Kids Central Incorporated

Defined Contribution Medical Plan
Summary Plan Description

Effective January 1, 2008

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April 22, 2008

Plan Administrative Information

Plan Name: Kids Central Incorporated Defined Contribution Medical Plan

Plan Sponsor: Kids Central Incorporated PO Box 661 Norton, VA 24273 2766790518

Employer Identification No.: 54-1023958

ERISA Plan Number: 101

Type of Plan: Employee Welfare Benefit Plan

Plan Administrator: Kids Central Incorporated

Benefits Administrator: Vested Health LLC

Vested Health Plan Identification Number: HRA01

Agent for Service of Legal Process:

Funding Medium: Employer Contributions

Trustee: None

Plan Year: Beginning on January 1, 2008

Introduction

The purpose of this Summary Plan Description is to explain the Kids Central Incorporated Defined Contribution Medical Plan (the "Plan") in an easy-to-understand way and to give you information concerning the Plan that you may need in the future. Kids Central Incorporated (the "Company") maintains the Plan to reimburse you for certain medical expenses that are not covered by any other source, such as, but not limited to, an insurance policy. The detailed provisions of the Plan, set forth in the official Plan document, not this summary, govern the actual rights and benefits to which you may be entitled. You may obtain a copy of the Plan document from the Company.

Definitions

When used in this document and capitalized, these terms have the following meanings:

- "Annual Enrollment Period" means the 30-day period before a new Plan Year during which time you may enroll for coverage or modify a prior enrollment to be effective for the following Plan Year.
- "Company Credit" means the annual amount contributed to your Vested Health Account.
- "Company Medical Plan" means the high deductible group medical plan maintained by the Company, and approved by Vested Health, LLC, and known as the John Deere Plan.
- "Dependent" means any person considered a dependent under the terms of the Company Medical Plan.

- "Participant" means an Employee who properly enrolls for coverage under the Company Medical Plan in accordance with the enrollment section contained herein.
- "Retiree" means any former Employee who terminates employment as a result of a Retirement as defined by Company policy, and pursuant to the guidelines contained herein continues to be a participant in the Defined Contribution Medical Plan. A Retirement may include a disability or age/service based retirement.
- "Vested Health Account" means your account maintained by the Company containing your accumulated Company Credits. The Vested Health Account is a device used for the sole purpose of determining benefits and does not constitute a separate fund of assets.

Participation

Eligibility

You are covered under the Plan as of the first day of the month coincident with or next following the date that you properly enroll for coverage and become enrolled under the Company Medical Plan.

Enrollment

New Hire. As a condition of participation in the Plan, you must properly complete your Employer's benefit election process enrolling you and any Dependents you desire to cover in the Company Medical Plan on or before the day you first become eligible for coverage. The enrollment will be effective for the period beginning on the first day of eligibility and ending on the last day of the Plan Year in which your participation begins. If you fail to complete your Employer's benefit election process, you will be considered to have elected no coverage.

Annual Enrollment Period. Each Plan Year you may elect or change coverage by properly completing your Employer's benefit election process during the Annual Enrollment Period. Any election will be effective for the period beginning on the first day of the following Plan Year and ending on the last day of such following Plan Year. If you make no election or change during the Annual Enrollment Period, you will continue your existing coverage for the following Plan Year.

Special Enrollment Period. If you declined Plan participation because you were covered under another group health plan or had other health insurance coverage when you declined coverage, you may apply for coverage and make any necessary coverage change during the Special Enrollment Period discussed in this paragraph if you provide proof that you are no longer eligible for and covered under the other coverage, and if required by the Company, you stated when you declined coverage under the Company Medical Plan that you declined coverage because of the other coverage.

The Special Enrollment Period begins on the date the other coverage is lost and ends 31 days later. Therefore, you must properly complete your Employer's benefit election process within the Special Enrollment Period. If you properly enroll, coverage under the Plan is effective as of the beginning of the Special Enrollment Period.

If you acquire a Dependent, you may apply for coverage for any Dependent (and for you if previously not covered), and make any necessary coverage change, during the Special Enrollment Period. The Special Enrollment Period begins on the date the Dependent is acquired, and ends 31 days later. If you properly enroll within the Special Enrollment Period, coverage under the Plan is effective as of the beginning of the Special Enrollment Period.

If you declined Plan participation for a Dependent because that Dependent was covered under another group health plan or had other health insurance coverage when coverage was declined, you may apply for coverage for any Dependent (and for you if previously not covered), and make any necessary coverage change, during the Special Enrollment Period if you provide proof that a Dependent is no longer eligible for and covered under such other coverage, and if required by the Company, you stated when coverage for such Dependent was declined that coverage was declined because such Dependent had other coverage.

The Special Enrollment Period begins on the date the other coverage was lost and expires 31 days later. If you properly enroll within the Special Enrollment Period, coverage will be effective as of the beginning of the Special Enrollment Period.

You cannot participate in the Plan unless you also participate in the Company Medical Plan.

Company Credits

On January 1 of each Plan Year, the person or committee appointed by the Company to oversee the plan will determine an equal Company Credit to allocate to you and each other Participant in the Plan in such amount as it, in its sole discretion, shall determine. The Company Credit will be allocated as of the first day of each month to the Vested Health Account established and maintained for you. The Vested Health Account is merely a bookkeeping device used for the sole purpose of determining benefits and does not constitute a separate fund of assets.

Company Credits are used to reimburse you for payment of Medical Expenses, as described in Supplement A, that are not covered under the Company Medical Plan or any other health plan coverage. You are entitled to reimbursement from your Vested Health Account for Medical Expenses incurred to the extent that such Medical Expenses do not exceed the amount of your Vested Health Account. Accordingly, if your Plan participation ends, and for any reason you have received any reimbursement that causes your Vested Health Account to have a negative balance, the Plan Administrator may, in its sole discretion, request reimbursement from you to the extent of the negative balance.

Any non-forfeited amount remaining in your Vested Health Account at the end of the Plan Year will be credited to your Account for the following Plan Year and will be aggregated with any Company Credit for the following Plan Year.

Payment of Benefits

The Plan reimburses you from your Vested Health Account for Medical Expenses as defined in Supplement A only if you furnish to the Benefits Administrator or the Plan Administrator satisfactory evidence that you have incurred or paid such Medical Expenses. A claim submitted by a Participant must exceed $ 0.00 to be eligible for payment/reimbursement.

Claims for Medical Expenses must be submitted on claim forms provided by the Benefits Administrator or the Plan Administrator and must include all information requested on the form. Reimbursement payments will be made directly to you as soon as possible after the claim has been approved, or subject to your written direction, to the person or institution on whose charges a claim is based.

You will not be reimbursed for Medical Expenses under the Plan to the extent that such Medical Expenses are paid to you or for your benefit, or to or for the benefit of your Dependent, under the provisions of any other plan or insurance policy, including a medical flexible spending account.

Period of Coverage, Termination and Continuation Coverage

Except as provided below, coverage for you and/or your covered Dependents terminates on the first to occur of the following dates:

- The date you are no longer eligible for coverage;
- With respect to a covered Dependent, the date such Dependent ceases to be a Dependent or the date you are no longer eligible for coverage;
- The date the Plan is terminated; or
- The date you cease or your covered Dependent ceases to be covered by the Company Medical Plan.

Unless you are eligible for and properly elect continuation coverage, upon your termination of coverage, your Vested Health Account balance will be forfeited.

Family and Medical Leave

Eligibility for Plan coverage will continue if you are granted a leave of absence under the Family and Medical Leave Act of 1993 ("FMLA") at the same level of contribution and under the same conditions as if the you had continued in employment. However, to the extent permitted by the FMLA, the Company may recover from you its cost of coverage and benefits provided if you fail to return from leave for reasons other than the

continuation or onset of a serious health condition (as defined in the FMLA), or other circumstances beyond your control.

The COBRA Continuation Coverage provisions set forth below may be available after the completion of FMLA leave if you do not return to employment following such leave.

Continuation Coverage

COBRA Continuation Coverage

If any Plan benefit subject to continuation coverage under Section 4980B of the Internal Revenue Code and Section 601 of the Employee Retirement Income Security Act, which is commonly known as "COBRA," becomes unavailable as the result of any qualifying event (as defined therein), each qualified beneficiary (as defined therein) shall be entitled to elect continuation coverage as provided under those Sections.

Retiree Continuation Coverage

If your employment with the Company terminates, you are a Retiree, and you do not elect COBRA Continuation Coverage, you are eligible to continue coverage for yourself and any Dependent covered at the time of your termination of employment. In that case, you will not continue to receive a Company Credit, but you may continue to use any balance in your Vested Health Account for Medical Expenses until your balance is zero. A monthly administrative fee will continue to be charged. This Retiree continuation coverage provision does not create a vested benefit. The Company reserves the right to discontinue or modify Retiree Continuation Coverage at any time.

Post-Termination Continuation Coverage

If your employment with the Company terminates without Cause, you do not elect COBRA continuation coverage, and you are not eligible for Retiree Continuation Coverage, you are eligible to continue coverage for yourself and any Dependent covered at the time of your termination of employment. In that case, you will not continue to receive a Company Credit, but you may continue to use any balance in your Vested Health Account (limited by the following "Continuation Schedule") for Medical Expenses until your balance is zero. A monthly administrative fee will continue to be charged. The continuation coverage provisions do not create a vested benefit. The Company reserves the right to discontinue or modify this Post-Termination Continuation Coverage at any time.

"Cause" exists if, and only if, you engage in intentional wrongdoing that results in harm to the business or property of the Company or any affiliate, including but not limited to fraud, theft, or destruction of money or property.

Continuation Schedule

For purposes of Post-termination Continuation Coverage, the balance in your Vested Health Account will be determined by multiplying the amount in your Account on the date coverage would otherwise end by the following Continuation Percentage:

Years in the Plan	Continuation Percentage
Less than 1 year	0%
1 year	20%
2 years	40%
3 years	60%
4 years	80%
5 years	100%
6 years	100%
7 years	100%
8 years	100%
9 years	100%
10 years	100%

"Years in Plan" means the whole number of 12 consecutive month periods of your participation in the plan beginning on the later of your date of hire and the initial effective date of the Plan, and ending on your employment termination date.

The Continuation Schedule provisions contained herein are not intended to create any vested benefits. The Company reserves the right to remove or amend the Plan in any respect, including removing or amending any benefits related to this Continuation Schedule. You may utilize the balance in this Continuation Account for a maximum of 3 months after your employment termination date.

Survivorship Continuation Coverage

If a Participant or Retiree dies and his or her coverage tier is Single coverage, the remaining balance in his or her Vested Health Account will be forfeited, effective the day after death.

If a Participant or Retiree dies and his or her coverage tier is non-Single coverage (e.g., Employee+Spouse, Employee +Child(ren), Family, etc.) then any surviving Dependent shall be eligible for the continuation coverage described below, if he or she does not elect COBRA continuation coverage. Such surviving Dependents will not continue to receive a Company Credit, but may continue to use any balance in the deceased Participant's or Retiree's Vested Health Account for Medical Expenses until the balance is zero, provided they pay a reasonable administrative fee and continue to meet the definition of Dependent as herein set forth. These Survivorship Continuation Coverage provisions do not create a vested benefit. The Company reserves the right to discontinue or modify Survivorship Continuation Coverage at any time.

Administration of Plan

The Plan Administrator has all of the discretionary duties and powers necessary to administer the Plan. These duties and powers include the right to interpret the Plan, construe Plan terms, and decide questions and disputes. The Plan Administrator also has the power to determine eligibility for and the amount of benefits payable under the Plan, and to determine the status and rights of all persons who may be entitled to receive a benefit under the Plan. The decisions of the Plan Administrator are conclusive for all purposes under the Plan. The Plan Administrator has delegated some of its responsibilities to the Benefits Administrator. The Benefits Administrator and the Plan Administrator investigate and process claims for benefits. Benefits under the Plan will be paid only if the Benefits Administrator or the Plan Administrator decides in its discretion that the applicant is entitled to them.

Benefit Claims Procedures

Consideration of Initial Claim

a) **Filing Initial Claim**. An initial claim for benefits under the Plan must be made to the Benefits Administrator. The Benefits Administrator will process benefit claims under the procedures set forth below.

b) **Urgent Care Claims**. In the case of an Urgent Care Claim, the Benefits Administrator will provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim by the Plan. If the claimant does not provide sufficient information for the Benefits Administrator to make a determination, within 24 hours after receipt of the claim he or she will be notified of the specific information needed to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she will have a reasonable amount of time, but not less than 48 hours, to provide the missing information. The Benefits Administrator will notify the claimant of its decision regarding the completed claim either within 48 hours of receipt of the missing information, or within 48 hours of the end of the reasonable time period indicated in the notice.

   For purposes of this Article, an "Urgent Care Claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or the ability of the claimant to regain maximum function, or in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

c) **Pre-Service Claims**. In the case of a Pre-Service Claim, the Benefits Administrator will provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This 15-day period may be extended for up to 15 days due to matters beyond the control of the Plan if, prior to the expiration of the initial 15-day period, the Benefits Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Benefits Administrator expects to render a decision. If the claimant does not provide sufficient information for the Benefits Administrator to make a determination, within five days after receipt of the claim he or she will be notified of the specific information necessary to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she will have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

   For purposes of this Article, a "Pre-Service Claim" is any claim where the Plan requires approval of the benefit in advance of obtaining the medical care, in whole or in part.

d) **Post-Service Claims**. In the case of a Post-Service Claim, the Benefits Administrator will provide notice of an adverse determination to the claimant within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan. This 30-day period may be extended for up to 15 days for matters beyond the control of the Plan if, prior to the expiration of the initial 30-day period, the Benefits Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Benefits Administrator expects to render a decision. If the claimant does not provide sufficient information for the Benefits Administrator to make a determination, the claimant will receive notice of the specific information necessary to complete the claim. Once the claimant is notified he or she will have a reasonable amount of time but not less than 45 days from receipt of the notice to provide the missing information.

   For purposes of this Article, a "Post-Service Claim" is any claim that is not an Urgent Care Claim, a Pre-Service Claim, or a Concurrent Care Claim.

e) **Concurrent Care Claims**. In the case of an ongoing course of treatment, the claimant will receive notice of any reduction or early termination of treatment in advance so that the claimant may appeal the reduction or termination and obtain a determination on review before the treatment is reduced or terminated. If the claimant submits an Urgent Care Claim to extend any ongoing course of treatment beyond the period of time or number of treatments initially prescribed, the Benefits Administrator will notify the

claimant of the determination to extend the treatment within 24 hours after receipt of the claim, provided the claimant submits the claim at least 24 hours prior to the expiration of the prescribed treatment. The Benefits Administrator will be solely responsible for handling all Concurrent Care Claims.

If the Benefits Administrator Denies the Initial Claim

If the Benefits Administrator denies all or any portion of a claim, it will provide notice of the denial stating (a) the specific reason for the denial; (b) reference to the specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (d) a description of the Plan's review procedures (as set forth below) and the time limits applicable to those procedures.

If the Benefits Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to the claimant free of charge, or the claimant will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request. If the Benefits Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the medical circumstances) will be provided free of charge to the claimant, or the claimant will be informed that such explanation shall be provided free of charge to the claimant upon request.

If the Benefits Administrator denies a claimant's Urgent Care Claim in whole or in part, the Benefits Administrator will provide a description of the expedited review process for Urgent Care Claims (as set forth below). The Benefits Administrator will provide notice to the claimant orally, followed by written or electronic notice within three days of the oral notification.

Appeal to the Plan Administrator

a) **In general**. If the Benefits Administrator denies all or any portion of a claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Plan Administrator by sending a written request for review to the Plan Administrator within 180 days of receipt of the Benefits Administrator's notice of claim denial.

   A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant will receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied. The claimant's letter will include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

Upon receipt of a claim, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Benefits Administrator's adverse benefit determination, and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The Plan Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination to the claimant, without regard to whether the advice was relied upon in making the benefit determination.

b) **Expedited Review for Urgent Care Claims**. In the case of an Urgent Care Claim, a claimant may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Plan Administrator's determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile, or another similarly expeditious method. The Plan Administrator will notify the claimant of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination.

c) **Pre-Service Claims**. In the case of a Pre-Service Claim, the Plan Administrator will notify the claimant of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of a claimant's request for review.

d) **Post-Service Claims**. In the case of a Post-Service Claim, the Plan Administrator will provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review.

If the Plan Administrator Denies a Claim on Appeal

If the Plan Administrator denies all or any portion of a claim on appeal, it will notify the claimant of the following, in a manner calculated to be understood by the claimant: (a) the specific reason or reasons for the denial; (b) reference to the specific Plan provisions on which the denial is based; (c) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (d) a statement describing any voluntary appeal procedures offered by the Plan and a claimant's right to obtain information about such procedures; and (e) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims procedure process.

If the Plan Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to the claimant free of charge, or the claimant will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request. If the Plan Administrator relied upon medical necessity or experimental treatment or a similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances) will be provided to the claimant free of charge or the claimant will be informed that such explanation will be provided free of charge to the claimant upon request.

In addition, the notice will include the following statement: 'A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office.'

Rights under ERISA

As a Participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Company's office all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the United States Department of Labor, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Company. The Company may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Company is required by law to furnish each Participant with a copy of the summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an 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 fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator 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 Company and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case the court may require the Company 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 Company. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or you may file suit in a federal court. The court will decide who should pay the 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 to be frivolous. If you have any questions about the Plan, you should contact the Company. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the United States Labor Management Services Administration, Department of Labor.

Amendment and Termination of the Plan

Amendment

The Company, through resolution of its Board of Directors or the Board's delegate, reserves the right to amend, in whole or in part, any or all of the provisions of the Plan. Any such amendment may have retroactive or prospective effect.

Termination

Although the Company has established the Plan with the bona fide intention and expectation that it will be permanent, the Company is not required to continue the Plan for any given length of time. Accordingly, the Company may, through resolution of its Board of Directors, in its sole and absolute discretion, discontinue Company Credits or terminate the Plan at any time.

Collective Bargaining Agreement

Notwithstanding the foregoing, the right to amend or terminate the Plan is subject to the express terms of any applicable collective bargaining agreement.

Supplement A

Medical Expenses

Medical Expenses
A-1. Medical Expenses means amounts paid by you for Medical Care of yourself or any Dependent, to the extent such payment is not provided for under any other source. Medical Care has the meaning set forth by the Insurance Carrier.

A-2. Examples of Non-Reimbursable Medical Expenses. Examples of non-reimbursable expenses include:

cosmetic surgery;
marriage counseling;
any expense deemed non-payable by the Insurance Carrier
health club dues;
electrolysis;
health care aids, purchased without a prescription; or
any expense denied by the Company Medical Plan as an Ineligible Expense.
No prescription drugs will be reimbursed

Consumer Activation Program. Any Employee or Spouse covered under the Company Medical Plan shall be eligible to participate in the Vested Health Consumer Activation program and all applicable fees associated with this program may be deducted from the employee's account.

The examples set forth in Supplement A are for illustrative purposes only. Any determination as to coverage under this Supplement A shall be made solely with regard to whether an item in question is a Medical Expense. Medical Expenses covered by the Plan shall be the Medical Expenses not covered by the Company Medical Plan or any other group or individual health or accident plan.

In the case of a Retiree and/or their Dependents, the definition of Medical Expense within this Supplement A shall be amended to include within the definition the meaning as set forth in Section 213 (d) of the Code, including any regulations, ruling, statements, and releases issued thereunder.

Treatment for Partners

Partners will count the full annual allocation each plan year as personal taxable income.