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This Plan is administered by:

Watkins Associated Industries, Inc.
P.O. Box 1738
Atlanta, GA 30301-1738

Toll free number: (800)-333-3841
Local number: (404) 873-2939*

*If you have access to a company phone at a Watkins location, please use the business number instead of the toll free number.

Customer Service Representatives are available from 9:00 a.m. to 4:30 p.m. Eastern Standard Time Monday through Thursday, and 9:00 a.m. to 4:00 p.m. on Friday.

Send Claims to:
Watkins Employee Benefits
P.O. Box 1738
Atlanta, GA 30301-1738

To find a network provider sign on to the following Internet sites:

To find a medical provider: www.aetna.com/docfind
Or, call Watkins Employee Benefits at 800-333-3841 or 404-873-2939 for assistance

To find a dental provider: www.ppousa.com
Or, call Connection Dental at 877-277-6872

To find a vision provider:
Sign on to www.cmvc.com
Or, call Vision One at 1-800-804-4384

Advance PCS (to inquire about participating pharmacies or to request a provider directory)
Sign on to www.advancerx.com
Or, call 800-966-5772

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INTRODUCTION

This booklet is the Summary Plan Description that describes our Group Health Plan (the "Plan"). The Plan provides medical, dental, and vision benefits for eligible employees and their eligible dependents, and is sponsored by Watkins Associated Industries, Inc. ("Watkins"). The Plan also provides prescription drug coverage administered by Advance PCS. This booklet also describes the Watkins Flexible Spending Account Plan (the "FSA Plan"), which allows you to pay for certain medical and dependent care expenses with before tax dollars. These Plans are designed to offer high quality, cost effective health care coverage.

Health care costs continue to increase. This increase affects us all. These costs increases present significant challenges to our goal of providing these benefits to our employees and at the same time continuing to afford these benefits. We continue to work hard to design a plan that meets these challenges. Our Plan offers all of us the ability to obtain quality health care services while maintaining cost controls. Because you and your employer's premium payments are the only source of funds for claim payments, wise use of the medical services and supplies offered under the Plan will create savings for you and Watkins.

This booklet is intended to answer questions you may have about the Plans. Please take the time to read and understand how the Plan benefits affect you. As you review this Booklet, you will notice certain words and phrases that are *italicized*. You should become familiar with these words, as they are very important to understanding the benefits offered under this Plan. These words are defined in the "Definitions" section at the end of this Booklet.

As you read this Booklet, please keep in mind that the written terms will govern whatever benefits you receive under the Plan. If you have any questions after reviewing this booklet, please contact the Watkins Employee Benefits Department. No one is authorized to make exceptions to the Plan or to pay benefits not provided under the Plan. Watkins may change the Plan from time to time, and it may be terminated if Watkins decides to discontinue it.

ONLY THE WATKINS EMPLOYEE BENEFITS DEPARTMENT OR THE PLAN ADMINISTRATOR IS AUTHORIZED TO ANSWER YOUR QUESTIONS AND PROVIDE INFORMATION ABOUT THE PLAN.

Your participation in this Plan does not guarantee your continued employment with a *Participating Employer*. If you quit, are terminated, or laid off, the Plan does not give you a right to any benefit or interest in the Plan except as specifically described in this document.

GROUP HEALTH PLAN

OUR MEDICAL BENEFITS

THE NETWORK

The Plan has an agreement with Aetna that allows us to access discounts through their Open Choice PPO Network ("Open Choice Network"). The Open Choice Network consists of health care providers chosen by Aetna that have agreed not only to provide quality services but also to special fee arrangements. These fees are lower than fees for comparable services charged by other health care providers who are not in the Open Choice Network. The use of the Open Choice Network is one of the ways that we are able to control our costs. It is very possible that your doctor is already an Open Choice Network member.

You have open access to the Open Choice Network. If you reside out of the Open Choice Network area, but choose to commute to an Open Choice Network provider, you will have the benefit of the special Open Choice Network fee arrangements as well as the higher *Plan Share* percentage. (See the "Cost Sharing" section.)

THE DEDUCTIBLE

The deductible is the amount that you must pay before the *Plan Share* begins.

Expense	**Annual Individual Deductible**
In network, out of area and for emergencies	$100
Out of network	$300

If any three members of your family independently reach the applicable annual individual deductible in the same calendar year, the annual individual deductible will be treated as having been met for all family members for that calendar year.. Amounts used to satisfy the in-network, out of network and out of area deductibles accumulate to a common annual deductible.

COST SHARING

The *Plan Share* and the *Participant Share* differ depending on whether you use an Open Choice Network provider. This chart lists the different *Plan Share*s for covered medical expenses. For more information see the Partial Summary of Benefits chart.

Expense	***Plan Share***	***Participant Share***
If you use the Open Choice Network	90%	10%
If you do not use the Open Choice Network	50% of the *U&C Limit*	The remainder
Emergencies and services performed out of the Open Choice Network's geographical area	80% of the *U&C Limit*	The remainder
In-patient confinement not authorized at an Open Choice Network hospital	60%	40%
In-patient Confinement not authorized and at a hospital not in the Open Choice Network	40%	60%
Mental Health (see Plan Maximums sections)	50%	50%

INDIVIDUAL OUT-OF-POCKET MAXIMUM

This chart lists the maximum amount that each covered individual will be required to pay for eligible medical expenses incurred each calendar year.

If you use the Open Choice Network	$2,100
If you do not use the Open Choice Network	No maximum
Emergencies and services performed out of the Open Choice Network's geographical area	$4,100

The individual out-of-pocket maximum includes the annual deductible but excludes the (i) office co-pay, (ii) penalty amounts for failure to preauthorize an expense, (iii) expenses not eligible for coverage under the Plan, and (iv) amounts in excess of the lifetime individual limit.

If any three members of your family independently reach their annual individual out-of-pocket maximums in the same calendar year, no other family member will be required to pay any further amounts for eligible medical expenses for the remainder of that calendar year.. Amounts used to satisfy the in-network, out of network and out of area individual limits accumulate to a common annual maximum.

MAXIMUM LIFETIME LIMIT

The maximum Lifetime Limit payable for each individual is $1 million.

DOCTOR'S OFFICE VISITS IN NETWORK (Office Co-Pay)

If you use a Network provider, you will be required to pay a $15 office exam co-pay that covers the office exam and also the cost of minor diagnostic procedures such as x-ray and laboratory expenses performed in conjunction with that office exam up to a maximum of $75 each visit. Eligible routine diagnostic procedures in excess of this $75 limit apply to the annual deductible and applicable cost share. The $15 co-pay does not apply towards your annual deductible or your annual Individual Limit.

AUDIT REWARDS FOR YOU

Hospitals and doctors sometimes make mistakes in billings. If you catch an overcharge on your bill greater than $100 and you can document it, the Plan will reimburse you half of the savings up to a maximum payout of $1,000. To take advantage of this program, you should request a corrected copy of your bill from the provider.

COVERED MEDICAL EXPENSES

As described in this Booklet, the Plan covers all *Medically Necessary* expenses unless they are specifically excluded. (See "Expenses that Are Not Covered By This Medical Plan"). The

applicable *Plan Share*, deductibles and individual out-of-pocket maximums listed in this Booklet will apply to your expenses.

BENEFITS WITH SPECIAL LIMITS OR RULES

Pre-Existing Conditions

Any physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to your most recent date of hire is a Pre-existing Condition. A diagnosis is not required for a Pre-existing Condition to exist.

Pre-Existing Conditions are excluded by this Plan for 12 months after your most recent date of hire. However, the Pre-existing Condition exclusion period will be reduced, on a day for day basis, by periods of *Creditable Coverage.* You must provide a certificate of *Creditable Coverage* from your prior plan in order to reduce the Pre-existing Condition exclusion period. If you have trouble getting a certificate of *Creditable Coverage* from your prior plan, contact the Watkins Employee Benefits Department for assistance.

Pregnancy, at any stage, will not be considered a Pre-existing Condition. No Pre-existing Condition limitations will be placed on your newborn dependent child or newly adopted dependent child who is enrolled within 30 days of his or her birth or adoption.

Certificates of Creditable Coverage

When you or your eligible dependent stops being covered under the Plan, you will be given a Certificate of *Creditable Coverage*. You need this certificate when enrolling in another health plan that has a pre-existing condition exclusion limitation. If you did not receive a certificate, or if you need another certificate, please call the Watkins Employee Benefits Department. Also, you may request a certificate at any time within 24 months after active or COBRA coverage ends.

Pre-authorization for Hospital

Pre-authorization helps you and your health care providers understand what will be covered by the Plan. The Plan has an agreement with Intracorp who will review the medical necessity of a requested hospital admission. You are not required to obtain *Pre-authorization* and you are free to obtain whatever treatment you or your physicians believe is appropriate. However, failure get a *Pre-authorization* may result in the *Plan Share* of benefits being reduced to 60% (40% for out of network hospitals). If your confinement is not *Medically necessary* the Plan may refuse to reimburse you for some, or all, of that confinement.

Pre-authorization **is not a guarantee of benefits since the Plan's requirements for eligibility and** ***covered medical services*** **must be satisfied.**

Case Management

All health care delivery requires some level of management, but some cases need more focused management than others. Those cases requiring a higher level of attention will be referred to Intracorp for management. You will be told if your case has been placed with Intracorp for focused management.

Reconstructive Surgery Following Mastectomy

If you or your eligible dependents are currently receiving benefits in connection with a mastectomy, the Plan will also cover the cost of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast if necessary to produce a symmetrical appearance, and prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedema. The deductible, *Plan share*, individual out-of-pocket maximums and life time limits and all other provisions of the Plan apply to these benefits the same they do to any other medical benefits available under the Plan.

Hospital Stay After Childbirth

The Plan provides a minimum of 48 hours hospital stay after childbirth for both the mother and child for natural childbirth, and 96 hours for cesarean section. However the doctor may, after consulting with the mother, discharge the mother or her newborn earlier than the 48 or 96-hour period. Stays longer than the 48 or 96 hour period will be considered if *Medically Necessary* and the normal *Pre-authorization* requirements are met.

Wellness Benefit

Certain medical services, such as annual physicals or check-ups, lab tests in conjunction with annual physicals (such as PAP smears, blood tests, etc.), and other similar health maintenance procedures, are considered "Wellness Benefits." The Plan will pay 100% of the costs for any Wellness Benefit, up to a maximum of $200 in a given *Plan Year.* This amount for Wellness Benefits will be paid regardless of whether you have met the Plan deductible for the *Plan Year*. However, once the Plan has paid $200, the Plan will not pay any portion of any cost for further Wellness Benefits for any individual in any one *Plan Year*.

Mental Health and/or Substance Abuse Treatments

A maximum of 3 days of in-patient care and 5 days for out-patient care will be covered for treatments for a mental condition, disease, deficiency or functional nervous disorder, including but not limited to substance abuse, mood and personality disorders, autism, attention-deficit hyperactivity disorder, learning, conduct or behavioral disorders, schizophrenia and depression. The maximum number of days for in-patient and out-patient care are independent of each other,

and cannot be substituted one for another. The applicable deductible and *Plan Share* will apply to the cost of any mental health and/or substance abuse treatment. Determination of whether a particular claim is coverable under this mental health and/or substance abuse treatment benefit will be based solely on symptoms, rather than the diagnosis, cause or origin of the disease or disorder.

Note: This chart is only a partial summary of the benefits provided by the Plan. Please review the entire booklet for complete information concerning your benefits.

PPO MEDICAL PLAN – PARTIAL SUMMARY OF BENEFITS EFFECTIVE JANUARY 1, 2003			
PLAN FEATURES	**CHARGES & COVERAGES WHEN YOU …**		**WHEN OPEN CHOICE NETWORK IS NOT AVAILABLE**
	USE THE OPEN CHOICE NETWORK	**DON'T USE THE OPEN CHOICE NETWORK**	
YEARLY DEDUCTIBLE	$100 per person with a max of three per family	$300 per person with a max of three per family	$100 per person with a max of three per family
COST SHARING	You pay 10%. Company pays 90%.	You pay 50% of the U&C charge plus any balance. Company pays 50% of the U&C charge.	You pay 20% of the U&C charge plus any balance. Company pays 80% of the U&C charge.
YEARLY PER PERSON OUT-OF-POCKET MAXIMUM	$2000 + $100 deductible.	Unlimited.	$4000 + $100 deductible.
LIFETIME BENEFIT PER PERSON	$ 1 million of total benefits under the Plan		
OFFICE VISITS **(CHIROPRACTIC -** Company pays up to $500 per year.)	$15 office visit co-pay. See Doctor's Office Visit section for lab and x-ray cost share. Company pays 100% of the balance.	After $300 deductible, you pay 50% of the U&C charge, plus any balance. Company pays 50% of the U&C charge.	After $100 deductible, you pay 20% of the U&C charge, plus any balance. Company pays 80% of the U&C charge.
WELL CHILD CARE (Maximum of three visits per year for dependents under 7 years of age.)	$15 office visit co-pay. See Doctor's Office Visit section for lab and x-ray cost share. Company pays 100% of the balance.	After $300 deductible, you pay 50% of the U&C, plus any balance. Company pays 50% of the U&C charge.	After $100 deductible, you pay 20% of the U&C charge, plus any balance. Company pays 80% of the U&C charge.
IMMUNIZATIONS	No deductible or co-pay. Company pays 100% of the cost.	After $300 deductible, you pay 50% of the U&C, plus any balance. Company pays 50% of the U&C charge.	After $100 deductible, you pay 20% of the U&C charge, plus any balance. Company pays 80% of the U&C charge.
WELLNESS BENEFIT	$200 annual maximum.	$200 annual maximum.	$200 annual maximum.
MENTAL CONDITIONS (In or Outpatient)	After the applicable deductible has been met, the plan pays for 50% of the U&C charge with a maximum eligible payout for three days of inpatient care and five days of outpatient care.		
ARTIFICIAL LIMBS & HEARING AIDS	After the deductible, the company pays 80% of the U&C charge for the repair or replacement of an artificial limb, or the initial cost of a hearing aid, up to a maximum annual payout of $400 for each artificial limb or hearing aid.		
SPEECH THERAPY	After the deductible, the company pays 80% of the U&C charge. The maximum lifetime payout by the Plan is $1600.		
STOP SMOKING	The deductible does not apply to these services; the company pays 50% of these charges. The maximum lifetime payout by the Plan is $250.		
HOSPITAL CONFINEMENT AUTHORIZATION	Failure to follow the authorization requirements may result in a penalty.		

EXPENSES THAT ARE NOT COVERED BY THE MEDICAL PLAN

The Plan does not cover the following expenses:

1. Any expenses incurred for services or supplies not prescribed, recommended or approved by a *Physician* as *Medically Necessary* for the care and treatment of an illness or injury.

2. Any expenses incurred for services or supplies determined by the Claim Administrator not to be *Medically Necessary*.

3. Any expenses incurred due to occupational illness or injury, or covered by Worker's Compensation or similar coverage.

4. Any expenses which result directly or indirectly from war, whether declared or undeclared.

5. Any expenses resulting from injury or illness which was intentionally self-induced, sustained while committing a crime (including but not limited to driving with blood alcohol in excess of local limits), or sustained while illegal drugs are present in your system. Determination of whether you were committing a crime does not depend on whether you were prosecuted or convicted.

6. Treatment associated with an injury caused by failure to wear a seat belt.

7. Care and treatment of the teeth, gums or alveolar process, or for dentures, appliances and supplies, except for expenses incurred as a result of an injury or the surgical removal of bony impacted wisdom teeth. Note, however that dental coverage is provided under the Dental section of this Booklet.

8. Expenses incurred in connection with refractive services, including surgery, and visual training. Note, however that vision coverage is provided under the Vision section of this Booklet.

9. Expenses for cosmetic, reconstructive surgery, or complications arising from cosmetic surgery, unless such surgery is *Medically Necessary,* as determined by the Claims Administrator to correct or alleviate an injury or illness or to correct a congenital abnormality, or which is covered under to the mastectomy provisions of this Plan. (See, Reconstructive Surgery Following Mastectomy).

10. Expenses for travel, even if to receive *Medically Necessary* medical treatment.

11. Expenses incurred as a result of the pregnancy of a dependent other than the spouse of the employee.

12. Expenses incurred for biofeedback therapy.

13. Expenses incurred for occupational training or programs that prepare you to return to work.

14. Expenses for research, investigational, and experimental procedures, supplies and devices and for care or treatment that is still under study and is not formally recognized throughout the medical profession in the U.S. as safe and effective for diagnosis or treatment accepted or approved as determined by the Claims Administrator.

15. Expenses for diagnostic, non-surgical, and other treatments in connection with temporomandibular jaw joint and the complex of muscles, nerves and other tissues related to that joint, except as allowable under the dental benefits portion of this Plan.

16. Treatment of conditions that are not the result of an illness or accidental injury.

17. Expenses relating to family planning, including induced abortions, infertility testing or treatment, in vitro fertilization, artificial insemination, elective sterilization, or surgical reversal of elective sterilization, fertility drugs and treatment, contraceptive services and supplies, impotence or sexual dysfunction, including sex change procedures.

18. Any services not provided by a licensed provider.

19. Daily private hospital room charges in excess of the semi-private room rate.

20. Primary custodial care regardless of where provided.

21. Vitamins, minerals, nutritional supplements and similar substances, including drugs and other supplies that can be purchased over the counter.

22. Expenses related to *Pre-existing Condition*s.

23. Expenses resulting from weak, unstable or flat feet, or bunions, unless an open-cutting operation is performed; or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed; or purchase of orthopedic shoes or other device for support of the feet.

24. The purchase or rental of supplies of common use, environmental control or for use outside the home such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows, mattresses, waterbeds, motorized transportation equipment, escalators or elevators, modification to the home or vehicle, saunas, steam baths or swimming pools, wheel chair lifts.

25. Any charges for services and supplies furnished for an employee or dependent prior to the effective date of coverage, or subsequent to the termination date of coverage, except as specifically provided herein.

26. Any charges the Participant is not legally obligated to pay in the absence of this Plan and any charges for services provided by the Participant's spouse or other relative(s) unless specifically approved by the Administrative Committee.

27. Any expense that would not otherwise qualify as an eligible medical expense.

28. Any amount of an otherwise covered expense that exceeds *U&C Limit*, as determined by the Claims Administrator.

29. Any cost or amount for a Wellness Benefit in excess of the amount described in that section of this Booklet.

OUR DENTAL BENEFITS

THE NETWORK

The Plan has an agreement with PPO USA that allows us to access discounts through their Connection Network (the "Dental Network"). The Dental Network consists of dental providers in certain areas that have agreed not only to provide quality services but also to special fee arrangements. These fees are lower than fees for comparable services charged by other dental providers who are not in the network. The use of the Dental Network is one of the ways that we are able to control our costs. It is very possible that your dentist is already a member.

You have open access to the Dental Network. If you reside out of the Dental Network area, or choose not to use a Dental Network provider, you will lose the benefit of the special network fee agreements.

THE DEDUCTIBLE

There is no deductible for Dental Benefits.

COST SHARING

The *Plan Share* is 50%.

Out-of-Network providers are restricted to the *U&C Limit.* You must pay all charges over and above the *U&C.*

The Plan will reimburse you for one routine dental exam per covered individual, with associated cleaning and bitewing x-rays, at 100% of the PPO discounted amount or the *U&C Limit* per calendar year.

INDIVIDUAL LIMITS

This chart shows the dental plan limits for each plan participant.

Maximum Annual Payout	$1,000
Maximum Lifetime Orthodontic Payout	$1,000 (up to the *U&C limit*)

COVERED DENTAL EXPENSES

The Plan covers all *Medically Necessary* dental expenses that are not specifically excluded. (See, Dental Expense That Are Not Covered). The applicable *Plan Share* and individual limits described in this Booklet will apply to your expenses.

BENEFITS WITH SPECIAL RULES

Orthodontic payments are based on the service dates rather than your payment schedule. Generally, Orthodontists require a down payment, then equal monthly payments until treatment is complete. That initial down payment (usually 25%) is eligible as are the monthly payments thereafter (subject to the requirements of the Plan).

DENTAL EXPENSES THAT ARE NOT COVERED

The Plan does not cover the following dental expenses:

1. Treatment performed for cosmetic purposes.

2. Treatment by other than a licensed dentist, except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of the dentist.

3. Expenses incurred in connection with dentures, bridgework, crowns or prosthetic devices started prior to the effective date of coverage, or (b) for replacement made less than three years after a placement or replacement, or (c) for extension of bridges or prosthetic devices previously paid for under this Plan, unless extended into new areas, or (d) for replacement of teeth which were absent or extracted prior to the effective date of coverage, or (e) for replacement due to loss or theft.

4. Any charges incurred for services or supplies not recommended by a dentist.

5. Any expenses incurred due to occupational illness or injury or covered by Worker's Compensation or similar coverage.

6. Any charges incurred which result directly or indirectly from war (whether declared or undeclared).

7. Any expenses resulting from injury or illness which was intentionally self-induced, sustained while committing a crime (including but not limited to driving with blood alcohol in excess of local limits), or sustained while illegal drugs were present in your system. Determination of whether you were committing a crime does not depend on whether you were prosecuted or convicted for that crime.

8. Expenses for research, investigational, and experimental procedures, supplies and devices and for care or treatment that is still under study and has not been formally recognized throughout the dental profession in the U.S. as safe and effective for diagnosis or treatment by the American Dental Association.

9. Any charges for services and supplies furnished for an employee or dependent prior to the effective date of coverage, or subsequent to the termination date of coverage, except as specifically provided herein.

10. Any charges the Participant is not legally obligated to pay and any charges for services provided by the Participants' spouse or other relative(s) unless specifically approved by the Claims Administrator.

11. Any charges for services or supplies in connection with multiple tooth implants.

12. Any expense that is not *Medically Necessary* as determined by the Claims Administrator.

13. Any amount of an otherwise covered expense that exceeds *U&C Limit*, as determined by the Claims Administrator.

OUR VISION BENEFITS

THE NETWORK

The Plan has an agreement with Cole Vision that allows us to access discounts through their "Vision One" Network (the "Vision One Network"). The Vision One Network consists of vision care providers in certain areas that have agreed not only to provide quality services but also to special fee arrangements. These fees are lower than fees for comparable services charged by other vision care providers who are not in the network. The use of the Vision One Network is one of the ways that we are able to control our costs. It is very possible that your vision care provider is already a member.

You have open access to the Vision One Network. If you reside out of the Vision One Network area, or choose not to use a Vision One Network provider, you will lose the benefit of the special network fee agreements.

You will receive a flyer telling you how to get the discount and file a claim, as well as a chart showing the Vision One discounts. If you do not receive this flyer see the "Contacts Section" for contact information.

COST SHARING

The Plan will pay the first 50% of your vision care expenses, including the cost of eye exams, corrective lenses, frames, and contact lenses, incurred by you and /or your eligible dependants, up to a maximum plan payment of $100 per calendar year per individual.

DEDUCTIBLE

There is no Deductible for Vision Benefits.

INDIVIDUAL LIMIT

$100 maximum payable yearly for each covered individual.

OUR PRESCRIPTION DRUG PROGRAM

THE NETWORK

The Prescription drug benefits are administered by Advance PCS ("PCS"). PCS is a network of drug stores and pharmacies. A list of participating pharmacies is included in a separate booklet called "Your Drug Card Benefits" sent to you when you enroll in the Plan. If you have any additional questions about the Prescription Drug Program, you should contact PCS. See the "Contacts" Section at the end of this booklet for PCS' contact information. If you need a booklet, contact Watkins Employee Benefits Department.

COVERED EXPENSES

The Prescription Drug Program allows participants to purchase, after a set co-pay, up to a 30-day supply of prescribed drugs at a PCS participating retail drug store or a 90-day supply of prescribed drugs under a mail service program. A list of covered drugs is provided to you automatically in the "Your Drug Card Benefits" booklet and "Commonly Prescribed Medications" brochure sent to you when you enroll. The Plan also participates with PCS in a program called Performance RX. If you and your doctor agree, your pharmacist may be able to provide you with a lower cost prescription for certain medical conditions. Please refer to the "Your Drug Card Benefits" booklet for more information on the Performance RX program.

COST SHARING

The entire cost of the drugs that you purchase at a PCS participating pharmacy or through the mail order program is paid by the *Company* except for a small co-payment. There are three levels of co-payments. The level that applies depends on whether you purchase generic, select brand, or additional brand name drugs. The specific co-payment amount, as well as plan definitions, is described in "Your Drug Card Benefits" booklet. You do not have to submit a claim form when you purchase drugs at a PCS participating pharmacy. The claim is filed with PCS for you.

Drugs purchased at a non-participating pharmacy must be paid for by you, then submitted to PCS with a PCS claim form for payment. Up to 50% of the prescription cost of eligible prescription drugs purchased at a non-participating retail pharmacy will be reimbursed by PCS. You can get a claim form from PCS, the Watkins Employee Benefit Department, or through the PCS Internet site.

FLEXIBLE SPENDING ACCOUNT PLAN

The Flexible Spending Account Plan ("FSA Plan") allows you to pay for certain expenses with pre-tax dollars and saves you money on taxes by reducing your taxable income.

SUMMARY OF PLAN BENEFITS

The FSA Plan offers three "Options."

- The Group Health Premium Option lets you save taxes on Group Health Plan premiums for your spouse and/or dependents by paying your premiums with pre-tax dollars; and
- the Dependent Care Reimbursement Option lets you set up your own account with pre-tax dollars to pay for your dependents' daycare; and
- the Health Care Reimbursement Option lets you set up your own account with pre-tax dollars to pay unreimbursed medical, dental, vision and drug expenses for you and your tax dependents.

FSA PLAN ELECTIONS

Regardless of the Option or Options you choose, your elections are irrevocable for the *Plan Year* unless you experience a *Life Event*. (See, Enrolling or Changing Coverage After Initial Enrollment).

Group Health Premium Option

You are automatically enrolled in the Group Health Premium Option when you fill out your enrollment forms for the Group Health Plan. If you do not wish to participate in this Option, you must inform your Human Resources Department when you first fill out your enrollment forms or during any *Annual Enrollment Period*.

Dependant Care Reimbursement Option

When you first join the Group Health Plan, and during each *Annual Enrollment Period* thereafter, you can elect to set aside an amount (up to a certain maximum – see Maximum Reimbursement Under the Dependant Care Reimbursement Option) that you believe you will spend in the following *Plan Year* for your dependants' daycare. The amounts you elect to set aside will be deducted (before federal and state taxes) in equal amounts from each paycheck during the *Plan Year*. When determining how much to set aside, please remember that the "Use it or Lose it Rule" applies.

Health Care Reimbursement Option

When you first join the Group Health Plan, and during each *Annual Enrollment Period* thereafter, you can elect to set aside an amount (up to a certain maximum – see Maximum Reimbursement Under the Health Care Reimbursement Option) that you believe you and your dependants will spend for medical expenses in the following *Plan Year* that will not be paid by the Plan or reimbursed from any other source (for example, Plan deductibles or doctor's office visit co-pays). The amounts you elect to set aside will be deducted (before federal and state taxes) in equal amounts from each paycheck during the *Plan Year*. When determining how much to set aside, please remember that the "Use it or Lose it Rule" applies.

USE IT OR LOSE IT RULE

The Use it or Lose It Rule applies to the Dependant Care Reimbursement Option and Health Care Reimbursement Options only. You must make your requests for reimbursement of expenses incurred under the Health and Dependent Care Reimbursement Options during the *Plan Year* or no later than 90 days after the end of the *Plan Year* in which the expense was incurred. Any money that is left in your account after reimbursement of expenses incurred during the *Plan Year* will be forfeited as required under IRS regulations. Therefore, it is important to be as accurate as possible when deciding the amount to be withheld and credited to your Dependent Care and Health Care Reimbursement Option accounts. If you are estimating expenses you may want to estimate low to avoid forfeiting any of your deductions. The Group Health Premium Option is not subject to this rule since it works on a "pay-as-you-go" basis.

HEALTH CARE REIMBURSEMENT OPTION

The Health Care Reimbursement Option allows you to pay for certain unreimbursed eligible medical care expenses for yourself and your eligible dependants, such as deductibles, co-payments, and deductible medical expenses that are not covered under the Watkins Group Health Plan (or any other health plan), with pre-tax dollars. For purposes of this Option, an eligible medical care expense is a service or supply that is necessary for the diagnosis and/or treatment of a physical or mental condition, as defined by Code Section 213 (except for qualified long term care expenses and health insurance premiums). IRS Publication 502 (which is available from the IRS website at www.irs.gov) generally describes which medical expenses will qualify. The Health Care Reimbursement Option will reimburse your eligible medical expenses for services received during the Plan Year by you, your spouse, or your tax dependents up to the amount you have elected to set aside.

Expenses with Special Rules

Certain expenses, like obstetrical and orthodontia fees are subject to special reimbursement rules.

Obstetrical. Physicians may bill in advance for the entire 9 months of care, including the delivery. This is commonly called "global billing". Because only expenses incurred for services actually received by you are eligible for reimbursement, the pre-billed portion of the global fee is not eligible for immediate reimbursement. Instead you may submit the cost of the individual

office visits, labs, tests and the delivery fee as they are incurred. Keep in mind this may cross a year boundary so that the reimbursement may be paid from different plan year accounts.

Orthodontia. Generally Orthodontists require a down payment, then equal monthly payments until treatment is complete. That initial down payment (usually 25%) is eligible as are the monthly payments thereafter. Orthodontic payments are based on the service dates rather than the orthodontist's billing schedule.

Maximum Reimbursement Under the Health Care Reimbursement Option

The maximum benefit you may elect under this Option is limited to an annual maximum amount that will be included each year in the applicable enrollment materials.

How to Get Reimbursed Under the Health Care Reimbursement Option

Doctor's office co-pays and deductibles under the Group Health Plan are automatically debited from your account and paid to you. Expenses like drug co-pays that are not processed by the Group Health Plan or are not a covered expense under the Group Health Plan first must be submitted by you for reimbursement.

For these expenses you must submit a copy of the bill or receipt from the medical care provider along with a completed claim form. A claim form is available from your Human Resources Department or the Watkins Employee Benefits Department or on line at www.waibenefits.com. On the claim form you verify that the expense has been incurred and that it will not be reimbursed from any other source. Remember, you cannot claim medical expenses reimbursed under this plan as a medical expense deduction on your federal income tax return.

DEPENDENT CARE REIMBURSEMENT OPTION

This FSA Plan allows you to pay for out-of-pocket, dependent day-care costs with pre-tax dollars. The expenses must be incurred so that you and your spouse (if applicable) can be employed or looking for work. Married employees can use the FSA Plan if both you and your spouse work or, in some situations, if your spouse goes to school full-time or is incapable of self-care. Single employees with children can also use the account. Expenses must be incurred for the care of a *Qualifying Individual* at:

- A dependent (day) care center, which is a facility that provides care for more than six individuals (other than ones who live there) and receives a fee, payment, or grant. In addition, the center must comply with applicable state and local laws.

- An educational institution for preschool children (pre-kindergarten). For older children, only expenses for non-school care are eligible.

- An "individual" who provides care inside or outside your home. This caregiver may not be a child of yours (including your stepchild) under the age of 19 at the

end of the Plan Year or anyone you claim as a dependent for federal tax purposes. If care is provided outside your home, the eligible dependent must reside with you at least 8 hours per day.

Maximum Reimbursement Under the Dependent Care Reimbursement Option

The law places limits on the amount of money that can be set aside and paid to you in a calendar year from your Dependent Care Reimbursement Option account. Generally, your reimbursements may not exceed the lesser of your and your spouse's earned income or $5,000 (if you are single or married filing a joint return) or $2,500 (if you are married filing separate returns). In addition, if your spouse is a full-time student or incapable of self-care, your spouse will be deemed to have earned income of $200 per month if you have one child and $400 per month if you have two or more children.

In addition, be aware that federal tax laws permit a tax credit for certain dependent care expenses, called a "Household and Dependent Care Tax Credit." You cannot claim this tax credit if you use this Dependant Care Reimbursement Option for reimbursement. Contact your tax advisor for more information on the dependent care credit.

How to Get Reimbursed Under the Dependent Care Reimbursement Option

You must submit a completed Dependent Care Reimbursement form and provide a statement from your caregiver, including their name, address, and, their Social Security number or taxpayer identification number. You will also need proof that the claimed expense has been incurred. A claim form is available from the Watkins Employee Benefits Department or on line at www.waibenefits.com.

EXCESS/INELIGIBLE REIMBURSEMENT

You must notify the Watkins Employee Benefits Department or your Human Resources Department if you later receive a second reimbursement for a medical or dependent care expense from any other source or if you have reason to believe that any expense for which you have received reimbursement is not an eligible medical or dependent care expense. Failure to so notify the Company will result in your being liable for any additional tax and/or tax penalty attributable to such ineligible expenses.

ELIGIBILITY AND PARTICIPATION

EMPLOYEES

To be eligible to participate in the Plans, you must be an *Eligible Employee*. An *Eligible Employee* is an individual who is classified by a *Participating Employer* as a full-time common-law employee and who satisfies the applicable *Waiting Period*. The Human Resource Department of the *Participating Employer* with whom you are employed will advise you of the *Waiting Period* that applies to you.

EMPLOYEES ON AN APPROVED LEAVE OF ABSENCE OR REDUCTION IN FORCE

Special provisions apply depending on the type of leave or absence that applies to you.

Paid Leave of Absence

If you are on a paid leave of absence, you will be required to continue your coverage under the Group Health Plan and the Flexible Spending Account Plan during the paid leave.

Unpaid Leave Other than FMLA

If you are on an approved unpaid leave of absence (other than FMLA leave), or are not working as a result of a reduction in force, you will be eligible for continued coverage in accordance with COBRA. (See, COBRA Continuation Coverage).

FMLA Leave

If you are on approved leave of absence under the FMLA, you will be entitled to continue your coverage under the Group Health Plan and the Health Care Reimbursement Option on the same terms and conditions as before the leave. If your coverage stops while you are on FMLA leave (e.g., for non-payment of required contributions or you choose not to continue), when you return from leave you may be reinstated at the same level as before the leave. With respect to the Health Care Reimbursement Option, you may make a new election upon return.

Leave for Military Service (USERRA Leave)

Certain leave for military purposes is covered by a special rule under a law known as USERRA. If you are called to active duty in the military forces of the United States (including the Reserves), you should contact your local Human Resources Department to see if you have USERRA rights, including the right to elect continuing coverage under this Plan while on military service.

RETIREES

You and your eligible dependents may be eligible for coverage as a "Retiree." See "Benefits Available After You Retire" section of this booklet.

DEPENDENTS

You may also cover your "eligible dependents." Employees may be required to pay premiums if they and their eligible dependents wish to be covered by the Plan. Your Human Resource Department will provide you with the premium amounts when you enroll and on request.
Eligible dependents (for other than the Dependent Care Reimbursement Option) means any one of the following:

1) your *Spouse;*

2) unmarried natural children who are under age 19 and who are considered as receiving over half of their support from you. If you are legally separated or divorced, your natural children are considered to be your dependents for Plan purposes even though they may not receive over half their support from you;

3) unmarried step, adopted (or children placed for adoption), or foster children under the age of 19 who live with you the majority of the year and are claimed as your dependents on your federal income tax return; and

4) Children under the age of 19 for whom you are required to provide coverage through a Qualified Medical Child Support Order (see below for additional information on QMCSOs).

5) Children meeting either of the following:

   a. The child is unmarried, your natural, step, adopted or foster child, and is between the age of 19 and 25 and attending class as a full-time student (except during a break) at an *Accredited Institution.* You must send verification that the child has commenced attending class as a full-time student (as defined by the *Accredited Institution*) to your local Human Resources Department within 30 days after attendance begins and then within 30 days of the beginning of each new subsequent quarter, semester, trimester, whichever is applicable, for coverage to remain in effect. The child will remain covered during the periods between each quarter, semester, trimester, etc.; however, if you fail to provide the required verification described above following the beginning of the next period, the child's coverage will end the day immediately preceding the date the new period began; or,

   b. The child was covered by the Plan and became disabled (i.e. unable to care for themselves under normal circumstances), as determined by the Plan Administrator, before age 19. The disabled child will be covered under the Plan until they are no longer disabled. Annual confirmation of the disability is required from the child's physician. The Plan Administrator will advise you if coverage will continue.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A QMCSO is a judgment, decree, court order (including an approval of a settlement agreement) that requires you to provide health coverage for your child under the Plan. The Group Health Plan and the Health Care Reimbursement Option will comply with a QMCSO decree issued from a state court or administrative agency that satisfies certain federal requirements and that directs the Plan to cover your dependent child. When a court order or decree is received, each affected *Eligible Employee* and each dependent child covered by the order or decree will be notified of the Plan's procedures for determining whether the order or decree is a QMCSO. You will be told the additional premium amount that you will need to pay, if any, by your Human Resource Department. You may request a copy of the Plan's QMCSO procedures from the Human Resource Department.

EFFECTIVE DATE OF COVERAGE

Eligible Employees

When you become eligible, for example new hires, rehires, and employees moving from part-time to full-time, you must complete and submit an enrollment form provided by your Human Resource Department during the *Initial Enrolment Period* in order to participate in the Plan. If you properly enroll, you will become a "Participant" and your coverage will be effective on the first day after the *Waiting period* ends. You may also enroll or change your elections each year during the *Annual Enrollment Period* or if you have a *Life Event.*

Eligible Dependents

You may enroll your eligible dependents at the same time that you enroll. Coverage for a properly enrolled eligible dependent is effective on the same day as yours.

If you gain an eligible dependent during the year (including a newborn) you must submit an enrollment form to your Human Resource Department within 30 days after you acquire the eligible dependent if you wish to have that dependent covered. That dependent's coverage is effective on the first day of the first pay period following the date that you notify the Human Resource Department except as provided below. You can obtain an enrollment form by contacting your Human Resource Department, the Watkins Employee Benefits Department or by going on line to www.waibenefits.com.

There is an exception for dependents you gain through birth or placement for adoption. Coverage is effective on the date of the birth, adoption or placement for adoption provided you notify Watkins Employee Benefits Department within 30 days of birth or adoption.

ENROLLING OR CHANGING COVERAGE AFTER INITIAL ENROLLMENT

Life Events

Generally, you cannot change your election to participate (or not to participate) in the Group Health Plan and/or FSA Plan except during the *Annual Enrollment Period.* However, if you experience a qualifying *Life Event* during the *Plan Year,* and that *Life Event* causes you or a dependant to gain or lose eligibility under this Plan or another group health plan, you may make certain changes to your election under the Group Health and/or FSA Plans. These changes need to be consistent with the *Life Event* (for example, if a dependant loses eligibility, you may drop the person from coverage). In order to change your elections under the Group Health Plan and/or FSA Plan, you must notify your Human Resources Department within 30 days of the date of the *Life Event* by completing and submitting an enrollment change form. If you do not submit a completed enrollment change form within 30 days of the *Life Event*, you will be required to wait until the next *Annual Enrollment Period* to make the change. Coverage will be effective the first pay period following the date that a properly completed enrollment form is received by your Human Resources Department.

You may also be able to enroll or change your election during the *Plan Year* under the Plan's Special Enrollment rules that are described below.

Special Enrollment – Loss of Other Coverage (Does not apply to coverage for Retirees or their eligible dependents)

When you or your eligible dependents lose other health coverage (except as a result of your fraud or non-payment of premiums), you may enroll yourself, your *Spouse*, and/or your eligible dependents that lose coverage, if the following conditions are met:

- You indicated to the Plan when you first became eligible for coverage that you or your eligible dependents were at that time declining coverage because you had other health coverage under another plan; and
- If the other coverage is COBRA continuation coverage, you or your eligible dependents subsequently lose that other coverage because the maximum COBRA coverage period has expired; or
- The other plan covering you has been terminated; or
- You or your dependents lose eligibility under the other plan; or
- The other employer stops making contributions under the other plan.

You must request enrollment within 30 days of the loss of coverage.

Coverage is effective on the first day of the first pay period following the date that a properly completed enrollment form is received.

COORDINATION OF BENEFITS

The purpose of the Group Health Plan is to protect you against unanticipated medical and dental expenses. The Plan is not intended to reimburse you in excess of your covered medical or dental expenses. Therefore, if you are covered under another medical, dental or vision plan or have any other coverage which pays medical, dental, vision or prescription expenses covered by the Plan, coverage under the Group Health Plan will be coordinated with your other coverage to ensure you are properly reimbursed. PPO benefits do not apply when this Plan is the second payer.

The coordination of benefits rules are complicated. In general they work like this:

A. Property, casualty or auto insurance will pay before the Plan pays.

B. Coverage of an individual as an employee will pay before coverage of the same individual as a dependent.

C. If a legal divorce decree assigns sole responsibility for an eligible dependent's medical coverage to an individual, that individual's medical coverage will be responsible for the dependent's medical expenses first.

D. When the Plan is secondary to other coverage (as described in these rules) and the other coverage considers the expenses as ineligible, the Plan will cover 20% of those expenses as long as they are eligible under the Plan.

E. If both you and your *Spouse* work and both of you have coverage for your dependent child(ren), the parent with the earliest birth date month will have primary coverage. For example, if your *Spouse's* birthday is May 15 and yours is August 20, claims for your dependents must be submitted to your *Spouse's* insurance company before they are submitted to the Plan (the year of the birth is irrelevant).

F. If there is another plan that may have primary coverage responsibility but that will only provide excess or secondary coverage, this Plan will pay up to a maximum of 50% of the expense, not to exceed 100% of the expense, as long as such expenses are eligible under the Plan.

G. If the other plan with primary coverage responsibility is an HMO or other form of managed or preferred care, the Plan will not pay any benefits where a participant could have used the other plan but chose not to. In addition, the Plan will not consider any expense that is higher than what the other plan's HMO provider has agreed to accept as payment in full for the same service or treatment under the HMO arrangement.

In all cases, you should submit the expenses to the medical plan who has primary payment responsibility (as described above) first in the way that the primary plan requires, and then submit copies of those same expenses, along with copies of any and all payments made by the primary paying plan, to the secondary paying plan.

SPECIAL MEDICARE COORDINATION RULES

As a general rule, if you or your Eligible Dependents covered under the Plan become eligible for Medicare, there are rules that determine whether the Plan pays benefits first, or whether Medicare pays benefits first. The following is a summary of those rules:

- if you are an active employee covered by the Plan, the Plan pays benefits first for you and your covered eligible dependent who is eligible for Medicare (e.g., due to a disability or being age 65 or older).
- if you are disabled and not actively working, the Plan pays benefits first for you and your covered eligible dependents who are eligible for Medicare for the first six calendar months of the disability period. After the six-month period, if you are not actively working with a *Participating Employer,* Medicare pays benefits first for you and any covered eligible dependents.
- In the event a covered eligible employee or covered eligible dependent is eligible for Medicare due to End Stage Renal Disease (ESRD), the Plan pays benefits first during the first 30 months of ESRD. Thereafter, Medicare pays benefits first.

However, the Plan will coordinate benefit payments with Medicare to the extent permitted by law (even if such coordination goes beyond that described above).

In all cases, you should submit the expenses to the plan that has primary payment responsibility (as described above) first in the way that the primary plan requires, and then submit copies of those same expenses, along with copies of any and all payments made by the primary paying plan, to the secondary paying plan.

BENEFITS AVAILABLE AFTER YOU RETIRE

Certain covered *Eligible Employees* have the option to continue coverage under the Group Health Plan after retirement. Retirees are not eligible for the FSA Plan.

ELIGIBILITY

Eligible Retirees

If you are covered under the Plan on the date that you terminate employment, you may continue coverage as a "Retiree" if you satisfy the following conditions:

- You have completed twelve continuous years of employment with the *Company* and you are at least 60 years old when you terminate employment with the *Company*, or
- You have completed five continuous years of employment with the *Company*, and you are at least 65 years old when you terminate employment with the *Company*.

Eligible Dependents

Your eligible dependents can be covered.

Enrollment

You must enroll for Retiree coverage within 30 days after becoming eligible for Retiree coverage. If you do not enroll you will permanently lose eligibility under the Plan. If you did not receive an enrollment package, see the Contacts section at the end of this booklet.

If you do not enroll for Retiree coverage, you and/or your covered dependents may be able to elect to continue your active coverage under COBRA. For more information, see "COBRA Coverage."

Resuming Employment

If you are participating under the Plan as a Retiree, and you are subsequently re-hired by a *Participating Employer*, you may resume coverage in the Plan as an active employee. You will not have to satisfy the applicable *Waiting Period*. Then, you will be eligible to re-enroll in the Plan as a Retiree when you terminate your re-employment if you maintained continuous active coverage under the Group Health Plan while re-employed.

RETIREE COVERAGE

Retiree coverage is the same as active employee coverage. When a Retiree and/or Retiree's dependent reaches the age he/she becomes eligible for Medicare benefits, all claims eligible for coverage under any part of Medicare must first be submitted to Medicare for processing. The

Plan will deduct Medicare reimbursement from the entire claim, whether or not Medicare reimbursement is actually made.

Your Retiree benefits are not vested. As with the active employee coverage, the *Company* reserves the right to change or terminate the coverage provided to Retirees under the Plan. These changes may include changes in the type or level of coverage provided and contributions required as well as termination of various benefits. Amendments apply to current participants and covered dependents as well as future participants and covered dependents.

TERMINATION OF COVERAGE

Coverage will terminate upon the death of the Retiree. Your covered dependent may be eligible for COBRA continuation coverage if coverage is lost following the Retiree's death. Your dependent will be notified by the Watkins Employee Benefits Department of his or her COBRA rights.

CONTRIBUTIONS FOR RETIREE COVERAGE

The Administrative Committee will establish premiums on a periodic basis. Premiums are due on the 1st of each month. Coverage under the Plan will terminate if premiums are not received within 30 days of the due date. If coverage terminates, there will be no opportunity to re-enroll in the Plan, and you will permanently lose eligibility under the Plan. The Watkins Employee Benefits Department will not send out reminder statements. It is your responsibility to be sure required premiums are paid on time.

ADMINISTRATIVE COMMITTEE / PLAN ADMINISTRATOR

The Board of Directors of Watkins Associated Industries, Inc. has established an Administrative Committee to oversee all of the activities relating to the Plans and to act as Plan Administrator. The Administrative Committee has the exclusive right and discretion to decide all questions or issues relating to the administration or interpretation of the Plan, including questions of fact and issues pertaining to eligibility for, and the amount of, benefits to be paid by the Plan. Any such interpretations will be conclusive and binding on all interested persons, subject to the following claims appeal procedures.

This Administrative Committee has delegated certain day-to-day activities and claims administration and processing duties to the Claims Administrator. If you have any problem with the Plan or your coverage, contact the Claims Administrator at 1-800-333-3841.

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CLAIMS APPEAL PROCEDURE

You must submit all initial claims to the Claims Administrator. If you fail to submit your claim within 365 days of the date on which the service was rendered or the cost incurred, the Plan will not cover it and you will have waived your right to contest the denial through these claim procedures and in court. There are four types of claims and different rules and time limits apply to the appeal process for each. If you disagree with the decision made on your claim, you **must** pursue these procedures before bringing any legal action. If you do not, you will waive your right to sue. If your claim is denied on final appeal and you wish to pursue legal action, you must do so within one year of the date of the final denial. If you would like to review any information pertaining to your claim, you may request it from the Claims Administrator at any point in the appeal procedure.

Claims Review Chart		
Type of Claim	**Steps to Take**	
URGENT CLAIMS		
Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain. If the claim ceases to be "urgent" it will be treated as a "Pre-Service Claim" below.	**Step 1:**	The Plan will respond within **72 hours** after receiving your initial claim.
	Step 2:	If denied, you have **180 days** after receiving the denial to request an **initial appeal** of the Plan's decision by the Claims Supervisor.
	Step 3:	The Plan has **72 hours** after receiving your **initial appeal** to notify you of its decision.
	IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Plan has **24 hours** after receiving your initial claim to notify you that your claim is improper or incomplete.
	Step 2	You have **48 hours** after receiving notice from the Plan to correct or complete your claim. If you do not correct or complete your claim, the Plan will be forced to make a determination based on the information that it has (which may not be as favorable to you as it would if the Plan had full information about the claim).
	Step 3:	The Plan will advise you whether your claim is approved or denied within **48 hours** of the later of receiving the information to correct or complete your claim, or the deadline to submit the information.
	Step 4:	If denied, you have **180 days** after receiving the claim denial to request an **initial appeal** of the Plan's decision by the Claims Supervisor.

PRE-SERVICE CLAIMS

Claims Review Chart		
Type of Claim	**Steps to Take**	
Group health claims where treatment must be preauthorized before it is performed or failure to obtain pre-approval results in less than full payment.	**Step 1:**	If your claim is proper and complete, the Plan will advise you whether the initial claim was approved or denied within **15 days** after receipt. If your claim is improper or incomplete, you will be notified (see section below).
	Step 2:	If the claim is denied you have **180 days** after receiving the denial to request an **initial appeal** of the Plan's decision by the Claims Supervisor.
	Step 3:	The Claims Supervisor will review the claim and notify you of its determination no later than **30 days** after receiving your **initial appeal**.
	Step 4	If the **initial appeal** is denied you have **180 days** after receiving the denial to make a **second appeal** of the decision to the Claims Administrative Committee.
	Step 5	The Claims Administrative Committee will respond to your **second appeal** in writing within a period no longer than **30 days** after receipt minus the number of days used to review your **initial appeal** in Step 3.
	Step 6	If your claim is denied in Step 5, the Plan provides an **optional** third level of **appeal** which may reduce or eliminate the delay/cost of legal action. You have **60 days** after receipt of the denial of your **second appeal** to appeal to the Administrative Committee.
	Step 7	Within **60 days** the Administrative Committee will respond in writing to your **optional appeal**. (90 days if the Administrative Committee requires additional time.) No further appeals are available under the Plan.
	IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	If your initial claim is improper, the Plan will notify you within **5 days** after receiving your initial claim if the Plan needs more information or if your claim is otherwise improper.
	Step 2	If the Plan needs more information and tells you so during the initial 15-day period, the Plan has **15 days** after receiving the information to notify you of its decision. (The time the plan waits for the information is not counted.)
	Step 3:	You have **45 days** after receiving the extension notice to provide additional information to complete the claim.
	Step 4:	If your claim is denied, the appeal procedures set forth in Steps 2 through 7 above apply.

POST-SERVICE CLAIMS		
Group health claims where you request reimbursement after treatment has been performed.	**Step 1:**	The Plan will notify you whether the claim is covered within **30 days** after receiving your initial claim.
	Step 2:	If your claim is denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision to the *Claims Supervisor*.

Claims Review Chart		
Type of Claim	**Steps to Take**	
	Step 3:	The Plan will notify you within **30 days** after receiving your appeal. If you wish to appeal, follow the procedure described in Steps 2 through 7 under "Pre-Service Claims".
	IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION	
	Step 1:	If the Plan needs more information and provides an extension notice during the initial 30-day period, the Plan has **45 days** after receiving the claim to notify you if your claim is covered. Days the Plan waits for your information are not included in the 45 days.
	Step 2	You have **45 days** after receiving the extension notice to provide additional information or complete your claim.
	Step 3:	If your claim is denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
	Step 4:	The same procedures for appealing "Pre-Service Claims" apply, except the Plan has **30 days** to respond in Steps 3 and 5.
ONGOING TREATMENT CLAIMS		
A course of treatment previously approved which is being reduced or terminated before scheduled reduction or termination.	**Step 1:**	If you disagree with the termination/reduction of your ongoing treatment, follow the claim procedures in Steps 2 through 7 under "Pre-Service Claims".
	Step 1: URGENT CARE	If termination/reduction of your ongoing treatment could jeopardize your life, health, ability to regain maximum function, or subject you to severe pain, follow Steps 1 through 3 under "Urgent Claims".

THE PLAN'S RIGHT TO RECOVER BENEFIT PAYMENTS

If you:

a. sustain an illness or injury as a result of the tortious act of another party, and

b. as a result of such illness or injury you receive benefits under the Plan or are eligible to receive benefits and you reach an agreement to settle with the responsible party, or a judgment against the responsible party is entered in your favor, then you agree to hold in trust for the benefit of the Plan the "net proceeds" (defined below) from the amount the responsible party will pay to you or to any other person or entity on your behalf. By receiving Plan benefits you expressly acknowledge that the Plan shall have a lien and/or constructive trust on any "net proceeds" paid to you or on your behalf as the result of a settlement or judgment with or against any party responsible for your illness or injury.

"Net proceeds" means the amount you recover minus all attorney's fee's and actual costs of recovery, and minus the medical expenses relating to the illness or injury actually paid by you and not reimbursed by the Plan or any other source. In some cases, this will mean that the entire "net proceeds" must be paid to the Plan. The Plan's lien/constructive trust against the "net proceeds" is not subject to further reduction for any reason, and will apply to the entire net proceeds of any recovery by the participant, whether by judgment, settlement, arbitration award or otherwise. Also, the Plan's lien/constructive trust is not limited by the characterization of the amount recovered nor any common law "make-whole" doctrine. This means the Plan has a lien/constructive trust against any net proceeds, even if you or your covered Eligible Dependents are not fully compensated for the loss and even if the proceeds are earmarked for something other than medical expenses, like "pain and suffering" or "lost wages".

You and/or your eligible dependents will be required to sign a form recognizing the Plan's lien/constructive trust prior to receiving Plan benefits. However, the Plan's lien/constructive trust applies, whether or not you sign the form, to any payments you may have already received for the illness or injury. You will also be required to cooperate with the Plan in asserting claims against the party responsible for your injury or illness and assigning your claim to the Plan if you do not pursue it. If you have recovered money from a responsible party before the Plan pays your claims, the Plan will offset (reduce) the amount it would otherwise pay under the terms of the Plan by the net proceeds recovered by you. **The Plan will have the right to withhold or offset future benefit payments or recover prior benefit payments through payroll deductions if you do not comply with these provisions.**

If it is determined that a Participant has received payments under this Plan that exceed the amount of eligible expenses under either the Plan or the FSA Plan that have been substantiated by such Participant during the Plan Year, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification. The Plan will have the right to withhold future benefit payments in an amount equal to the overpayment and/or to treat as otherwise required under the Internal Revenue Code.

REBATES RETAINED BY THE PLAN

Occasionally, the Plan will receive certain rebates or discounts from health care providers or suppliers. All claims submitted to the Plan will have co-pay and deductible amounts calculated according to the provider's charges without regard to any such rebates. Any rebates received will be used to pay benefits or the cost of administering the Plan.

WHEN DOES YOUR COVERAGE TERMINATE

Your coverage will automatically terminate (except as permitted in the next section) on the earliest of the following dates:

a. the date the Plan is terminated;

b. the last date for which any required contributions are timely received;

c. the date you cease to be eligible for any coverage under the Plan;

d. the date your employment with the *Company* terminates.

Dependent coverage will automatically terminate on the earliest of the following dates:

a. the date you lose coverage;

b. the date the dependent ceases to be an Eligible Dependent (for example, when a dependent child reaches the age 19 or when a dependent child over the age of 18 ceases to be a full-time student);

c. the date the dependent enters the armed forces of any country or international organization;

d. for your *Spouse*, the date of divorce or legal separation from you;

e. the effective date of a revocation of dependent coverage under the Plan.

You and/or your Eligible Dependents whose coverage terminates may be able to continue coverage under COBRA.

Special Rules for Dependent Care Reimbursement

If you terminate employment with the Company or otherwise lose eligibility, you may continue to submit eligible dependent care expenses incurred before and/or after you lose eligibility up to your Dependent Care Reimbursement account balance on the date you lose eligibility.

COBRA CONTINUATION COVERAGE

Continuation of benefits under the Group Health Plan and the Health Care Reimbursement Option is available to *Qualified Beneficiaries* only. Remember, a *Qualified Beneficiary* includes yourself as a former employee. *Qualified Beneficiaries* who wish to continue coverage must elect to do so within certain time limits and must pay the entire cost of coverage (both your portion as an employee and what the *Company* had paid for you) plus a 2% (50% if on disability extension) administrative fee on a regular and timely basis.

Qualified Beneficiaries become eligible for COBRA continuation coverage if they **lose coverage** under the Plan as a result of a "Qualifying Event". A "Qualifying Event" is any one of the following:

1. Termination of employment or reduction of hours worked, unless you are discharged for gross misconduct.

2. Divorce or legal separation from a covered employee.

3. Death of a covered employee.

4. Termination of coverage as a dependent child under the terms of the Plan, for example, because the child reaches age 19 or is no longer a full-time student.

The Plans have no way of knowing when you have had a divorce (or legal separation) or when a dependent child loses eligibility. Therefore, it is your responsibility or the responsibility of affected dependents to notify the Watkins Employee Benefits Department within 60 days of a divorce or legal separation, or loss of a child's dependent status under the Plan. If this notice is not received within 60 days, the dependent will permanently lose eligibility for the continuation coverage.

Children born to former employees, and children acquired by former employees through adoption during your period of continuation coverage can also be added to your coverage as a *Qualified Beneficiary*. If you have a child born to you or acquired through or placed for adoption during your period of continuation coverage, you must inform the Watkins Employee Benefits Department within 30 days of the birth, adoption or placement.

LENGTH OF COVERAGE

Continuation coverage under the Group Health Plan may extend for 18 months in the case of termination of employment and reduction of hours, and otherwise for 36 months.

Continuation coverage under the Health Care Reimbursement Option only extends through the end of the *Plan Year* in which you have a Qualifying Event.

SPECIAL EXTENSIONS (applicable only to the Group Health Plan):

Disability

If a *Qualified Beneficiary* covered under this continuation provision is determined by the United States Social Security Administration to have been disabled at the time or any time within the first 60 days following the Qualified Event, the coverage can be extended for an additional 11 months (for a total of 29 months after the continuation starting date). You must provide a copy of the disability award to the Watkins Employee Benefit Department within 18 months after termination of employment.

Second Qualifying Event

If the original Qualifying Event was due to your termination or reduction in hours, and a *Qualified Beneficiary* experiences a second Qualifying Event such as a divorce or ceasing to be a dependent, coverage may be extended for a maximum of 36 months from the original Qualifying Event date. You must notify the Watkins Employee Benefits Department within 60 days of the second Qualifying Event.

Medicare

If a former employee becomes entitled to Medicare during the 18 month continuation period, the employee's dependent's coverage may be extended for a maximum of 36 months from the original Qualifying Event date. You must notify the Watkins Employee Benefits Department within 60 days of the second Qualifying Event. In addition, if you become entitled to Medicare and then have a qualifying event that is a termination of or reduction in hours of employment within 18 months, your dependent covered on the date of the termination of employment or reduction in hours will be eligible for 36 months of COBRA coverage beginning on the Medicare entitlement date.

ELECTING COBRA COVERAGE

Qualified Beneficiaries will be notified in writing of their eligibility for continued coverage and of the election procedures. In order to obtain continued coverage, *Qualified Beneficiaries* must follow all instructions sent with the notice of eligibility. Generally, *Qualified Beneficiaries* will have 60 days from the date of notice to elect continued coverage. During this 60-day election period, the qualified beneficiaries must decide if they intend to continue their coverage by agreeing to pay the premiums on a monthly basis. Each *Qualified Beneficiary* has a separate right to elect COBRA coverage.

PAYMENTS FOR COBRA COVERAGE

The first premium is due within 45 days of your election. Subsequent payments for continued coverage are payable monthly in advance and are due by the first of each month. COVERAGE WILL TERMINATE WITHOUT REINSTATEMENT PRIVILEGES IF PAYMENT HAS NOT

BEEN RECEIVED BY THE WATKINS EMPLOYEE BENEFITS DEPARTMENT WITHIN 30 DAYS OF THE FIRST OF EACH MONTH. Watkins Employee Benefits Department will not send you payment reminders or overdue notices.

TERMINATION OF COBRA COVERAGE

The continuation coverage will terminate immediately if any one of the following occurs:

a The *Qualified Beneficiary* fails to pay the first premium within 45 days of the date of the initial coverage election and thereafter within 30 days of each monthly due date.

b. The *Qualified Beneficiary* becomes, after electing COBRA coverage, covered under another group health plan that does not limit coverage for *Pre-existing Condition*s, or any pre-existing condition period imposed by the other plan is satisfied by a Certificate of Coverage.

c. The *Qualified Beneficiary* becomes entitled to Medicare or Medicaid benefits after electing COBRA coverage.

CAN THE PLAN BE AMENDED OR TERMINATED?

The Plan has been established with the intention of being maintained indefinitely. However, the *Company*, through action of the Administrative Committee, reserves the right to amend or terminate the Plan in whole or in part at any time for any reason or for no reason. Retiree benefits can also be amended or terminated in the same manner. Nothing in this Booklet or the Plan is intended to provide vested or nonchangeable benefits.

DEFINITIONS

The following terms are used in this booklet and have the meanings set forth below:

1. *Accredited Institution* means a primary or secondary school that is accredited by the state board of education, or a junior college, college or university accredited by a nationally recognized educational organization.

2. *Annual Enrollment Period* means the period from November 1 through November 30 of each year during which eligible employees may make changes to their elections for the next *Plan Year*.

3. *Claim Appeal* means any dispute or disagreement you have with the operation of the Plan (or any of its component parts) including but not limited to partial payment or nonpayment of benefits.

4. *Company* means Watkins Associated Industries, Inc.

5. *Creditable Coverage* means a period of prior medical or health coverage under a group health plan or individual health insurance, including Medicare, Medicaid, medical coverage provided under Chapter 55 of Title 10 of the United States Code (medical and dental coverage for certain family members and former members of the armed services), a medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool, the Federal Employee Health Benefit Program, a public health plan, or health benefit plan under Section 5(e) of the Peace Corps Act. *Creditable Coverage* does not include health plan coverage that provides "excepted benefits" as defined in ERISA Section 732(c). You will not receive credit for *Creditable Coverage* accumulated before a 63 (or more) day period during which you do not have coverage.

6. *Dentist* means a person legally licensed as a dentist (or equivalent designation) under the laws of the state in which a covered expense is incurred to the extent that the services rendered are within the scope of his or her license.

7. *Eligible Employee* means an individual who is classified by a *Participating Employer* as a full-time common-law employee and who (i) is scheduled to work with that *Participating Employer* 30 or more hours per week and (ii) satisfies the applicable *Waiting Period*. Individuals classified by a *Participating Employer* as "independent contractors", "leased employees", "seasonal employees" or "peak employees" are not *Eligible Employees* under this Plan even if they are regularly scheduled to work 30 or more hours per week. If you were originally classified as an "independent contractor" or other non-eligible classification, and you are subsequently reclassified, you will only be able to participate prospectively.

8. *Initial Enrollment Period* means the period following your full time hire date during which you must make an election to participate in the Plan. Your employer will notify you of the applicable *Initial Enrollment Period*.

9. *Life Event* means any one of the following events that result in your and/or your dependents' gain or loss of eligibility under either this Plan or a plan of your *Spouse's* or eligible dependent's employer:

   (i) a change in the eligible employee's legal marital status (including marriage, death of the *Spouse*, divorce, legal separation, or annulment);

   (ii) a change in the eligible employee's number of tax dependents (including birth, adoption or placement for adoption of a dependent, or death of a dependent);

   (iii) any change in employment status of the *Eligible Employee*, the *Eligible Employee's Spouse* or the *Eligible Employee's* dependents that affects benefit eligibility under a cafeteria plan (including this Plan) or other health benefit plan of the employer of the *Eligible Employee*, the *Spouse*, or dependents. Such events include: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or part-time to full-time or vice versa; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;

   (iv) an event that causes an *Eligible Employee's* dependent to satisfy or cease to satisfy the dependent eligibility requirements for a particular benefit, such as attaining a specified age, getting married, ceasing to be a student, or any similar circumstance provided by the applicable plan; and

   (v) a change in the place of residence of the *Eligible Employee*, the *Eligible Employee's Spouse*, or the *Eligible Employee's* dependent.

10. *Medically Necessary* means a service or supply that it is determined by the Claims Administrator, in its sole discretion, to be required for the diagnosis, care or treatment of a disease, injury, condition or pregnancy in accordance with generally accepted medical or dental practice. To be medically necessary, a service or supply must also be:

   - care or treatment that is as likely to produce as significant a positive outcome as any alternative service or supply, with respect to both the disease or injury and to the person's overall health.

- a diagnostic procedure, indicated by the health status of the person, that is as likely to result in information that could affect the course of treatment as any alternative service or supply with respect to both the disease or injury and to the person's overall health.
- diagnosis, care, and treatment, that is no more costly than any alternative service or supply that meets the above test.

11. *Participant Share* means the portion of your expense that you are required to pay after you have first satisfied your deductible.

12. *Participating Employer* means the *Company* and any other entity who has been authorized by the *Company* to adopt the Plan and has adopted this Plan in order to allow Eligible Employees employed by the entity to participate in the Plan. A list of *Participating Employers* is provided in the Information section at the end of this Booklet.

13. *Physician* means a person legally licensed as a physician, doctor or equivalent designation under the laws of the state in which the treatment is delivered, but only to the extent that the services rendered are within the scope of his/her license.

14. *Plan Share* means the amount the *Company* pays towards the cost of a service after you have satisfied the applicable deductible.

15. *Plan Year* means the period from January 1 through December 31 of each year.

16. *Pre-authorization* is required in advance of all inpatient confinements. Your provider, and the facility must call Intracorp before a planned admission, or within 48 hours of an emergency admission. Failure to get a *Pre-authorization* may result in the *Plan Share* of benefits being reduced to 60% (40% for out of network hospitals).

17. *Qualified Beneficiary* means any person who is, as of the day before a Qualifying Event, covered under the Plan and is (a) an employee of the employer ("Covered Employee") (b) the *Spouse* of the Covered Employee, or (c) a dependent child of the Covered Employee. A child born to or placed for adoption with a Covered Employee during continuation coverage will also be a *Qualified Beneficiary*.

18. *Qualifying Individual* means, for purposes of the Dependent Care Reimbursement Option, a child age 12 or under for whom you are entitled to a personal tax exemption as a dependent (as defined by the Code) and who resides with you. If the child resides with you and you would otherwise qualify for the personal tax exemption for the child, but you have agreed to allow a former *Spouse* to take the exemption, the child is still a *Qualifying Individual* with respect to you. In addition, a *Qualifying Individual* may be a *Spouse* or other tax dependent (as

described under Code Section 152) who is physically or mentally incapable of caring for himself or herself.

19. *Spouse* means an individual of the opposite sex to whom you are legally married under the laws of your state of residence. However, Common Law marriages are not recognized under the Plan even if recognized under applicable state law.

20. *U&C Limit* means usual and customary limit which is the charge that is the lower of the health care provider's usual charge or the prevailing fee for a service or supply in your geographic area, as determined by the Claims Administrator.

21. *Waiting Period* means the number of days of continuous employement that you must complete before you become eligible to participate in the Plan. The *Waiting Period* may vary by *Participating Employer* and you will be notified by your Human Rsource Department of the applicable *Waiting Period* when you are hired.

INFORMATION ON PLAN ADMINISTRATION

Name of Plans:	The Watkins Associated Industries, Inc. Group Health Plan. The plan is an employee welfare benefit plan as defined in ERISA Section 3(1). The Watkins Associated Industries, Inc. Flexible Spending Account Plan.
Employer EIN Number:	58-1902037
Plan Number:	Group Heal Plan - 501 Flexible Spending Account Plan - 502
Plan Sponsor:	Watkins Associated Industries, Inc.
Plan Administrator:	The Administrative Committee is the "Plan Administrator" as defined in ERISA.
Funding:	The Group Health Plan is funded by contributions to a trust that are made by the *Company* and by participating employees. The funds held in trust are used to pay medical, dental, vision and prescription benefits. The Flexible Spending Account Plan is funded with pre-tax employee contributions and benefits for the Health Care Reimbursement Option and Dependent Care Reimbursement Option are paid from the employer's general assets.
Agent for Service Process:	The Plan Administrator is the agent for service of legal process.
Trustee:	The Administrative Committee serves as the Trustee of the Trust for the Group Health Plan.
Plan Year:	The *Plan Year* is the calendar year.

Participating Employers:

Highway Transport, Inc.
LandSpan, Inc.
Navaho Western Land Company, Inc.
Radio Training Network
Sunco Carriers, Inc.
Tampa Maid Foods, Inc.
The Groves
Tucker Door and Trim Corp, Inc.
WACO Fire and Casualty Co., Inc.
Watkins Associated Developers, Inc.
Watkins Associated Industries
Watkins Motor Lines, Inc.
WILWAT Properties, Inc.

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:

Receive Information About Your Plan and Benefits

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, 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 Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreement, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 the 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 from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Plan 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 $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

CONTACTS

The following is a list of applicable addresses, telephone numbers, and/ or web sites.

Plan Sponsor

Watkins Associated Industries, Inc.
P.O. Box 1738
Atlanta, GA 30301-1738

Administrative Committee (Plan Administrator)

Watkins Associated Industries, Inc.
ATTN: Administrative Committee
P.O. Box 1738
Atlanta, GA 30301-1738
(404) 873-2939
(800) 333-3841

Claims Administrator

For medical, dental and vision benefits:

Watkins Associated Industries, Inc.
ATTN: Watkins Employee Benefits Department
P.O. Box 1738
Atlanta, Georgia 30301-1738
(404) 873-2939
(800)-333-3841

The Watkins Employee Benefits Department is available to assist you with questions from 9:00 a.m. to 4:30 p.m. EST Monday through Thursday, and 9:00 a.m. to 4:00 p.m. on Friday.

Claims Administrator for Prescription Drug Benefits

Advance PCS
9501 East Shea Boulevard
Scottsdale, AZ 85260-6719
1-800-966-5772

Pre-authorization and Care Management

Intracorp, Inc.
Two Liberty Place
TLP-11
1601 Chestnut Street
Philadelphia, PA 19192
1-800-291-5901

Network Contacts

To find a medical provider:

Sign on to www.aetna.com/docfind and follow the on-line instructions. When prompted, select the Open Choice PPO as your plan type. You may also call your local Human Resource or Benefits Department, or Watkins Employee Benefits at 800-333-3841 or 404-873-2939 for assistance.

To find a dental provider:

Sign on to www.ppousa.com
Call Connection Dental at 877-277-6872

To find a vision provider:
Sign on to www.cmvc.com
Plan Number: 47081
Call Vision One at 1-800-804-4384

To find a participating pharmacy or to refill a mail order drug:
Sign on to www.advancerx.com
Call 800-966-5772

Participating Companies

Highway Transport, Inc.
ATTN: Human Resources Department
P.O. Box 50068
Knoxville, TN 37950-0068
1-800-444-9814
www.hytt.com

Tampa Maid Foods, Inc.

ATTN: Human Resources Department
P.O. Box 3709
Lakeland, FL 33805-3709
(800) 237-7637
www.tampamaid.com

Tucker Door and Trim Corp. Inc.
ATTN: Human Resources Department
650 Highway 83
Monroe, GA 30655
(770) 267-4622

Watkins Motor Lines, LandSpan, Inc., The Groves and Sunco
ATTN: Benefits Department
P.O. Box 95007
Lakeland, FL 33805-5007
(888) 552-6215
www.watkins.com

Watkins Associated Industries
Watkins Payroll System, Inc.,
Watkins Associated Developers, Inc.
WILWAT Properties, Inc.
Radio Training Network
ATTN: Human Resources Department
P.O. Box 1738
Atlanta, GA 30301-1738
(404) 873-2939
800-333-3841

WACO Fire and Casualty Co., Inc..
6555 B McDonough Drive
Norcross, GA 30093
(404) 873-2939