employee is no longer eligible, or if the employee fails to make payments by payroll deduction for coverage.

PLAN DOCUMENTS - This summary plan description and the master group insurance contract currently in effect constitute the Plan documents. If inconsistencies exist between the two the master group insurance contract will control.

INTERPRETATION - The Plan Administrator has the authority to interpret the Plan's provisions. His decisions are conclusive and binding.

CLAIMS PROCEDURE AND ERISA RIGHTS

FILING A CLAIM - Claims are typically filed by any participating dentist or specialist on your behalf, and reimbursements are made directly to the dentist. Your dentist will ask you to pay the balance of your bill that is not paid directly to them by the insurance company. If you use a dentist or specialist that is not a member of the Anthem network, you may have to pay the dentist or specialist in full, and request a reimbursement from Anthem on forms prescribed by Anthem.

If your claim is denied by Anthem, or if you are not satisfied with the reimbursement from them, you may make a claim directly to the Plan Administrator, who may assist you in an appeal to Anthem regarding your claim. This should be done after you have exhausted all appeals processes with Anthem. You may also make a claim to the Plan Administrator for any other benefit you feel you may be entitled to. In either case you should write to the Plan Administrator, and set forth all details regarding your claim. This constitutes your claim for an appeal or benefit to the Plan Administrator. Within 90 days, the Plan Administrator will notify you, in writing, that:

- Your claim for a benefit has been accepted, or
- Your claim for a benefit has been rejected, or
- Additional information is needed to reach a decision on your claim, or
- Additional time is needed to reach a decision on your claim.

If you are not contacted by the Plan Administrator within 90 days of your submission of a claim for appeal you should consider your claim denied, and you can request a review of the denial.

Should your claim for a benefit be rejected, the Plan Administrator will state the specific reasons for the rejection and will reference the Plan provisions upon which the rejection is based. He will also describe the steps you may take to request a review of his decision.

Should additional information be needed to reach a decision on your claim, the Plan Administrator will list the items which you must provide. He will also indicate why the additional information is necessary.

Should additional time be needed to reach a decision on your claim, the Plan Administrator will let you know why more time is needed. He will also indicate when he anticipates arriving at his decision. The Plan Administrator must, however, reach a decision within l80 days of the date you initially submitted your claim for a benefit.

REQUESTING A REVIEW - If your claim for a benefit is rejected by the Plan Administrator, you can ask him to reconsider his decision.To do so, you, or your authorized representative, must submit to the Plan Administrator a written request for a review of his decision. This written request must be made within 60 days of the Plan Administrator's rejection of your claim. You, or your authorized representative, can examine any of the documents that relate to your claim and can submit written comments. Within 60 days of your request for a review, the Plan Administrator will notify you, in writing, that:

- A review has been made and your claim for a benefit has been accepted, or
- A review has been made and your claim for a benefit has been rejected, or
- Additional time is needed to review the decision on your claim.

If you are not contacted by the Plan Administrator within 60 days of your request for a review, you should consider your request denied.

If, after reviewing his decision, the Plan Administrator decides to reject your claim, he will state the specific reasons for his rejection. He will also state the specific Plan provisions upon which his decision is based.

If the Plan Administrator needs more time to review his decision, he will state the reasons his review requires more time. Under no circumstances, however, will it take more than l20 days to complete the review.

Any questions concerning the filing of a claim or requesting a review should be directed to the attention of YOUR PLAN ADMINISTRATOR.

Federal law and regulations require your Summary Plan Description to include a statement outlining 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 l974 (ERISA). ERISA provides that all Plan Participants

shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, such as worksites, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. 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 the summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension on your Normal Retirement Age and if so, what your benefits would be on your Normal Retirement Age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, 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. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay the costs and fees. If you lose, the court may order you to pay these costs and fees. For example, if it finds your claim is frivolous. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

TERMINATION OR AMENDMENT - The Plan sponsor has the right to amend or terminate the Plan at any time and for any reason.