Hoss's Steak and Sea House Insured Welfare Plan

And

Summary Plan Description

Amended and Restated
Effective January 1, 2005

Hoss's Restaurant Operations

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended, and summarizes the welfare benefits offered under the Hoss's Steak and Sea House Insured Welfare Plan.

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GENERAL INFORMATION ABOUT THE PLAN

Employer Name:	Hoss's Steak and Sea House
Plan Name:	Hoss's Steak and Sea House Insured Welfare Plan
Employer Address:	170 Patchway Road Duncansville, PA 16635-8431
Employer's Telephone Number:	814-695-7600
Plan Number:	501
Plan Year – Medical Benefits:	January 1 to December 31
Plan Year – Short and Long Term Disability:	June 1 to May 31
Plan Year – Life & AD&D:	January 1 to December 31
Employer's Federal Tax Identification Number:	25-1504612
Plan Sponsor:	Hoss's Steak and Sea House 170 Patchway Road Duncansville, PA 16635-8431
Plan Administrator:	Hoss's Steak and Sea House 170 Patchway Road Duncansville, PA 16635-8431 Attention: Human Resources Department
Agent for Service of Legal Process:	Director of Human Resources Hoss's Steak and Sea House 170 Patchway Road Duncansville, PA 16635-8431 Service for legal process may also be made on the Plan Administrator
Funding Medium and Type of Plan Administration:	Benefits under the Plan are fully-insured. The medical program (including drugs) is fully insured by Highmark Blue Cross Blue Shield. Dental benefits are fully insured by United Concordia and vision benefits are

insured by Opti-Choice. Long-term disability, short-term disability programs are fully insured by Educators Mutual Life Insurance Company, group term life and AD&D programs are fully insured by Harleysville Insurance Company. The Employee Assistance Plan (EAP) is administered through The Lytle Group. The insurance companies, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies for administering these program benefits.

Insurance premiums for employees and their eligible family members are paid in part by the Company out of its general assets and in part by employees' pre-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the component benefit programs, as applicable. A schedule of required employee pre-tax contributions for the current Plan Year is found as an Attachment to this document.

DEFINITIONS

AD & D means accidental death and dismemberment insurance.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means the Internal Revenue Code of 1986, as amended.

Company means Hoss's Steak and Sea House and its successors in interest, the sponsor of this Plan.

Eligible Employee means any individual employed by the Employer as a common law employee.

Employee means an employee of Hoss's Steak and Sea House.

Employer means the Company, any of its Affiliates, and any other persons, firms, or organizations that have expressly adopted this Plan with the consent of the Company.

Enrollment Period means such period of time prior to the beginning of the Plan Year as may be specified by the Administrator and communicated to Eligible Employees during which Eligible Employees and Participants may elect, or reject, to participate in the Plan, provided however, that with the exception of the initial plan year such period shall be no less than the 30 day period beginning on the first day of the last month of the Plan Year.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Health Insurance Policy means the Policy providing such health insurance coverage to Employees as may be agreed upon between the Employer and Insurer.

Health Insurance Program means the insured welfare benefit plan sponsored by the Employer providing such medical and similar benefits.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Insurer means any insurance company selected by the Employer to provide component benefit coverage. The Employer may change insurance companies from time to time and at any time without the prior notice to or necessity of consent of any Employee or Participant. Any dividends, retroactive rate credits or other refunds which may become payable under any agreement with an Insurer shall be retained by the Employer.

Mid-Year Change - Life Event means, and is limited to: (a) a change in an Employee's marital status; (b) the addition of an Employee's dependent; (c) loss of a dependent of an Employee (2) remaining dependents; (d) commencement or termination of employment by an Employee's spouse and gain or loss of health coverage by an Employee's spouse under employee welfare

benefit plans sponsored by the spouse's employer; (3) termination of employment by an Employee; (f) status change from full to part time or part to full time by an Employee or spouse and the subsequent gain or loss of health coverage by the Employee or spouse; or, (g) a significant change in the health coverage of an Employee or spouse due to such coverage attributable to the spouse; (h) a change in the residence of the participant, or the participant's spouse or dependent.

NMHPA means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

Participant means an Eligible Employee who has met the requirements of component benefit in the Plan and participates in the Plan.

Plan means Hoss's Steak and Sea House Insured Welfare Plan.

Plan Administrator means the Administrative Committee or its designee.

Plan Year means the period beginning and ending on January 1 to December 31st or June 1st to May 31st for disability benefits.

Policy means the Health Insurance Policy and any other group insurance contract maintained by Hoss's Steak and Sea House for the benefit of Employees.

Qualified Beneficiary Under COBRA means an individual, on the day before a COBRA Qualifying Event, is a spouse or dependent child of an Employee and who is covered under the Health Insurance Program. In the case of a Qualifying Event, Qualified Beneficiary means an individual who on the day before the Qualifying Event, is an Employee.

Qualifying Event Under COBRA means any of the following events: (a) death of an Employee; (b) the voluntary or involuntary termination (other than by reason of gross misconduct) of an Employee; (c) a change in an Employee's status to a part-time Employee; (d) divorce or legal separation of an Employee from his or her spouse; (e) an Employee's commencement of entitlement to coverage under Medicare or a similar governmental benefit plan; (f) a dependent child ceasing to be a dependent child under the terms of the Employer's Health Insurance Policy.

Salary Reduction means a separate written authorization of the Employee to have his or her after-tax salary reduced in exchange for the Employer making equivalent pre-tax contributions on the Employee's behalf directly to the Insurer to pay for the level of health insurance coverage elected by the Employee for himself and his dependents under the Health Insurance Program. The maximum Employer pre-tax contributions which can be made hereunder in consideration of a Salary Reduction cannot exceed the cost of the level of coverage elected by the Participant under the Health Insurance Program reduced by any Employer Non-Elective Contribution.

WHCRA means the Women's Health and Cancer Rights Act of 1998, as amended.

INTRODUCTION

Hoss's Steak and Sea House Insured Welfare Plan is an employee welfare benefit plan within the meaning of Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and Hoss's Steak and Sea House is the Plan sponsor. If you are eligible to participate in the Plan, you may participate in one or more of the following component plans:

- Hoss's Steak and Sea House Medical Plan ("Medical Plan")
- Hoss's Steak and Sea House Dental Plan ("Dental Plan")
- Hoss's Steak and Sea House Vision Plan ("Vision Plan")
- Hoss's Steak and Sea House Group Life and AD&D ("Life Insurance Plan")
- Hoss's Steak and Sea House Short-Term Disability Insurance Plan ("STD Plan")
- Hoss's Steak and Sea House Long-Term Disability Insurance Plan ("LTD Plan")

The purpose of the Plan is to provide Employees of the Employer with the opportunity to choose among those benefits available to them under the Plan. As well as to allow eligible employees to contribute towards medical and/or certain other coverages under the program on a "pre-tax" basis, through salary reduction.

Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another governing document prepared by the insurance company. A copy of each booklet, summary or other governing document can be found on Hoss's Website www.hosspeople.com and can also be obtained from the Plan Administrator.

This document and its Attachments constitute the summary plan description for each of the component plans as required by ERISA Section 102.

GENERAL

Eligibility, Enrollment and Participation

Eligibility

Hoss's Restaurant Operations

An eligible employee with respect to the Plan will either be a salaried manager, a designated full-time employee, or a part-time employee of Hoss's Steak and Sea House. Based on the eligibility requirements listed below, employees may be able to receive benefits under one or more of the component benefit programs. Your dependents may be eligible to participate in the Plan, as described in the attached booklet(s). You may contact the Human Resources Department if you have any questions regarding your eligibility. A summary of this information is set forth below.

Salaried Manager is a member of the management team who is paid on a salaried basis.

Designated Full-Time Employee is an employee who is paid an hourly wage who is designated as a full-time employee by the General Manager. Designation is based on factors including performance, availability, and business necessity. Designated Full-Time Employees work an average of 36 hours or more per week in a 12-month period.

Part-Time Employees are employees with six months of service and an average of 20 hours per week six months prior to annual open enrollment.

Component Benefit	When Participation Begins
Management and Full Time Employees	
Medical (including drugs)	1st of the month following 60 day probationary period or at annual open enrollment
Dental	1st of the month following 60 day probationary period or at annual open enrollment
Vision	1st of the month following 60 day probationary period or at annual open enrollment
Group Term Life Insurance and AD&D	1st of the month following 60 day probationary period or at annual open enrollment
Management	
Group Long Term Disability	1st of the month following 60 day probationary period or at annual open enrollment
Group Short Term Disability	1st of the month following 60 day probationary period or at annual open enrollment

Part Time Employees	
Dental	Annual open enrollment
Vision	Annual open enrollment

If you are rehired within 30 days after your termination date and meet the same eligibility requirements at rehire, you will be required to reinstate your elections under the Cafeteria Plan as such elections were in effect as of your termination date, as determined by the Plan Administrator. If you are rehired after 30 days, all employment eligibility requirements apply.

If both you and your spouse are eligible employees of Hoss's Steak and Sea House, you may be covered under the Plan as an eligible employee or as a dependent of your spouse. Your dependent children may be covered under the Plan either by you or your spouse, but not both.

Generally, you cannot change your election to participate in the medical, dental or, vision component of the Plan or vary the salary reduction amounts you have selected during the Plan Year (known as the irrevocability rule). Your election will terminate if you are no longer working for the Employer. Of course, you can change your elections for benefits and salary reductions at annual open enrollment in February with an effective date of April 1st for medical, dental, and vision.

There are several important exceptions to the irrevocability rule, known as *Change in Election Events*. "Change in Election Events" include the following events, as more fully described below: FMLA leave, Change in Status, certain judgements, decrees and orders; Medicare and Medicaid: Change in Cost, and Change in Coverage. However, the Change in Election Events applies only to medical, dental and vision benefits.

If a Change in Election Event (including a Change in Status) occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days of the occurrence.

1. FMLA Leave. You may change an election under the Plan upon FMLA leave.

2. Change in Status. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:

- A change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation or annulment). *"Spouse"* means the person who is legally married to you and is treated as a spouse under the Internal Revenue Code *(Code)*;
- A change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). *"Dependent"* means your tax dependent under the Code:

- Any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility including (this Plan or other employee benefit plan of you, your Spouse, or your Dependents). Such events include any of the following changes in employment status, termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave absence, a change in work site, switching from salaried to hourly paid, union to non-union, or full-time to part-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 benefit;
- An event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a benefit (such as attaining a specified age, student status, or similar circumstance); and
- A change in your, your Spouse's or your Dependent's place of residence.
- **Change in Status-Other Requirements**. If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a change in Status event if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For accident and health benefits (here, the medical insurance under the Health Insurance Plan), a special rule governs which type of election changes are consistent with the Change of Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

  Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee -plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year. Sharon loses eligibility for coverage under the Plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no health coverage. The health coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse or your Dependent gains eligibility for coverage under another employer's cafeteria plan (qualified benefit plan) as a result of a change in your marital status

or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

- **3. HIPAA Special Enrollment Rights.** If you, your Spouse or a Dependent is entitled to special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) under a group health plan, you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in your Employer's Health Insurance Plan for yourself or your eligible Dependents because of medical coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (that is, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage, provided that you request enrollment within 30 days after the applicable event. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly-acquired Dependent, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- **4. Certain Judgements, Decrees and Orders**. If a judgement, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under the Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child.
- **5. Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage under the Health Insurance Plan. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.
- **6. Change in Cost.** If the Administrator notifies you that the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if there is no option available under the Plan that provides similar coverage; (d) coverage under another employer plan, such as a Spouse's or Dependent's employer, is treated as similar coverage. For insignificant increases or decreases in the cost of benefits, however, the Administrator will automatically adjust your election contributions to reflect the minor change in cost.
- **7. Change in Coverage.** You may also change your election for the Plan if one of the following events occurs:
- *Significant Curtailment of Coverage.* If the Administrator notifies you that your coverage under the Plan is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible), then you may revoke your election and elect coverage under the plan of your Spouse's employer that provides similar coverage. If the Administrator notifies you that your coverage under the Plan is significantly curtailed with a loss of benefit coverage, you may elect similar coverage under the plan of your Spouse's employer, or drop

coverage but only if there is no option available under the plan that provides similar coverage.

- *Addition or Significant Improvement of Plan Option.* If the Plan adds a new option or significantly improves an existing option, the Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Administrator may permit eligible Employees to elect the new option on a prospective basis, subject to limitations imposed by the component Plan.
- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse or Dependent, if any of you loses coverage under any group health coverage sponsored by a government or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (Including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your Spouse during his/her employer's open enrollment to drop coverage, you may add coverage to replace the dropped coverage.

Qualified Medical Child Support Orders

With respect to component benefit plans that are group health plans, Hoss's Steak and Sea House Insured Welfare Plan will also provide benefits as required by any qualified medical child support order, or "QMCSO" (defined in ERISA Section 609(a)). The Plan will provide benefits to dependents children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries, in accordance with ERISA Section 609(c).

In order for this Plan to recognize a Qualified Medical Child Support Order it must satisfy the following criteria:

1. It must be a judgment, decree or other court order relating to health benefits coverage for a dependent Child of a covered Employee; and
2. The order must specify:
    a. the name and address of the Employee or their designee;
    b. the name and mailing address of each dependent child covered by the order;
    c. a reasonable description of the type of coverage afforded by the Plan;
    d. a beginning period for which the order applies; and
    e. the name and address of each Dependent child, which means the spouse, former spouse, legal guardian of the dependent child or the child of an Employee.

Upon receipt of a medical child support order, the Plan Administrator shall promptly notify the Employee and dependent child. The Plan Administrator shall determine whether an order received meets the criteria and promptly notify the Employee an each dependent child. In the event of a dispute regarding any medical child support order furnished to the Plan Administrator, the Employee or dependent child shall promptly notify the Plan Administrator in writing.

Coverage shall commence on the date specified in the order.

Any order that requires this the Hoss's Steak and Sea House Insured Welfare Plan to provide any type of benefit or increased benefits not otherwise provided by this Plan, other than under COBRA, will not be recognized as a Qualified Medical Child Support Order.

Questions regarding procedures for determining whether an order qualified as a QMCSO can be directed to the Plan Administrator.

Family Medical Leave Act of 1993 (FMLA)

If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA) the Company will continue to maintain your Benefit Package Options providing health coverage on the same terms and conditions as though you were still active (e.g., the Company will continue to pay its share of the contribution to the extent you opt to continue coverage).

In the event of unpaid FMLA leave, if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave (or pre-tax dollars to the extent you receive compensation during the leave). In the event of unpaid leave, you will be invoiced for the amount of your premium contribution until your return to work.

If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions or request to cancel), you will be permitted to re-enter the Plan at the next open enrollment.

Procedures and guidelines for the Family Medical Leave Act can be obtained from the Plan Administrator.

Plan Administration, Coverage and Contributions

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Human Resources Department has been designated to act on behalf of the Plan Administrator.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedure, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

The Company will bear its incidental costs of administering the Plan.

Power and Authority of Insurance Company

Benefits under the Plan are fully insured or provided by contract with an insurance company. The insurance companies are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit plans, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

Required Contributions for Coverage

As of the date of this SPD:

Hoss's pays the entire cost of eligible participant's coverage under the following:

- Group Term Life & AD&D
- Short Term Disability
- Long Term Disability

Eligible participants are responsible for a portion (as determined by Hoss's in its sole discretion) of coverage elected under the following:

- Medical

Eligible participants are responsible for the entire cost of any coverage you elect under the following:

- Dental
- Vision

Additionally, you or your spouse, former spouse, or dependents are required to pay for any continued coverage under the Medical, Dental and Vision Plan after a qualifying event, as described in the section entitled, "COBRA Rights," below.

Paying for Coverage

Generally, you pay for coverage you elect under the Plan by requesting that Hoss's deduct amounts from each of your paychecks throughout the year (other than coverage described in the sections entitled, "COBRA Rights," below). A summary of your premium contribution requirement can be found in Attachment 1.

In the event your compensation is not sufficient to cover the cost of benefits, after-tax dollars will be used to fund the cost of those benefits.

Questions

If you have general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under the fully insured component benefit plans, please contact the appropriate insurance company.

Termination of Participation in the Plan

Your participation and the participation of your eligible family members in the Plan will terminate on the last day of the month in which you terminate your employment for medical, vision, dental and group term life insurance. You have a right to convert your group term life insurance coverage to an individual policy within 30 days of the date of your termination of employment. Please see your Plan Administrator for details regarding the conversion privilege. Short and long term disability benefits will end on your last day of employment. Additionally, if you do not elect certain benefits during an open enrollment or special enrollment period, you will not participate in the Plan with respect to such benefits. Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below any required hourly threshold, if you submit false claims or for any other reason as set forth in the benefit summaries or other governing documents for the component benefit program. However, you may be eligible to continue participation in the Plan with respect to group health plan coverage governed by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") if you would otherwise lose such coverage, as described in the section entitled "COBRA Rights," below.

If your coverage under the medical, dental and vision plans ends, you will receive written certification of your prior coverage under the medical, dental and vision plan, to the extent required by law in the form of a Certificate of Creditable Coverage from the insurance company, and upon your request. If you terminate employment or otherwise stop participating in the Plan, you may submit claims for covered events that occurred, or expenses that were incurred, on or before the date your participation in the Plan terminated by following the procedures described in the section entitled "Claims Procedures".

COBRA Rights – Medical, Dental and Vision Only

A federal law known as COBRA requires Hoss's to offer a temporary extension of health coverage to employees and their family members in certain circumstances where coverage would otherwise end. This section summarizes your rights and obligations regarding COBRA Coverage. You and your family members should take the time to review this section of the SPD carefully.

What is COBRA Coverage?

If you or your family members were covered under the Medical, Dental and Vision Plans immediately before a "qualifying event," as described in the section entitled "Who is Covered by COBRA," below, each covered person might be entitled to elect to continue coverage under these plans for a specified period of time at his own expense; this is COBRA Coverage. For example, if you participate in the Medical, Dental or Vision Plan, your participation ends on the date you terminate employment with Hoss's, unless you are eligible for, elect and pay for COBRA Coverage.

Who is Covered by COBRA?

Employees. If you are an employee of Hoss's and are covered by the Medical, Dental or Vision Plan immediately before a "qualifying event," you are a "covered employee" and have a right to pay for continued coverage if you would otherwise lose coverage under the Medical and Dental Plan as a result of the following "qualifying events":

- a reduction in your hours of employment, except for a reduction in hours in connection with Family and Medical Leave;
- the termination of your employment with Hoss's for reasons other than gross misconduct on your part; or

- Spouses of employees. If you are the spouse of a Hoss's employee and are covered under the Medical, Dental or Vision Plan immediately before a "qualifying event," you are a "qualified beneficiary" and have the right to pay for continued coverage if you would otherwise lose coverage under the Medical, Dental or Vision Plan as a result of any one of the following "qualifying events":
  - death of your spouse;
  - your divorce from the covered employee;
  - reduction in your spouse's hours of employment with Hoss's, except for a reduction in hours in connection with Family and Medical Leave;
  - termination of your spouse's employment with Hoss's for reasons other than gross misconduct;

- your spouse becomes enrolled in Medicare; or

Dependent children of an employee. If you are the dependent child of a Hoss's employee and are covered under the Medical, Dental or Vision Plan immediately before a "qualifying event," you are a "qualified beneficiary" and have the right to pay for continued coverage if you would otherwise lose coverage under the Medical, Dental or Vision Plan as a result of any one of the following "qualifying events":

- death of your parent who is a Hoss's employee;
- reduction in your parent's hours of employment with Hoss's, except for a reduction in hours in connection with Family and Medical Leave;
- termination of your parent's employment with Hoss's for reasons other than gross misconduct;
- your parents' divorce or legal separation;
- your parent who is a Hoss's employee becomes enrolled in Medicare;
- you cease to be a "dependent" of a Hoss's employee, as determined under the Medical, Dental or Vision Plan; or

A child born to or placed for adoption with a covered employee during a COBRA Coverage period also is a "qualified beneficiary," if the child is a dependent of the covered employee, as determined under the Medical, Dental or Vision Plan; the child's COBRA Coverage period will end on the same date as coverage ends for the covered employee.

What is the Maximum COBRA Coverage Period?

The nature of the qualifying event determines the maximum length of your COBRA coverage period under the Medical, Dental or Vision Plan, as described below:

Qualifying Event (If Coverage is Lost)	Maximum Coverage Period
Employee's reduced work hours, except for a reduction in hours in connection with Family and Medical Leave	18 months
Employee's termination (except for gross misconduct) or retirement	18 months
Employee's death	36 months
Divorce or legal separation of the employee and spouse	36 months
Dependent child's loss of eligibility (for example, by reaching the age limit, no longer being a full-time student, getting married or becoming a full-time employee)	36 months

Dependent's loss of coverage because employee enrolls in Medicare	36 months

Second qualifying event. If the occurrence of a qualifying event entitles you or your family members to 18 months of continuation coverage and a second qualifying event occurs during the initial 18-month COBRA Coverage period, COBRA Coverage may be extended for an additional 18 months, for an aggregate of 36 months measured from the date of the first qualifying event, as determined by the Plan Administrator and subject to the notification requirements described below.

Disability. If you are a covered employee or qualified beneficiary who is eligible for 18 months of COBRA Coverage under the Medical, Dental or Vision Plan, that coverage may be extended for an additional 11 months if you are determined by the Social Security Administration to have been disabled during the first 60 days of COBRA Coverage, provided that you or your qualified beneficiaries follow the notification requirements described below.

Conversion. If the Medical, Dental or Vision Plan offers individual conversion policies when your COBRA Coverage expires (other than as a result of the occurrence of an event described in the section entitled "When Does COBRA Coverage Terminate?" below), you may be offered the option of purchasing an individual conversion policy.

What Notification Requirements Apply to COBRA Coverage?

COBRA Eligibility. In the event that (i) your hours are reduced or your employment with Hoss's is terminated, (ii) you die while employed by Hoss's (iii) you become enrolled in Medicare, or (iv) Hoss's commences certain bankruptcy proceedings, the COBRA Administrator notifies you and other qualified beneficiaries (within 14 days after receiving notice from the Plan Administrator) of any rights to elect COBRA Coverage.

Under COBRA, you or your family members are required to notify the Plan Administrator (at the address in the section entitled "Plan Administrator and Plan Information,") of the divorce or legal separation of a covered employee, or if your child loses dependent status under the Medical, Dental or Vision Plan; this notice must be provided within 60 days after the later of the date of the qualifying event or the date a qualified beneficiary would lose coverage under the Plan on account of the qualifying event. If the notice described in the preceding sentence is not provided to the Plan Administrator, the Plan might not be required to offer COBRA Coverage in connection with the qualifying event. A covered employee and each qualified beneficiary will have 60 days to elect COBRA Coverage; this 60-day period begins on either the date coverage would otherwise be lost or the date the notice of the right to elect continuation coverage was sent, whichever is later.

Second qualifying event. If a second qualifying event that is the divorce or legal separation of a covered employee or an individual's ceasing to satisfy the definition of "dependent" under the Medical, Dental or Vision Plan occurs during the initial 18-month COBRA Coverage period, you or your family members must notify the COBRA Administrator within 60 days after the occurrence of such qualifying event. See the section entitled "What is the Maximum COBRA

Coverage Period?" above regarding extended coverage in connection with a second qualifying event. If a second qualifying event occurs during a disability extension, as described below, COBRA Coverage may be extended for an aggregate of 36 months measured from the date of the first qualifying event and you may be charged 150% of the cost of coverage for the 19th through the 36th month of COBRA Coverage.

Disability. If you have been determined to be disabled by the Social Security Administration, you must provide to the COBRA Administrator a written copy of the disability determination from the Social Security Administration not later than (i) 60 days after the date of the disability determination, or (ii) the last day of the 18-month COBRA Coverage period, whichever occurs first.

If, during the COBRA Coverage period, the Social Security Administration determines that you are no longer disabled, you must notify the COBRA Administrator of this determination in writing within 30 days after the determination is made.

How Much Does COBRA Coverage Cost?

You or your qualified beneficiaries must pay the "cost of coverage" plus a 2% administrative fee for COBRA Coverage. However, during an extension of coverage for disability (as described below), you and your qualified beneficiaries may be required to pay 150% of the "cost of coverage" under the Medical, Dental and Vision Plans. The "cost of coverage" under the Medical, Dental and Vision Plans is the total of the employer-paid portion and the employee-paid portion of premiums. The COBRA Administrator will notify you and other qualified beneficiaries of the amount of COBRA Coverage premiums. You will be notified if Hoss's designates a different COBRA Administrator.

Once your COBRA Coverage is active, you must make your scheduled premium payments on time. If you fail to make a scheduled payment on time, you will have a 30-day grace period in which to pay your premium. If you do not make your payment by the time the grace period ends, your COBRA Coverage will be cancelled and cannot be reinstated.

When Does COBRA Coverage Begin?

Your first premium payment for COBRA Coverage is due within 45 days after you elect to receive the coverage. You will not be covered under the Medical, Dental and Vision Plan if timely payment is not received. Generally, when your first timely premium payment is received by the administrator, your COBRA Coverage will be retroactive to the date you would otherwise have lost group health coverage; the date of coverage may be different, however, if you waived and revoked a waiver of COBRA Coverage during the election period. If you wish, you may enclose your first premium payment with your completed COBRA election form to ensure that you have no lapse in coverage.

What Are My Coverage Options Under COBRA?

Medical, Dental and Vision Plans. Generally, your elections under the Medical, Dental and Vision Plans at the time of a qualifying event determine the coverage you and your qualified

beneficiaries will have for the remainder of the plan year (or the end of the COBRA Coverage period, if earlier). During open enrollment, COBRA continuees may change coverage under the Medical, Dental and Vision Plan in the same manner as active employees. If you move outside region-specific coverage under the Medical, Dental and Vision Plan, you will be allowed to elect alternative coverage Hoss's offers to active employee and their family members, if any.

When Does COBRA Coverage Terminate?

Just as certain qualifying events can lead to COBRA Coverage eligibility, other circumstances can result in termination of your COBRA Coverage before the expiration of the 18-, 29-, or 36-month period. COBRA Coverage will be terminated if, during the applicable period of coverage:

- Hoss's no longer provides group health coverage to any of its employees.
- The premium for COBRA Coverage is not paid in a timely manner.
- You or other qualified beneficiaries become covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition.
- You or other qualified beneficiaries become enrolled in Medicare.
- During a disability extension, you or other qualified beneficiaries are determined to no longer be disabled.

If your COBRA Coverage terminates for any reason, it cannot be reinstated.

Who Do I Contact If I Have Questions?

This section of the SPD is a summary of the law and therefore is general in nature. The law and any applicable Plan provisions must be consulted with regard to the application of these provisions in any particular circumstance. If you have questions about the law, please contact the Human Resources Department. Also, if you have a change in marital status or you or your spouse or dependents have a change of address, please notify the Human Resources Department at the address in the section entitled "Plan Administrator and Plan Identification".

All COBRA premium payments should be forwarded to the COBRA Administrator at the following address:

HM Administrators, Inc.

Attn: COBRA Administration

P.O Box 642882

Pittsburgh, PA 15264-2882

Claims Procedures

I. Notice of Claim.

This Summary Plan Description is intended to provide summary information regarding claims procedures. Always review the attached insurance carrier booklet, summary plan description or governing documents for more information about how to file a claim and for details regarding the insurance company's claim procedures.

If you have been notified of an adverse decision you must follow the procedures described below in order to make a claim for benefits under the Plan. You or your authorized representative (on your behalf) may submit an initial claim for benefits under the Plan or may submit a claim for review if the claim has been denied. The Claims Administrator will, in its sole discretion, determine whether an individual has been authorized to act on your behalf.

II. Notice of Decision of Claim

A. Claims Under the Health Plan(s)

If your claim for benefits under the Plan is denied, you will receive a written notice of the decision to deny the claim within 90 days after the designated claims processor's receipt of the claim, unless special circumstances require an extension of up to 90 additional days to process the claim. If such an extension of time for processing the claim is required, as determined in the designated claims processor's sole discretion, you will receive written notice of the extension before the end of the initial 90-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the designated claims processor expects to render a benefit determination.

If your claim for benefits is denied, the written notice of denial shall include:

1. The specific reason or reasons for the denial;

2. Reference to pertinent Plan provisions on which the denial is based;

3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and

4. Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit the claim for review.

B. Claims Made Under the Short-Term Disability Plan or the Long-Term Disability Plan

If your claim for benefits under the STD Plan or the LTD Plan is denied, you will receive a written notice of the decision to deny the claim within 45 days after the receipt of the claim by the Educators Mutual Life Insurance Company or any successor thereto ("Disability Claims Processor"), unless the Disability Claims Processor determines that matters beyond the control of the Plan necessitate an extension of up to 30 days to process the claim. If the Disability Claims Processor determines that a decision cannot be rendered during the first 30-day extension period due to matters beyond the control of the Plan, the period for making a determination regarding your claim may be extended for an additional 30 days.

If an extension of time for processing the claim is required (as described above), you shall be provided with a written notice of the extension before the end of the initial 45-day period with respect to the first 30-day extension period and before the end of the first extension period if a second 30-day extension is required. Each extension notice shall include the following:

- An explanation of the circumstances requiring the extension of time;
- The date by which the Disability Claims Processor expects to render a decision on the claim;
- An explanation of the standards on which entitlement to a benefit is based;
- A description of the unresolved issues that prevent a decision on the claim; and
- A description of additional information needed to resolve such issues.

If the extension notice requires you to provide additional information to process your claim, you must provide the information to the Disability Claims Processor within 45 days after the date the notice is sent to you. If an extension notice requests specific information, the extension period will not begin to run until you respond to the Disability Claims Processor's request for information. If you do not respond to the Disability Claims Processor's request for additional information within 45 days, your claim will be decided without such information.

If your claim for benefits under the STD Plan or the LTD Plan is denied, the written notice of denial shall include:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material and information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, protocol, or other criterion was relied upon in making the adverse determination and will be provided to the claimant free of charge upon request; and

6. If the adverse benefit determination is based on a medical necessity or experimental treatment or other similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to the claimant's medical circumstances will be provided to the claimant free of charge upon request.

III. Review Procedures for Denied Claims

A. Review of Claims under the Health Plan(s)

The following claims review procedures apply without regard to any conflicting procedures described in the attached booklet.

1. Appeal. If your claim for benefits is denied, you may file a written request for review in accordance with the procedures described in this paragraph. Additionally, if you receive no notification as to the disposition of your claim or no notification as to an extension of the determination period within 90 days after submission of the claim to the designated claims processor, the claim for benefits will be deemed to have been denied. If your claim has been denied or is deemed to have been denied, you may appeal the denial of the claim by filing a written request for review with the Claims Administrator.

You must file a written request for review of a denied claim within 60 days after you receive written notice of the denial of the claim, or within 60 days after the date such claim is deemed to be denied. In connection with an appeal, you shall be permitted to review pertinent documents with respect to your claim, as determined by the Claims Administrator. Additionally, you may submit to the Claims Administrator written issues and comments relating to your claim in connection with the Claims Administrator's review of your claim.

2. Review. The Claims Administrator will review claims submitted for its review in writing and within the periods described in the previous paragraph. The Claims Administrator will render a decision regarding the claim within 60 days after the date the Claims Administrator receives your request for review, unless the Claims Administrator, in its sole discretion, determines that special circumstances require an extension of time for reviewing the claim, in which case

the Claims Administrator will render a decision as soon as possible, but not later than 120 days after the Claims Administrator's receipt of your request for review. If such an extension of time for review is required, the Claims Administrator shall furnish written notice of the extension of time to the claimant before the end of the initial 60-day period. The extension notice shall indicate the special circumstances requiring an extension of time.

The Claims Administrator may, in its sole discretion, request additional information or a meeting to clarify any matters related to the review of the claim.

3. Disposition on Review. You will receive written notification of the Claims Administrator's decision as to the disposition of a claim submitted for review and the notice will be written in a manner calculated to be understood by you. If your claim is denied on review, the notice shall include:

a. The specific reason or reasons for the denial of the claim; and

b. Specific references to pertinent plan provisions on which the benefit determination is based.

If the decision on review is not furnished within the period specified in section III.A.2, above, the claim shall be deemed denied on review at the expiration of that period.

B. Review of Claims Made Under the Short-Term Disability Plan or the Long Term Disability Plan

The following claims review procedures apply to the review of claims denied under the STD Plan or the LTD Plan without regard to any conflicting claims appeal or review procedures described in the attached booklet.

1. Appeal. If your claim for benefits under the STD Plan or the LTD Plan is denied, you may file a written request for review in accordance with the procedures described in this paragraph. Additionally, if you receive no notification as to the disposition of your claim under the STD Plan or the LTD Plan or no notification as to an extension of the determination period within 45 days after submission of the claim to the Disability Claims Processor, the claim will be deemed to have been denied. If your claim has been denied or is deemed to have been denied, you may appeal the denial of the claim by filing with the Claims Administrator a written request for review, provided that your request for review of a claim must be submitted within 180 days after (a) your receipt of the written notice of the denial or (b) the date of the deemed denial of the claim.

2. Review. The Claims Administrator will review claims submitted for its review in writing and within the periods described in the previous paragraph. The Claims Administrator will render a decision regarding the claim within 45 days after the date the Claims Administrator receives your request for review, unless the Claims Administrator, in its sole discretion, determines that special

circumstances require an extension of time for reviewing the claim, in which case the Claims Administrator will render a decision as soon as possible, but not later than 90 days after the Claims Administrator's receipt of your request for review. If such an extension of time for review is required, the Claims Administrator shall furnish written notice of the extension of time to the claimant before the end of the initial 45-day period; such notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render a determination on review. The Claims Administrator may, in its sole discretion, request additional information or a meeting to clarify any matters related to the review of the claim.

If you request that the Claims Administrator review your claim, you may submit written comments, documents, records and other information relating to the claim. Additionally, you shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, provided that the Claims Administrator shall determine, in its sole discretion, whether documents, records and information are relevant to your claim, subject to applicable regulations.

In reviewing your claim, the Claims Administrator shall take into account all comments, documents, records, and other information you submit that relates to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. Additionally, the Claims Administrator's review of your claim shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate Claims Administrator of the Plan who is neither the individual who made the initial adverse benefit determination regarding your claim nor a subordinate of such individual. In deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, provided that such health care professional shall not be the individual who was consulted in connection with the initial adverse benefit determination regarding the claim or a subordinate of such individual.

3. Disposition on Review. You will receive written notification of the Claims Administrator's decision as to the disposition of a claim submitted for review and the notice will be written in a manner calculated to be understood by you. If your claim is denied on review, the notice shall include:

a. The specific reason or reasons for the denial of the claim;

b. Reference to the specific Plan provisions on which the benefit determination is based; and

c. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents,

records, and other information relevant to the claim for benefits, provided that the Claims Administrator shall, in its sole discretion, determine whether documents, records and information are relevant to your claim under applicable regulations;

d. A statement of your right to bring an action under ERISA;

e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request;

f. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to your medical circumstances will be provided free of charge upon request; and

g. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

You may, upon request and free of charge, obtain the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination regarding your claim, without regard to whether such expert's advice was relied upon in making a benefit determination on review.

ERISA Rights

Your Rights Under ERISA

As a participant in the Plan**,** you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continued Group Health Plan Coverage

You have the opportunity to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under a group health 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.

Continue group health plan coverage for yourself, spouse or dependents for reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from 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 you and other Plan participants and beneficiaries. No one, including your employer or any other

person, may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

Plan Contributions

Generally, you are required to make contributions under the Plan in order to receive benefits under the Plan. For certain benefits, both you and Hoss's make contributions for coverage under that benefit and for other benefits Hoss's pays the entire cost of coverage. Hoss's, in its sole discretion, determines the amount you and it are responsible to pay for coverage under the Plan.

Inspection of Documents

The Plan and any policies that are incorporated as part of the Plan are on file in the Human Resources Department of Hoss's Corporate headquarters located at 170 Patchway Road, Duncansville, PA. You may inspect these documents at any time during normal business hours. Additionally, you may request copies of these documents, a reasonable copying fee may be charged.

Amendment or Termination of the Plan

Hoss's reserves the right to modify the Plan, including but not limited to, an increase in employee contributions or reduction in benefits, or the suspension or termination of the entire Plan or any benefit offered under the Plan, at any time. Should the Plan or any benefit offered under the Plan terminate, all eligible claims incurred prior to the termination date will be paid, subject to the procedures described in the section entitled "Claims Procedures,". Any claims incurred after the date of termination of the Plan or any benefit offered under the Plan will not be considered for payment, except to the extent required by law.

Miscellaneous

Third-party Reimbursement

The Plan requires you to reimburse the Plan for benefits you receive if you also receive payment from a third-party who was responsible for your medical expense. This is sometimes referred to as subrogation. Accordingly, if you receive payments under the Plan, Hoss's will be subrogated to all the rights of recovery you may have to the extent of the amount paid by the Plan. Additionally, you may be required to execute and deliver instruments and papers and take other actions that may be necessary to secure Hoss's rights of recovery and, as a condition of receiving benefits under the Plan; you are prohibited from taking any action that may prejudice such rights.

Assignment

Your benefits under the Plan may not be assigned, except as described in this SPD or to the extent required by law or legal process or with Hoss's consent.

No Contract of Employment

No provisions of the Plan or this SPD give you or any individual any right to commence or continue employment with Hoss's Steak and Sea House or shall in any way prohibit changes in the terms of employment of any individual covered by the Plan.

Maternity Minimum Stay Provisions

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