EMPLOYEE INJURY BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

PLAN NO. 501

Specimen

TABLE OF CONTENTS

INTRODUCTION 1
IMPORTANT DEFINITIONS 1
PARTICIPATION, REPORTING, CONDITIONS & REQUIREMENTS 3
Q&A 1 Who is Eligible? 3
Q&A 2 Do I need to enroll in the Plan? 3
Q&A 3 When does coverage cease? 3
Q&A 4 When & how do I report an Accident or Injury? 4
Q&A 5 Can I be subject to screenings? 4
Q&A 6 How do I receive treatment? 4
Q&A 7 What evaluations must I undergo? 4
Q&A 8 What requirements relate to return to work? 4
PLAN BENEFITS & EXCLUSIONS 5
Q&A 9 What are the Plan benefits? 5
Q&A 10 Is there a limit on Plan benefits? 5
Q&A 11 Do I have to communicate with Claims Administrator regarding my treatment? 5
Q&A 12 Are there exclusions from benefits under the Plan? 5
Q&A 13 Can benefits under the Plan be forfeited? 6
Q&A 14 Does the Plan coordinate benefits? 7
Q&A 15 Does the Plan have subrogation and rights of recovery? 7
INDEMNITY BENEFITS 8
Q&A 16 When am I eligible for indemnity benefits under the Plan? 8
Q&A 17 What is the amount of indemnity benefits and how long do they continue? 8
Q&A 18 Will other income reduce indemnity benefits? 8
Q&A 19 When will Indemnity Benefits cease or be reduced? 9
MEDICAL EXPENSE BENEFITS 9
Q&A 20 When am I eligible for medical expense benefits? 9
Q&A 21 What are covered charges under the Plan? 10
Q&A 22 What other limits and conditions apply to medical expense benefits? 10
Q&A 23 When do medical benefits cease? 11
AD&D BENEFITS 11
Q&A 24 When am I eligible for AD&D Benefits under the Plan? 11
Q&A 25 Are there limits on AD&D benefits? 12
CLAIMS PROCEDURES 12
Q&A 26 What is a Claim & How do I file a Claim? 12
Q&A 27 Am I entitled to a second opinion? 13
Q&A 28 What if my claim is denied? 13
Q&A 29 What is the timeframe for a determination of claims? 14
Q&A 30 What type of notice of denial will I receive? 16
Q&A 31 May I appeal the denial? 17
Q&A 32 What is the timing of the Benefit Determination on review? 18
Q&A 33 How will I be notified of a Benefit Determination on review? 18
Q&A 34 Must I exhaust the Claims and Appeals procedures? 19

Specimen

Q&A 35 What is my responsibility in keeping the Plan notified? 20
MISCELLANEOUS INFORMATION 20
Q&A 36 How is the Plan funded? 20
Q&A 37 Who administers the Plan? 20
Q&A 38 Can the Plan be amended or terminated? 20
Q&A 39 Does the Plan modify my employment with my employer? 21
Q&A 40 Are Plan benefits transferrable or assignable? 21
Q&A 41 What laws govern the Plan? 21
Q&A 42 Do I have any rights & protections under ERISA? 21
APPENDIX A –SCHEDULE OF BENEFITS 23

Specimen

INTRODUCTION

This is the Summary Plan Description ("SPD") of the Employee Benefit Plan ("Plan") sponsored and maintained by the Company. The Plan is an occupational accident welfare plan subject to ERISA and established to provide benefits to eligible employees of Company or any of its subsidiaries or affiliated that participate in the Plan (collectively referred as the "Company") who are injured in a work-related incident while performing their job. The Plan is the exclusive remedy for work-related injuries and provides disability and related medical expense benefits and accidental death and dismemberment benefits to participants or their beneficiaries. Company has engaged the party listed on Appendix A to act as third-party administrator to handle the day to day administration of the Plan and to review and decide Claims ("Claims Administrator"). Any dispute arising from a workplace injury, other than a Claim for benefits under the Plan, is covered by the Company Alternative Dispute Resolution Policy and Binding Arbitration Agreement.

This SPD briefly describes the benefits available to you under the Plan and describes the procedures to be followed in the event you are injured in a work-related accident. The official terms are set forth in the Plan document, as it may be modified from time to time. The Plan document is available for your inspection and review from Company. In the case of any conflict between the terms and provisions of the Plan and the terms and provisions of this SPD, the Plan will control and govern.

Although Company currently intends to continue the benefits described in this SPD, Company reserves the right to amend, reduce or terminate these benefits at any time and for any reason. Company (and its delegates, including certain employees of Company) in the Plan Administrator and has specific authority to interpret the Plan provisions, to establish administrative rules and to amend the Plan. Any amendments or termination of the Plan will be made in accordance with the procedures specified in the governing documents. Amended or termination of coverage may happen at any time. In no event will you become entitled to any vested rights under the Plan.

IMPORTANT DEFINITIONS

The Plan contains important definitions that you should familiarize yourself with. Most of these terms are defined below and will be used throughout the SPD, but some terms are defined in those section of the SPD to which they relate. Defined terms will be in bold lettering.

"**ACCIDENT**" or "**ACCIDENTAL INJURY**" mean an injury to a Participant which: (1) was unforeseen and unexpected; (2) occurred at a specifically identifiable time and place; (3) occurred by chance, unexpectedly, and/or not in the usual course of events; (4) was caused by an external factor associated with Participant's work or with the workplace, (5) resulted directly in Bodily Injury to the covered Participant; (6) occurred in the course and scope of the covered Participant's assigned duties and employment with the Company; (7) occurred during the pendency of this Plan; and (8) for which medical treatment with an Approved Provider under this Plan was initiated within 14 days of the Injury producing event. Accidental Injury does not include Occupational Disease or Cumulative Trauma, except under the limited circumstances identified in the Plan. Accidental Injury does not include injuries or ordinary diseases of life to which the general public is exposed outside the Participant's assigned duties in his Scope of Employment.

"**APPROVED PROVIDER**" means an authorized, licensed medical doctor, physician or health care provider approved by the Plan who is acting within the scope of his or her license or credentials (as applicable) and

Specimen

rendering care or treatment to a Participant for his or her Injury that is appropriate for the conditions and locality.

"**CLAIM**" shall mean any request for a Benefit or a Disability Claim made by a Participant or by an authorized representative of a Participant.

"**COMPANY**" shall mean the entity identified in Appendix A, Schedule of Benefits and any of its wholly-owned subsidiaries or controlled group members of the Company, as defined in Internal Revenue Code § 414(b) or (c), that adopt the Plan, which may be amended from time to time without a formal written amendment to the Plan with the Company's consent. This list of Company locations covered by the Plan are contained in the Company's DWC 005 annual filing with the Texas Department of Insurance and is available for review upon request from the Plan Administrator.

"**CUMULATIVE TRAUMA**" means damage to the physical structure of the Participant's body occurring as a result of repetitious, physically traumatic activities that occur in the Scope of Employment with the Company and independent of all other causes. The Plan only covers Cumulative Trauma for Employees working at least 180 consecutive days before report of the Injury. Cumulative Trauma does not include Accidental Injury or Occupational Disease.

"**ELIGIBLE WAGES**" for purposes of calculating Indemnity Benefits means: (i) with respect to hourly Employees (not eligible for commissions): the Employee's base hourly rate of pay at the time of the Accident, including overtime pay, includes any sign on bonuses, (ii) with respect to Hourly Employees with commission eligibility: the Employee's base hourly rate of pay at the time of the Accident, overtime pay, includes sign on bonuses, and any commissions received within the prior 8 weeks before the Accident; and (iii) with respect to Salary Employees: the Employee's base salary, including commissions and sign on bonus. Disability wages are calculated using an average amount of compensation over the 8 weeks prior to the Accident. Discretionary Bonuses and/or other "extra" compensation received by those Participants will NOT be included as an Eligible Wage for Disability Calculation purposes.

"**INJURY**" means identifiable damage or harm to the physical structure of the body that is incurred solely as the result of a covered Occurrence or Accident. The term does not include: 1) any mental trauma, emotional distress or similar injury; or 2) a heart attack, stroke, aneurysm or seizure. The Injury must be caused solely by an Accident or Occurrence. All injuries sustained by one Participant in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

"**OCCUPATIONAL DISEASE**" means a disease that is caused solely from the performance of the Participant's regular duties of his or her job and causes damage or harm to the physical structure of the body. It does not include ordinary diseases to which the general public is exposed outside the Participant's regular duties of his or her job. It does not include an Injury resulting from an Accident or Cumulative Trauma. For purposes of this Plan, the date of an Occupational Disease is deemed to be the date on which the Participant was last exposed to the Occupational Disease producing agent or agents in his or her occupational environment. All Occupational Diseases suffered by any one Participant due to exposure to the same or related Disease -producing agent or agents present in his or her occupational environment within his or her Scope of Employment are deemed to be a single Occupational Disease.

"**OCCURRENCE**" means an Accident or series of Accidents arising out of one event causing Injury to one or more than one Participants, or an Occupational Disease or Cumulative Trauma causing Injury to one or more than one Participants.

Specimen

"**PARTICIPANT**" means an Employee eligible to participate and who is covered (or other payee, such as the Participant's beneficiary) under the Plan and has not for any reason become ineligible to participate further in the Plan.

"**PRE-EXISTING CONDITION**" means a condition caused by, or diagnosed to be, a condition or injury for which the Participant (1) experienced symptoms or (2) received medical treatment, care or advice prior to the date the Participant's coverage became effective under the Plan. For a Pre-Existing Condition to be covered under this Plan, there must be evidence that the Accident caused a New Injury. A Pre-Existing Condition will not be covered under this Plan if (1) the Participant received treatment for the condition for which Participant seeks coverage during the 6 months prior to the date of the Accident or Occurrence, or (2) the condition has been previously diagnosed or, (3) there is no evidence of a new injury.

"**SCOPE OF EMPLOYMENT**" means an activity of any kind or character that involves or has to do with and originates in the work, business, trade or profession of the Company and that is performed by the Employee while engaged in or about the furtherance of the affairs or business of the Company. Travel between Company locations for business purposes is included in the "Scope of Employment." "Scope of Employment" includes only an activity in which a Participant engages in the carrying out of the Company's business which is reasonably foreseeable by the Company. "Scope of Employment" does not include a Participant's transportation to and from the Participant's residence and the Participant's workplace. Participant reporting to work and leaving work are in the "Scope of Employment" as long as that Participant is on the Company premises. Time spent at lunch or during breaks is not in the "Scope of Employment." "Scope of Employment" does not include Accidents occurring off Company premises, such as sidewalks and parking lots, unless Company maintains and is responsible for keeping in good working order."

"**URGENT CARE CLAIM**" means a Claim for medical care or treatment that, if not received, (i) could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function; or (ii) in the opinion of an Approved Provider with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If an Approved Provider with knowledge of the Participant's medical condition, deems the medical care or treatment urgent, then the claim is an Urgent Care Claim. This does not include routine medical care that takes place at an urgent care clinic.

PARTICIPATION, REPORTING, CONDITIONS & REQUIREMENTS

Q&A 1 Who is Eligible?

If you are coded in a participating Company's payroll system as a W-2 employee residing in the State of Texas and you are in "active service" you are automatically a participant in this Plan. Active service means you are actively at work performing all regular duties (or restricted or modified duty at the direction of your Company) at your Company's place of business or someplace the Company requires you to be in the course of your Scope of Employment. Individuals classified as leased, staffing, payroll, or temporary agency employees, consultants, or independent contractors are not eligible.

Q&A 2 Do I need to enroll in the Plan?

No. If you are an eligible employee, you are automatically a participant in the Plan if you have a workplace accident or injury. No enrollment forms are necessary.

Q&A 3 When does coverage cease?

Your participation in the Plan generally will terminate upon the earliest of the following to occur:

Specimen

- You terminate employment;
- You cease to be an eligible employee because of a change in employment status;
- The Plan terminates.

Q&A 4 When & how do I report an Accident or Injury?

You must immediately report any Accident, Accidental Injury or Occupational Disease from a known cause or exposure to your manager or other person designated by the Company, and no later than 24 hours after the date of injury. You must report every Accidental Injury, regardless of the nature or severity. Further, you must provide a report on an approved form by no later than the end of the shift, except in instances of an emergency that prevents completion of this report in which case the report form will be provided as soon as practical. Failure to immediately report an Accidental Injury, Occupational Disease or Cumulative Trauma may result in denial of benefits. For purposes of this reporting requirement "**Immediately**," with regard to an Injury due to an Accident or for a known exposure to an Occupational Disease, means no later than the end of your scheduled shift during which the Occurrence took place. For an actual Injury due to Cumulative Trauma or Occupational Disease from an unknown exposure, verbal notice must be provided within the earliest of (1) 72 hours after being medically diagnosed or (2) 7 days after the Participant should have known of the Injury.

Q&A 5 Can I be subject to screenings?

In the event of an Accident requiring medical care, you may be required to submit to a drug and alcohol screen. Whether the screen is performed is within the management's sole discretion. This screen will be performed prior to the rendering of medical care, unless it is impractical to do so. Failure to submit to a drug and alcohol screen within 24 hours of management's request will result in a denial of benefits under this Plan.

Q&A 6 How do I receive treatment?

You must seek initial medical treatment with an Approved Provider within 14 days of an Accident or Occurrence. ***You are required to accept referral to an Approved Provider. If you choose to go to a physician of your choice without prior approval, the Plan will not be responsible for the expenses incurred by you in so doing.***

Q&A 7 What evaluations must I undergo?

The Plan and/or Claims Administrator reserves the right to require that you undergo an initial and subsequent evaluation by an Approved Provider who will make the determination regarding return to work after an Accident or Occurrence. Additional medical opinions relating to any Injury may be required prior to benefits being paid or benefits being continued. You must attend scheduled appointments. If you miss one scheduled appointment, benefits may be suspended or terminated, at the Plan's discretion. If you miss a second scheduled appointment, benefits can be terminated at the Plan's discretion. Benefits will terminate if you go <u>60 or more consecutive days</u> without treatment with an Approved Provider after initial treatment. If you fail to submit to an additional opinion upon request may result in denial of benefits under this Plan.

Q&A 8 What requirements relate to return to work?

After initial treatment, the Approved Provider may instruct you not to return to work pending further treatment and until released at a later date. Upon being released to work or receiving a change in work status by an Approved Provider, you must report that change of work status immediately to your manager. You must report to work when directed by your manager.

If, after treatment, the Approved Provider releases you to return to work, whether at full capacity, part-time, or light duty, and you fail to return to work (or a work alternative offered by your Company) when directed by your manager, all salary and medical benefits will immediately cease. In the case of light duty, if your Company does not have suitable light duty available, then benefits will not cease.

PLAN BENEFITS & EXCLUSIONS

Q&A 9 What are the Plan benefits?

The Plan applies to Accidents, Cumulative Trauma and Occupational Disease sustained by participants during the Scope of Employment. Plan benefits consist of (i) indemnity benefits for periods of disability described in Q&As 16-19, (ii) medical expense benefits for Covered Charges by an Approved Provider described in Q&As 20-23, and (iii) applicable accidental death and dismemberment (AD&D) benefits described in Q&A 24-25.

Q&A 10 Is there a limit on Plan benefits?

The combined benefit amount per Participant of all possible benefits under this Plan (including, but not limited to, payment of medical expenses, indemnity benefits, accidental death and dismemberment benefits) payable to a Participant or on his behalf per Occurrence can be found in Appendix A, Schedule of Benefits. The combined benefit amount per Occurrence of all possible benefits for any Occurrence (including, but not limited to payment of medical expenses, indemnity benefits, accidental death and dismemberment benefits) payable because of Accidental Injury, Occupational Disease and or Cumulative Trauma, regardless of the number of Participants, can be found in Appendix A, Schedule of Benefits.

Q&A 11 Do I have to communicate with Claims Administrator regarding my treatment?

Yes. You must contact the Claims Administrator or Plan Administrator **weekly** while receiving benefits to report on your progress and expected recovery time. Failure to do so may cause you to lose your benefits under the Plan. Further, you must promptly respond if contacted by Company or Claims Administrator or Plan Administrator.

Q&A 12 Are there exclusions from benefits under the Plan?

Yes. The following are excluded from benefits under the Plan. No benefits will be paid for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following:

- Any Claim that is not timely reported in accordance with Q&A 4 above.
- Repetitive motion and Cumulative Trauma Injuries unless you have worked in the job position which caused the Injury for at least 180 days.
- Pre-existing conditions unless there is evidence that the Accident or Occurrence caused a new injury (i.e. a medically diagnosed change in the physical structure of the body caused by the Accident). A pre-existing condition will not be covered under the Plan if you received treatment for the condition within the last 6 months prior to the date of the Accident or Occurrence or the condition has been previously diagnosed or there is no evidence of a new injury.
- Accident, Occupational Disease or Cumulative Trauma occurring while you have in your blood or urine any amount of alcohol, illegal drug, or a chemical substance that is obtained or consumed in violation of the U.S. Controlled Substances Act, or if you have in your blood or urine any prescription medication where that medication, amount of medication, or the manner of use of that medication has been prohibited by the Company's Alcohol and Drug Policy.

Specimen

- Hearing loss unless it falls under the definition of an Accident or is diagnosed by an Approved Provider as resulting solely from your job with the Company.
- All statutory or common law causes of action as well as any liability arising out of employment relationships.
- Any workers' compensation law, unemployment compensation law, disabilities benefits law or other similar law.
- An intentionally self-inflicted Injury, Occupational Disease or Cumulative Trauma caused or intentionally aggravated by you.
- Participation in: (i) an assault or a felony, except an assault committed in defense of the Company's business or property; (ii) any act of terrorism; (iii) any illegal act; (iv) service in the military of any country or any civilian non-combatant unit serving with such forces; or (iv) horseplay.
- Directly or indirectly, contributed by, caused by, resulting from, or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss: (i) war, invasion, terrorism, acts of foreign enemies, hostilities, or warlike operations (whether war be declared or not), civil war, mutiny, revolution, rebellion, insurrection, uprising, military or usurped power, confiscation by order of any public authority or government de jure or de facto, martial law, or; (ii) riots, strikes, or civil commotion; or (iii) an act of God.
- Accident, Occupational Disease or Cumulative Trauma to you while employed in violation of law, including but not limited to working without a valid H-1B visa or after such visa has expired, or working as an undocumented immigrant.
- The following exposure related items: (i) asbestos, asbestos fibers or asbestos products; (ii) lead or lead based products; (iii) the hazardous properties, including radioactive, toxic or explosive properties, of nuclear materials; (iv) mold; or (v) any and all medical conditions that are associated with silica related conditions, this is to include exposure to any all material, which also is known as silica dust, exposures to respirable crystalline silica, exposure to silicosis, exposure to mold, exposure to materials that may cause lung cancer, pulmonary tuberculosis, and airway diseases, autoimmune disorders, chronic renal disease, or other health conditions that are associated with exposure to silica based materials.
- Charges for: (a) biofeedback and other forms of self-care or self-help training or any related diagnostic testing; (b) hypnosis, acupuncture, chiropractic treatment or chiropractic therapy; (c) the purchase, rental or repair of environmental control devises, including but not limited to, air conditioners, humidifiers or air purifiers.
- Participation in any recreational, social or athletic activity not constituting part of your Scope of Employment, whether or not such participation occurs on the Company's premises or during normal business hours.
- Stress, anxiety, depression, insomnia, or other similar emotional and mental disorders, even if associated with an Injury.
- A heart attack, aneurism, stroke, or seizure.
- Any viral or bacterial infection, including the COVID-19 virus and any symptoms or illness associated with, or suspected to be associated with, the COVID-19 virus.
- Hernia, unless such hernia is an inguinal or umbilical hernia that: (a) appeared suddenly and immediately following the Accident; (b) did not exist in any degree prior to the Accident; and (c) is accompanied by pain.

Q&A 13 Can benefits under the Plan be forfeited?

Yes. Your entitlement to benefits, however provided for, under this Plan may be forfeited, suspended, or discontinued if you fail to comply with or satisfy any of the requirements or provisions of this Plan. For example, you shall not be entitled to the benefits under this Plan if:

Specimen

- The Accident or alleged Accident is not an Accident covered by the Plan, is determined to be intentional or feigned; or is determined to be an attempt to defraud the Company;
- The Accident is not timely reported in accordance with Q&A 4 above;
- You utilize a health care provider for an Injury other than an Approved Provider;
- You fail to follow the treatment and advice prescribed by the Approved Provider;
- You do not obtain treatment within 14 days of an on-the-job Injury or Accident or 60 consecutive days elapses between treatments with an Approved Provider;
- You refuse or fail to obtain a second opinion prior to surgery, if requested to do so;
- You fail to report to your manager for work immediately upon being released in whole or in part by the Approved Provider to return to work;
- It is determined that you have any amount of illegal drugs or alcohol in your system at the time of the Accident;
- It is determined that the Accident was caused by horseplay, scuffling, fighting, altercation, or other inappropriate behavior;
- It is determined the Injury is the resulted from an intentional or willful act by you;
- The Accident arises from a non-covered pre-existing condition;
- You become employed by another employer while receiving benefits under the Plan;
- You resign employment or are terminated from employment with Company as a result of gross misconduct or a Company policy violation;
- You fail to provide a complete statement, affidavit, or deposition upon request concerning the incident that you believe resulted in an Injury;
- You were untruthful regarding any aspect of the required information supplied as part of the employment process including, without limitation, information as to physical or mental abilities to perform the job;
- You refuse to submit to drug and alcohol testing; or
- You have an unrelated/intervening, personal medical condition that occurs while you are treating under Benefit Plan, your benefits will be suspended until you are released from care for the unrelated medical condition.

Q&A 14 Does the Plan coordinate benefits?

Yes. If you are covered under one or more other plans including, but not limited to, automobile or health insurance or coverage (excluding the Company group health program), the benefits under this Plan incurred in a calendar year shall be reduced by the amount of any benefits payable by such other plan so that the total benefits payable with respect to any one Injury or Accident will not exceed 100% of the expenses incurred. The Claims Administrator will determine which plan is the primary plan that will pay its benefits first according to the following rules:

- When only one of the plans has a coordination of benefits provision, then the plan without such a provision will be primary.
- If both plans have such a provision, the plan under which the Participant is covered as an employee will be the primary plan.
- If both of the foregoing rules do not establish which plan is the primary plan, then the plan that has covered the person for the longer period of time will be the primary plan.

Q&A 15 Does the Plan have subrogation and rights of recovery?

Yes. You may incur medical or other charges related to an Accident or Occurrence caused by the act or omission of another person; or another party may be liable or legally responsible for payment of charges incurred in connection with the Accident or Occurrence. If so, you may have a Claim against that other person or another party for payment of the medical expenses or other charges. In that event, the Plan

Specimen

will be subrogated to all rights you may have against that other person or another party and will be entitled to reimbursement. In addition, the Plan shall have the first lien against any recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that you may have to be "made whole." In other words, the Plan is entitled to the right of first reimbursement out of any recovery you procure or may be entitled to procure regardless of whether you have received compensation for any of his damages or expenses, including any of your attorneys' fees or costs. Additionally, the Plan's right of first reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits or collectability or responsibility, or otherwise. ***As a condition to receiving benefits under the Plan, you agree that acceptance of benefits is constructive notice of this provision and you agree to comply with the Claims Administrators procedures related to subrogation and rights of recovery, including, but not limited to entering into a subrogation and reimbursement agreement***.

INDEMNITY BENEFITS

Q&A 16 When am I eligible for indemnity benefits under the Plan?

You are eligible for disability benefits if you are disabled from performing your usual work for your Company by an Accident, Accidental Injury, Occupational Disease and/or Cumulative Trauma. You are considered disabled if you are not able to perform any of the material and substantial duties of your occupation, business, or employment which you held at the time of Injury due to an Accident while in the Scope of Employment. You must provide the Claims Administrator satisfactory proof of disability and of being under the continuous care of an Approved Provider. The Plan may require you to submit proof of continued disability as often as the Plan or Claims Administrator, in its sole discretion, considers necessary and reasonable. Failure to submit the required proof may cause the Plan to suspend benefits until such proof is received.

Q&A 17 What is the amount of indemnity benefits and how long do they continue?

If the conditions of the Plan are met, the Plan will pay benefits as identified in Appendix A, Schedule of Benefits, beginning immediately after the Occurrence of Accident. Indemnity benefits payments are payable on your regularly scheduled pay period.

The amount of indemnity benefits counts toward the combined benefit amount per participant of all possible benefits (indemnity, medical expense and AD&D) per Occurrence as well as the combined benefit amount per Occurrence of all possible benefits (indemnity, medical expense and AD&D) for any Occurrence regardless of the number of participants.

Q&A 18 Will other income reduce indemnity benefits?

Yes. Indemnity benefit payments will be reduced by other income benefits, which include amounts which you or your dependents receive (or are assumed to receive) under:

- If you remain disabled from working full time, but are able to return to work on a part-time basis or earns less than your hourly wage, you will be deemed partially disabled and the Indemnity Benefit will be reduced by the amount of the your earnings during the period of partial disability.
- The Indemnity Benefits shall be reduced by any amount for which the you are qualified to receive benefits under: (a) Social Security (including payments to eligible dependent); (b) Workers' compensation or any occupational disease act or law; (c) State compulsory Indemnity Benefits law; (d) Disability retirement, or other income benefits provided through the your employer; or (e) Any other amounts you receive outside of the Plan.

Specimen

Q&A 19 When will Indemnity Benefits cease or be reduced?

Indemnity Benefits are subject to the following limitations:

- If you go 60 or more consecutive days without treatment with an Approved Provider, Indemnity Benefits will cease.
- If you return to your regular work with your Company, Indemnity Benefits will cease.
- If you die, Indemnity Benefits will cease.
- If you leave employment for a reason other than inability to work solely because of the Injury or your Company not having suitable light duty, Indemnity Benefits will cease.
- If you are released from care by an Approved Provider or you refuse to participate in any medically recommended rehabilitation program or if the disability is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo and you have not availed yourself of the treatment, Indemnity Benefits will cease.
- If you are released to return to work without restriction or to Maximum Rehabilitative Capacity by an Approved Provider, but you do not return to work for any reason, indemnity benefits shall cease; "**Maximum Rehabilitative Capacity**" means the earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.
- If you remain disabled from working full time, but are able to return to work on a part-time basis or earn less than your pre-Injury wage, you will be deemed partially disabled and the indemnity benefit will be reduced by the amount of your earnings during the period of partial disability.
- If you are placed on light duty and Company cannot accommodate the Approved Provider's restrictions for you, then you will receive indemnity Benefits until either (a) Company can accommodate the your restrictions (b) you are placed on full duty or (3) you receive the maximum Indemnity Benefits.
- If Company can accommodate your light duty restrictions and you refuse to return to work, Indemnity Benefits will cease. This provision does not affect the Participant's Medical Expense Benefits.

Note: Any requests for a leave of absence or for accommodations relating to light duty or work restrictions should be directed to the Leave of Absence and Accommodations team.

In no event will the Plan provide coverage for successive periods of disability, resulting from entirely different and unrelated causes, unless such periods of disability are separated by at least one (1) full day during which the Participant is not disabled. Furthermore, the Plan will not provide coverage for successive periods of disability resulting from the same or related Accidents, unless such periods of disability are separated by at least six (6) months during which you are not disabled.

MEDICAL EXPENSE BENEFITS

Q&A 20 When am I eligible for medical expense benefits?

If you incur medically necessary expenses which constitute Covered Charges under the Plan as a direct result (and from no other cause) of an Injury due to an Accident, Cumulative Trauma and/or Occupational Disease, your medical expenses will be paid by the Plan. Only Covered Charges that are a direct result of an Injury and incurred within 104 weeks of the date of the Injury are covered under the Plan. The first Covered Charges that are caused by the Accident or Occurrence must occur within 14 days of the Accident or Occurrence.

Specimen

The medical care and treatment must be ordered and rendered by an Approved Provider. In addition, the medical care or treatment must be deemed Medically Necessary by the Claims Administrator. In no event will the Plan pay a charge which is more than the Usual and Customary charge for the service, the supplies or the equipment which are needed for such care and treatment. Additionally, the Covered Charges must be incurred as a result of an Injury, Occupational Disease, or Cumulative Trauma occurring after the Plan's effective date. See Q&A 21 below for definitions of Covered Charge, Medically Necessary and Usual and Customary.

Q&A 21 What are covered charges under the Plan?

"**Covered Charges**" are those Medically Necessary treatments, services and supplies that are prescribed by an Approved Provider and incurred by you within a certain time frame and subject to the combined benefit amount per participant and combined benefit amount per Occurrence, all identified in Appendix A, Schedule of Benefits. A Covered Charge is deemed to have been incurred on the date the Medically Necessary treatment was rendered, a service given or a supply delivered. Pre-approved expenses for mileage, transportation, food and lodging will be included as Covered Charges. The determination of whether a treatment, service or supply is a Covered Charge will be made by the Claims Administrator in its discretion.

"**Medically Necessary**" means that a service, procedure, medicine, prescription drug, or supply is necessary and appropriate for the diagnosis or treatment of an Injury based on generally accepted current medical practice. A service, medicine or supply will not be considered Medically Necessary if it: (i) is provided only as a convenience to you or a provider; or (ii) is not appropriate treatment for your diagnosis or symptoms; or (iii) exceeds, in scope, duration or intensity, that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment. The fact that a physician or health care provider may prescribe, order, recommend, or approve a service or supply does not make the service or supply Medically Necessary. The determination of whether a service, procedure, medicine, prescription drug, or supply is Medically Necessary will be made by the Claims Administrator in its discretion.

"**Usual and Customary**" means the usual charge made by a physician or other licensed health care provider acting within the scope of his or her license of treatment, services, procedures, supplies, medicine or prescription drugs that does not exceed the general level of charges made by other physicians or Approved Providers rendering or furnishing such care or treatment within the same geographic area. The determination of whether the charge for a treatment, service, procedure, medicine, prescription drug, or supply is Usual and Customary shall be made by the Claims Administrator in its discretion.

No medical expense benefits will be paid for any expenses incurred that are in excess of Usual and Customary, are not Medically Necessary or any expenses that are eligible for payment or reimbursement under any other medical expense plan or policy, as determined by the Claims Administrator in its discretion.

Q&A 22 What other limits and conditions apply to medical expense benefits?

Eligible Covered Charges are subject to the combined benefit amount per Participant and combined benefit amount per Occurrence. Those benefit limits are identified in Appendix A, Schedule of Benefits.

The Plan imposes certain pre-certification requirements that require you or an Approved Provider to obtain authorization from the Claims Administrator prior to incurring Covered Charges due to hospital admission (other than an admission of emergency care) physical therapy, MRI, CAT Scan, sonogram, or other such testing. Pre-certification requirements are designed to ensure that hospital admissions and lengths of stay, surgery and other medical services are Medically Necessary by having the Claims Administrator refer your file to a qualified Approved Provider to determine Medical Necessity. Your

Specimen

physician must request pre-certification at least 3 days prior to a non-emergency admission or treatment. If admission or treatment is for emergency care, notice to the Claims Administrator must be given: (i) within 24 hours after the Occurrence or Accident occurs; or (ii) on the first business day after admission or treatment on a weekend or legal holiday; or (iii) the earliest possible time thereafter.

The Claims Administrator may consult with the Approved Physician, hospital, or other facility to determine if the hospital stay or treatment is required for the Injury. If the Claims Administrator decides that the treatment you require could be provided just as effectively through a less expensive treatment plan, you will be notified of the decision. If you proceed with the treatment plan without asking for pre-certification or being given a pre-certification notice, your medical expense benefit will be denied entirely.

Q&A 23 When do medical benefits cease?

Medical expense benefits shall cease upon the earliest of:

- The date Maximum Rehabilitative Capacity is achieved, i.e. the earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.
- If you go 60 or more consecutive day without treatment from an Approved Provider after initial treatment.
- At the expiration of the Combined Benefit Period identified in Appendix A, Schedule of Benefits.
- The date the combined benefit amount per participant or the combined benefit amount per Occurrence identified in Appendix A, Schedule of Benefits is reached (see Q&A 10 above).
- Any other limitation or terminating event in this Plan.
- You leave employment (1) for some reason other than your Company not having suitable light duty or (2) solely because of inability to work because of your Injury.
- Benefits can be terminated based on the results of a second opinion from an Approved Provider or Independent Medical Exam (“IME”).
- Medical Benefits cease immediately if you seek treatment from a non-Approved Provider while receiving treatment from an Approved Provider.

AD&D BENEFITS

Q&A 24 When am I eligible for AD&D Benefits under the Plan?

You are eligible for accidental death and dismemberment (AD&D) benefits if as the result of an Accident you suffer any of the losses below within 365 days of the Occurrence or Accident. AD&D benefits are the percentage of the combined benefit amount shown in the table below for that loss. If multiple losses occur, only one benefit amount (the largest) will be paid.

Loss	Benefit Amount
Life	100%
Quadriplegia	100%
Two or more Members	100%
One Member	50%
Hemiplegia	50%
Paraplegia	50%
Loss of Hearing or Speech	50%
Thumb and Index Finger of the Same Hand	25%
Four Fingers of the Same Hand	25%

Specimen

Loss	Benefit Amount
Single Finger or Toe	10%

"**Quadriplegia**" means total Paralysis of both upper and lower limbs. "Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body. "Paraplegia" means total Paralysis of both lower limbs or both upper limbs. "Paralysis" means total loss of use. An Approved Provider must determine the loss of use to be complete and not reversible at the time the Claim is submitted. The loss of use must commence within 365 days of the date of the Accident or Occurrence and continue without interruption for a period of not less than 365 consecutive days. The loss of use must be total and irrevocable and beyond remedy by surgical or other means.

"**Member**" means Loss of Hand or Foot, Loss of Sight, Loss of Speech, and Loss of Hearing. "**Loss of Hand or Foot**" means complete Severance through or above the wrist or ankle joint. "**Loss of Sight**" means the total, permanent Loss of Sight of one eye. "**Loss of Speech**" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "**Loss of Hearing**" means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means. "**Loss of a Thumb and Index Finger of the Same Hand**" or "L**oss of Four Fingers of the Same Hand**" means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). "**Severance**" means the complete and permanent separation and dismemberment of the part from the body.

25% of the AD&D benefit amount will be paid in an initial lump sum and the remaining benefit amount will be paid out in equal, monthly installments over the course of 12 months.

Q&A 25 Are there limits on AD&D benefits?

Yes. AD&D benefits are subject to the combined benefit amount per Participant or the combined benefit amount per Occurrence is reached and any other limitation or exclusion contained in the Plan. Those benefit amounts are identified in Appendix A, Schedule of Benefits.

CLAIMS PROCEDURES

Q&A 26 What is a Claim & How do I file a Claim?

A "**Claim**" is any request for a benefit made by you (a participant) or beneficiary or by an authorized representative of you or a beneficiary that complies with the Plan procedures for making a benefit claim with the Claims Administrator. An "**Urgent Care Claim**" means a Claim for medical care or treatment that, if not received, (i) could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function; or (ii) in the opinion of an Approved Provider with knowledge of the Participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If an Approved Provider with knowledge of the Participant's medical condition deems the medical care or treatment urgent, then the claim is an Urgent Care Claim. This does not include routine medical care that takes place at an urgent care clinic.

You must file a Claim with the Claims Administrator who will make a Benefit Determination in accordance with the claims procedures that comply with ERISA. A "**Benefit Determination**" means a determination by the Claims Administrator on a Claim for benefits under the Plan. A Participant or beneficiary or duly authorized representative (referred to as a "claimant") must follow the procedures of the Claims Administrator, including, without limitation, requirements related to time frames for providing notice of an Accident or Occurrence, time frames for filing Claims or appeals, use of specific forms, protocols, and

Specimen

other procedures. If the Claims Administrator denies a Claim in whole or in part, the claimant will receive a written notification setting forth the reasons for the denial and describing rights, including a right to appeal the denial. A claimant must appeal the denial within certain timeframes. The Plan Administrator or its designee will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA, and provide the claimant written notification of its decision. The decisions of the Plan Administrator or its designee on appeal are final and binding.

The Plan will be deemed to have received a Claim for benefits if a claimant submits a written communication, except in the case of an Urgent Care Claim, in which case the Claim may be communicated orally, reasonably calculated to bring a request for a Claim to the attention of the Claims Administrator. If the Claims Administrator provides a form, such form must be used and no other written communication will be considered a Claim.

Q&A 27 Am I entitled to a second opinion?

Yes. If you disagree with the diagnosis or treatment recommended by an Approved Provider whose opinion is accepted by the Claims Administrator, then you may request a second, medical opinion. You must notify the Claims Administrator of the request for a second, medical opinion within 30 days of the diagnosis from an Approved Provider. Your shall have the right to a one-time examination at **your own expense** by another physician ("Second Physician"). You have the right to select the Second Physician who will examine you solely for the purpose of evaluating your condition and making a treatment recommendation.

If the diagnosis and treatment recommended by the Second Physician is contrary to that of the original, treating Approved Provider, the Claim Administrator shall designate a peer review physician who will evaluate the medical records and advise the Claims Administrator. The diagnosis and/or recommendation of treatment of the peer review physician will control any future medical treatment, incapacity and return to work.

Q&A 28 What if my claim is denied?

An "**Adverse Benefit Determination**" means any of the following: (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of eligibility to participate in the Plan; (ii) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit under the Plan, resulting from the application of Pre-Certification procedures or other utilization review procedures; and (iii) a failure to cover an item or service for which benefits under the Plan are otherwise provided because it is determined to be experimental and/or investigational or not Medically Necessary or because another exclusion applies under the Plan.

If your Claim is denied you will receive a notice of the denial within certain time frames. The deadline for providing the notice of a Claims denial depends on the type of Claim being denied and the reason the Claim is being denied, as set forth below.

1. If the Claim is being denied because the claimant did not follow the Plan's procedure for submitting the Claim, the Claims Administrator must notify the claimant of the correct procedure within five days after the Claim is received. Exception for Urgent Care: If the Claim is for urgent care, the notification must be given within 24 hours after the Claim is received.

2. If the Claim is being denied because the claimant followed Plan procedures but did not submit sufficient information for the Claims Administrator to determine whether the Claim is covered

Specimen

or payable by the Plan, the Claims Administrator shall notify the claimant of the additional information needed within five days after receipt of the Claim, and the claimant shall be given 45 days after the date the notice is received to provide the missing information. The Claims Administrator shall then review the additional information and notify the claimant within 15 days after the additional information is received of the Plan's determination with regard to the Claim. If no additional information is received during the 45-day response period, the Claims Administrator shall send a notice of the Claim's denial within 15 days after the end of the 45-day period. Exception for Urgent Care: If the Claim is for urgent care, the Claims Administrator shall notify the claimant of the additional information needed within 24 hours after the Claim is received, and the claimant shall be given 48 hours to provide the missing information. The Claims Administrator shall then review the additional information and notify the claimant within 48 hours after the additional information is received of the Plan's determination with regard to the Claim. If no additional information is received during the 48-hour response period, the Claims Administrator shall provide a notice of denial of the claim within 48 hours after the end of the response period.

3. If the claimant has followed Plan procedures and has submitted sufficient information for a determination to be made, but the Claims Administrator has determined that the Claim is to be denied, then the deadline for the Claims Administrator to provide the notice of denial is 90 calendar days after the receipt of the Claim (45 days for disability claims). Exception for Urgent Care Claims: If the Claim being denied is an Urgent Care Claim, then the deadline for providing the notice of denial is 72 hours after receipt of the Claim.

Notice given in writing shall either be sent by first class mail or by hand delivery. Notice may only be given electronically (that is, by email) if the Claims Administrator ensures that using email complies with ERISA's requirements applicable to electronic communication.

Q&A 29 What is the timeframe for a determination of claims?

1. Concurrent Care Decisions. In the case of a Claim review of a treatment or course of treatment before the end of a prescribed period of time or which is in addition to other treatments, if that review results in an Adverse Benefit Determination, the Claims Administrator shall notify the claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a Benefit Determination on Review of that Adverse Benefit Determination before the benefit is reduced or terminated.

   In the event of a concurrent care decision which is a request by a claimant to extend the course of treatment beyond the period of time or number of treatments and is an Urgent Care Claim, such concurrent care decision shall be decided as soon as possible, taking into account the medical exigencies. The Claims Administrator shall notify the claimant of the Benefit Determination, whether or not adverse, within 24 hours after receipt of the Claim by the Plan, provided that any such Claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether or not involving an Urgent Care Claim, shall be made in accordance with this Plan.

2. Other Medical Care Claims. In the case of a medical care Claim that is neither an Urgent Care Claim nor a Claim involving a concurrent care decision, the Claims Administrator shall notify the claimant of the Plan's Benefit Determination, as follows:

Specimen

a. Pre-service Claim. The Claims Administrator will render a Benefit Determination and provide notice to the claimant of such Benefit Determination (whether or not adverse) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the pre-service Claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a claimant's failure to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from the receipt of the notice within which to provide the specified information.

   In the event that the claimant fails to follow the Plan's procedures for filing a pre-service Claim, the claimant shall be notified of such failure and of the proper procedures to be followed in filing such a Claim. The notification shall be provided to the claimant as soon as possible, but not later than 5 days following the failure. Notification may be oral, unless written notification is requested by the claimant. For the purposes of this section, a failure to follow the Plan's procedures for filing shall mean only such a failure that is (i) a communication by claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under the Plan; and (ii) a communication that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

   Notification of an Adverse Benefit Determination made hereunder shall be made in accordance with this Plan

b. Post-service Claim. The Claims Administrator shall render a Benefit Determination and provide written notice to the claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the post-service Claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the post-service Claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

   Notification of an Adverse Benefit Determination made hereunder shall be made in accordance with this Plan.

3. Disability Claims. If a disability Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the claimant of any Adverse Benefit Determination within a reasonable period of time, but not later than 45 days after receipt of the disability Claim (the "Initial Period"). The Initial Period may be extended by the Plan for up to 30 days (the "First Extension"), provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies the claimant, prior to the

Specimen

expiration of the Initial Period, of the circumstances requiring the First Extension and the date by which the Plan expects to render a decision.

If, prior to the end of the First Extension, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the First Extension, the period for making the determination may be extended for up to an additional 30 days (the "Second Extension"), provided that the Claims Administrator notifies the claimant, prior to the expiration of the First Extension, of the circumstances requiring the Second Extension and the date as of which the Plan expects to render a decision.

In the case of any extension under this section, the notice of extension shall specifically explain (i) the standards on which entitlement to a benefit is based, (ii) the unresolved issues that prevent a decision on the Claim, and (iii) the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Notification of any Adverse Benefit Determination with respect to a disability Claim shall be made in accordance with this Plan.

Q&A 30 What type of notice of denial will I receive?

Except as otherwise provided, the Claims Administrator shall provide a claimant with written or electronic notification of any Adverse Benefit Determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv), as amended. The notification shall set forth in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the Adverse Benefit Determination, including the nature of the injury/ condition, relevant facts, and rationale for the denial;

2. Reference to the specific Plan provisions upon which the determination is based;

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

4. A description of the Plan's appeal procedures and time limits applicable to such procedures, including, in the case of an Urgent Care Claim, a description of the expedited review process applicable to such Claims, along with a statement of the right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;

5. In the case of an Adverse Benefit Determination regarding a disability Claim or a medical care Claim, if the Adverse Benefit Determination is based upon:

    a. An internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

    b. A medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Specimen

In the care of an Adverse Benefit Determination involving an Urgent Care Claim, the information described in above may be provided to the Participant orally, provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification is provided.

Q&A 31 May I appeal the denial?

Yes, you may appeal the denial of your Claim. If a claimant disagrees with an Adverse Benefit Determination the claimant shall file an appeal of an Adverse Benefit Determination to the Plan Administrator, or its designee, within 180 days following receipt of notification of an Adverse Benefit Determination. The claimant shall be provided a reasonable opportunity for full and fair review of an Adverse Benefit Determination, in accordance with the provisions of this Section.

1. General Review Procedures.

    a. Each claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the Claim which is the subject of the appeal.

    b. Each claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's Claim for benefits under the Plan.

    c. The appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

    d. Any new evidence considered at the appeal stage must be provided to the claimant, along with a notice to the claimant of his/her right to respond to the new information.

2. Disability Claims and Medical Care Claims Review Procedures. The following review procedures, in addition to those set forth herein shall apply to appeals of disability Claims and medical care Claims:

    a. The appeal shall not afford deference to the initial Adverse Benefit Determination and shall be conducted by a decision maker who is neither the individual who made the initial Adverse Benefit Determination that is on appeal nor any subordinate of such decision maker.

    b. In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, the decision maker shall consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment.

    c. All medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination on appeal shall be identified without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

    d. All health care professionals engaged for purposes of consultation shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is on appeal, nor the subordinate of such individual.

Specimen

In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the claimant, and all necessary information, including the Plan's Benefit Determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Q&A 32 What is the timing of the Benefit Determination on review?

1. Urgent Care Claim. In the case of an Urgent Care Claim, the Plan Administrator or its designee shall notify the claimant of the Plan's Benefit Determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal of an Adverse Benefit Determination by the Plan.

2. Pre-service Claims. In the case of a pre-service Claim, the Plan Administrator or its designee shall notify the claimant of the Plan's Benefit Determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the Plan of the appeal of an Adverse Benefit Determination.

3. Post-service Claims. In the case of a post-service Claim, the Plan Administrator or its designee shall notify the claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than 60 days after receipt by the Plan of the appeal of an Adverse Benefit Determination.

4. Disability Claims. In the case of a disability Claim, the Plan Administrator or its designee shall notify the claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than 45 days after receipt by the Plan of the appeal of an Adverse Benefit Determination, unless the Plan Administrator or its designee determines that special circumstances require an extension of time for processing the Claim. If the Plan Administrator or its designee determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45 day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on review.

5. Non-health Claims. In the case of a non-health Claim, the Plan Administrator or its designee shall notify the claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than 60 days after receipt by the Plan of the appeal of an Adverse Benefit Determination, unless the Plan Administrator or its designee determines that special circumstances require an extension of time for processing the Claim. If the Plan Administrator or its designee determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60 day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on review.

Q&A 33 How will I be notified of a Benefit Determination on review?

The Plan Administrator or its designee shall provide a claimant with written or electronic notification of the Plan's Benefit Determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv), as amended. In the case of an Adverse Benefit Determination on review, the notification shall set forth in a manner calculated to be understood by the claimant:

Specimen

1. The specific reason or reasons for the Adverse Benefit Determination on review;

    a. Reference to the specific Plan provisions upon which the Adverse Benefit Determination on review is based;

    b. 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 the Claim for benefits under the Plan.

2. A statement of the right to bring an action under Section 502(a) of ERISA;

3. In the case of an Adverse Benefit Determination on review regarding a disability Claim or a medical care Claim:
    a. If the Adverse Benefit Determination on review is based upon an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on review and that a copy of the rule, guideline, protocol, or other similar criterion will be provided, free of charge, to the claimant upon request; or

    b. If the Adverse Benefit Determination on review is based upon a Medical Necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided, free of charge, upon request.

A document, record, or other information shall be considered "relevant" to a claimant's Claim if such document, record, or other information:

1. was relied upon in making the Benefit Determination;

2. was submitted, considered, or generated in the course of making the Benefit Determination, without regard to whether such document, record, or other information was relied upon in making the Benefit Determination;

3. demonstrates compliance with any administrative processes and safeguards in making the Benefit Determination; or

4. in the case of a disability Claim or a medical care Claim, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Participant's diagnosis, without regard to whether such advice or statement was relied upon in making the Benefit Determination.

Q&A 34 Must I exhaust the Claims and Appeals procedures?

Yes. A participant or beneficiary must exhaust the claims procedures. No action at law or in equity may be brought to recover benefits under the Plan until all administrative remedies, including the full Claims and appeal procedures, have been exhausted. If a participant or beneficiary fails to file a timely Claim, or fails to request a review in accordance with the reasonable Claim procedures, such claimant shall have no right of review and shall have no right to bring any action in any court. The denial of the Claim shall

Specimen

become final and binding on all persons for all purposes. **A participant or beneficiary who has exhausted the Plan's Claims and Appeals procedures has the right to bring a civil action under Section 502(a) of ERISA provided the civil action is filed within 1 year after the final determination upon appeal under the Plan's Claims and Appeals procedures**.

Q&A 35 What is my responsibility in keeping the Plan notified?

In addition to the duties to report Accidents, Occupational Disease and/or Cumulative Trauma, and comply with all of the requirements to receive benefits under the Plan, each participant or beneficiary shall be responsible for providing the Claims Administrator and/or the Company with the participant's or beneficiary's current U.S. mailing address and electronic address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address furnished by the participant or beneficiary and mailed by regular United States mail or by electronic means as specified in 29 CFR 2520.104b-l of ERISA. The Claims Administrator, Plan Administrator, the Company shall not have any obligation or duty to locate a participant or beneficiary. In the event that a participant or beneficiary becomes entitled to a payment under the Plan and such payment is delayed or cannot be made:

- Because the current address according to the Claims Administrator's records is incorrect;
- Because the participant or beneficiary fails to respond to the notice sent to the current address according to the Claims Administrator's records;
- Because of conflicting claims to such payments; or
- For any other reason.

The amount of such payment, if and when made, shall be determined under the provisions of the Plan without payment of any interest or earnings.

MISCELLANEOUS INFORMATION

Q&A 36 How is the Plan funded?

The benefits provided under the Plan are paid from the general assets of Company. Nothing in the Plan requires Company, any Company or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any participant and no participant or other person has any claim against, right to, or security or other interest in any fund, account or assets of Company.

Q&A 37 Who administers the Plan?

The Administrator of the Plan is Company. Company has contracted with the Claims Administrator listed on General Information and Benefits Schedule Page (attached to this document) for the administration of the Plan. The Plan Administrator is responsible for ongoing administration of the Plan, such as establishing eligibility, setting procedures, interpreting Plan provisions, amending the Plan, and developing and distributing notices, governmental filings, and communications. The Claims Administrator is responsible for reviewing claims and determining entitlement to benefits.

Q&A 38 Can the Plan be amended or terminated?

While it is Company's intention to maintain the Plan indefinitely, Company has exclusive and discretionary authority to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by a duly authorized representative of Company. Upon termination, the right of participants to benefits is limited to claims incurred up to the date of termination.

Specimen

Q&A 39 Does the Plan modify my employment with my employer?

No. The adoption and maintenance of the Plan is not a contract of employment between the Company and any employee or other individual. Nothing in the Plan document or this SPD gives any employee or other individual the right to be retained in the employ of the Company or to interfere with the right of the Company to discharge any employee (or terminate a relationship with any other individual) at any time, with or without cause, nor does the Plan give the right to the Company to interfere with an employee's right to terminate his or her employment at any time.

Q&A 40 Are Plan benefits transferrable or assignable?

None of the payments, benefits, proceeds, claims or other rights afforded to any employee, participant or beneficiary under this Plan are subject to the any claim of any creditor, and, to the fullest extent permitted by law, shall be free from attachment, garnishment, trustees' process, or any other legal or equitable process available to any creditor. No employee, participant, or beneficiary shall have the right to alienate, anticipate, pledge, encumber, hypothecate, or assign any benefit, payment, proceed, claim, or other right, contingent or otherwise, which she or she may be entitled to expect to receive or assert under this Plan.

Q&A 41 What laws govern the Plan?

The Plan shall be construed, administered and governed in all respects in accordance with the laws of the State of Texas to the extent not preempted by ERISA.

Q&A 42 Do I have any rights & protections under ERISA?

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 (as applicable)

1. Examine, without charge, at the Administrator's office, and at other specific locations, such as work sites, all plan documents and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Administrator, copies of documents governing the operation of the plan, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make reasonable charges for the copies.

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

Prudent Actions by Fiduciaries

In addition to creating rights for plan participants and their beneficiaries, ERISA imposes obligations upon the persons who are responsible for the operation of the plan. The people who operate the plan, called fiduciaries of the plan, have a duty to do so prudently and in the interest of 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.

Enforce Your Rights

If a claim for benefits 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.

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Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents on the latest annual report from the Administrator and do not receive them in 30 days, you may file a suit in federal court. In such a case, the court may require the Administrator to provide the materials, and pay you up to $110 per day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Administrator. If a claim for benefits is denied or ignored in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States 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 the claim is frivolous.

Assistance with Your Questions
If you have questions about your plan, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the 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, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 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.

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