EMPLOYEE INJURY BENEFIT PLAN

Specimen

OFFICIAL PLAN DOCUMENT

PLAN NO. 501

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I. INTRODUCTION

A. The Plan

The Company is pleased to sponsor this Employee Injury Benefit Plan for the employees of the Company (hereinafter the "Plan"). The Plan is an occupational accident plan established to provide benefits to employees who are injured in a work-related accident, while performing their job furthering the Company's business. The original effective date of the Plan is found in the Schedule of Benefits, Appendix B. The Plan is the exclusive remedy for work-related injuries and provides medical expense benefits, Indemnity Benefits, along with accidental death and dismemberment benefits to compensate employees or the beneficiaries for:

- ➢ Medical expenses arising from an accidental bodily injury;
- ➢ Accident death, dismemberment and loss of use; and
- ➢ Accidental disability.

The Company intends to continue the Plan indefinitely, but necessarily reserves the right to amend or terminate the Plan for any reason, in whole or in part, at any time without notice. In the case of any conflict between the terms and provisions of the Plan and the terms and provisions of the Summary Plan Description, the Plan will control and govern.

B. Fiduciaries and Plan Responsibilities

The Company and the Plan Administrator are fiduciaries whose duties and responsibilities are described herein.

C. Funding Policy

The amount, timing and source of funding for the Plan are determined by the Company in its sole and absolute discretion. The Plan Benefits are payable out of the general assets of the Company and participating employers. Nothing in the Plan will be construed to require the Company, any participating employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any employee or beneficiary and with regard to this Plan, no employee or beneficiary or any other person has any claim against, right to, or security or other interest in, any fund, account or assets of the Company or any participating employer. Company shall have no obligation, but shall have the right to obtain insurance contracts with one or more insurers in order to provide funds to the Company to reimburse the Company for or to pay certain benefits under this Plan. Any such insurance contract shall be owned by the Company and no employee or beneficiary shall have any interest in or right to any benefits payable under such contract.

D. ERISA Rights Statement

1. Your Rights Under Federal Law

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA").

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2. Receive Information About Your Plans and Benefits

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

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plans, including insurance contracts, and copies of the latest annual reports (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Obtain, upon written request to the plan administrator, a copy of the Plan's annual financial reports. The plan administrator is required by law to furnish each participant with a copy of the summary annual reports.

Obtain a statement specifying whether you have a right to receive a pension at your normal retirement age, as defined in this summary plan description, and if so, what your benefits would be at your normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you must work to earn a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate your plans, called "fiduciaries" of the plans, 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 (pension, welfare) benefit or exercising your rights under ERISA.

4. Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual reports from the plans and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's

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decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance with Your Questions

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

II. DEFINITIONS

Certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found in this section.

"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.

"Active Service" means a Participant is either 1) actively at work performing all regular duties either at the Company's place of business or someplace the Company requires Employee to be; or 2) actively at work performing restricted or modified duty work at the direction of the Company in the course of Employee's Scope of Employment.

"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

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the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's 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.

"Adverse Benefit Determination on Review" means the upholding or affirmation of an Adverse Benefit Determination by the designated appeals committee.

"Ambulatory Surgical Center" means an institution or facility, either free standing or as part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered to be an Ambulatory Surgical Center.

"Annual Plan Aggregate" means the maximum amount payable on behalf of the Plan and reimbursable during the Plan Year.

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

"Beneficiary" means the person or persons determined in the following priority:

A. If there is an Eligible Spouse, all Death Benefits shall be paid to the Eligible Spouse.

B. If there is no Eligible Spouse, Death Benefits shall be paid in equal shares to the Eligible Children.

C. If the Participant is not survived by an Eligible Spouse or Eligible Child, any Death Benefits shall be paid to a surviving dependent (as determined in accordance with the support criteria set forth in section 152 of the Internal Revenue Code and such other rules as the Claims Administrator may prescribe) of the Participant who is a parent, sibling, or grandparent of the deceased Participant. If more than one of those dependents survives the Participant, any Death Benefits shall be divided among them in equal shares.

D. If the Participant is not survived by an Eligible Spouse, Eligible Child, or dependent who is a parent, sibling, or grandparent, no Death Benefits shall be payable.

E. For purposes of this Section:

1. "Eligible Spouse" means the surviving Spouse, Same-Sex Spouse or Domestic Partner of the deceased Participant;

(a) "Spouse" means a person of the opposite gender from the Participant who is legally married to the Participant as recognized by a marriage certificate issued

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under the laws of the State of Texas or similar government authority, or by a court decree of common law marriage (obtained at such person's sole initiative and expense).

(b) "Same-Sex Spouse" means a person of the same gender as the Participant who at the relevant time either (i) is recognized as being legally married to the Participant under the laws of the state or country in which the relationship was created, or (ii) is a person who has joined with the Participant in a civil union that is recognized as creating some or all of the rights of marriage under the laws of the state or country in which the relationship was created.

(c) "Domestic Partner" means a person who is not the Spouse or Same-Sex Spouse of the Participant, but who at the relevant time is the Participant's significant other (together referred to as "partners") with whom the Participant lives and shares financial responsibility. A Domestic Partner may be the same gender or opposite gender of the Participant. A person will be considered a Domestic Partner of the Participant if the person can provide a domestic partnership certificate to the Employer from a city, county or state which offers the ability to register a domestic partnership. In addition, a Domestic Partner includes a person who has joined the Participant in a civil union that is recognized as creating some or all of the rights of marriage under the laws of the state or county in which the relationship was created.

2. "Eligible Child" means a surviving child of the deceased Participant, whether by blood, marriage, or legal adoption, and for which the parent-child relationship has been legally established prior to the date of the Participant's death by evidence of birth certificate, adoption decree, or other court decree of paternity or maternity, if the child is:

(a) under 18 years of age;

(b) enrolled as a full-time student in an accredited educational institution and is less than 26 years of age; or

(c) because of a physical or mental handicap, a dependent (as determined in accordance with the support criteria set forth in section 152 of the Internal Revenue Code and such other rules as the Claims Administrator may prescribe) of the deceased Participant at the time of the Participant's death.

"Benefit(s)" means the Medical Expense Benefits, Indemnity Benefits, and Accidental Death and Dismemberment Benefits.

"Benefit Determination" means a determination by the Claims Administrator on a Claim for benefits under the Plan, whether or not an Adverse Benefit Determination.

"Benefit Determination on Review" means a determination by the appeals committee designated by the Company on an appeal of an Adverse Benefit Determination, whether or not an Adverse Benefit Determination On Review.

"Chiropractic Care means chiropractic treatment or therapy provided by a person appropriately licensed to provide chiropractic services.

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

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"Claims Administrator" shall mean the Third Party Claims Administrator appointed by Company.

"Combined Benefit Amount Per Occurrence" is the combined aggregate of all Benefits for any Occurrence (including, but not limited to Medical Expense Benefits, Indemnity Benefits, and Accidental Death and Dismemberment Benefits) available because of Accidental Injury, Occupational Disease and or Cumulative Trauma, regardless of the number of Participants.

"Combined Benefit Amount Per Participant" is the maximum amount of Benefits available to a Participant or a Participant's beneficiary for each Occurrence under this Plan.

"Combined Benefit Period" or "Combined Coverage Period" means the period of time within which Covered Charges must be incurred and/or Indemnity Benefits are payable after an Injury, subject to the terms, limitations, and restrictions of the Plan. The Combined Benefit Period can be found in the Schedule of Benefits, Appendix B. A separate Combined Benefit Period or Combined Coverage Period will start for each Injury.

"Company" shall mean the entity named in Item 1 of Appendix B, Schedule of Benefits and any of its wholly-owned subsidiaries or controlled group members of the Company, as defined in Internal Revenue Code section 414(b) or (c), which are designated by affiliates that adopt the Plan Administrator as participating Company's in Appendix B which may be amended from time to time without a formal written amendment to the Plan with the Company's consent. The list of Company locations covered by the Plan is 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.

"Covered Charge" means those Medically Necessary treatments, services and supplies that are prescribed by an Approved Provider and actually incurred by the Participant during the Combined Benefit Period and subject to the Combined Benefit Amount Per Participant and Combined Benefit Amount Per Occurrence. A Covered Charge shall be 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.

"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 days before report of the Injury. Cumulative Trauma does not include Accidental Injury or Occupational Disease.

"Custodial Care" means care which is administered for assistance (rather than for training or education) of the patient in performing the activities of daily living. Such activities include, but are not limited to, walking, getting in and out of bed, personal hygiene feeding, preparing special

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diets and administering medication. Custodial Care also includes non-acute care for the comatose, semi-comatose, paralyzed, or mentally incompetent patient.

“Dependent” means the Participant’s Spouse and/or unmarried children who are under age nineteen (19); or who are between the ages of nineteen (19) and twenty-five (25) if enrolled as a full-time student in an accredited college, university, vocational or technical school and relies on the Participant for more than 50% of his or her support; or who is older than age 25 but is incapable of self-sustaining employment by reason of mental retardation or physical disability or handicap.

“Disabled” or “Disability” or “Total Disability” means a Participant is not able to perform, at any time during the Combined Benefit Period, any of the material and substantial duties of the Participant’s occupation, business, or employment which the Participant held at the time of Injury due to an Accident while in the Scope of Employment.

“Disability Claim” means a Claim for benefits that is conditioned upon a showing of Disability by the Participant.

“Effective Date” of this Plan is located in the Schedule of Benefits, Appendix B.

“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.

“Employee” or is a person directly employed by the Company in its regular business and who receives his or her pay on a regular basis by means of a salary or wage directly from the Company, receives a W-2 from the Company for reporting to the Internal Revenue Service, and whose salary or wage is subject to all applicable state and federal income taxes. An Employee must be employed by the Company in its regular business at the time and place of the Accident causing Bodily Injury and must be acting within his or her Scope of Employment. An Employee does not include subcontractors or independent contractors, whether they are contracted for the Company on an occasional, part-time or full-time basis or any individual who is not treated by the Company as an employee for payroll tax purposes at the time he or she performs services for the Company (including those individuals paid by a temporary or other staffing agency), whether or not such individual is subsequently determined by a government agency, by the conclusion or settlement of threatened or pending litigation, or otherwise to be or have been an employee of the Company during such period. An Employee does not include a third-party agent.

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"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations and other authority issued thereunder by the appropriate governmental authority. Reference to any section of ERISA shall include references to any successor section of ERISA.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations and other authority issued thereunder by the appropriate governmental authority.

"Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

A. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;

B. It has policies established by a professional group associated with the agency or organization, This professional group must include at least one (1) physician and at least one (1) registered graduate nurse to govern the services provided and it must provide for full-time supervision of such services by a physician or registered graduate nurse;

C. It maintains a complete medical record on each individual; and

D. It has a full-time administrator.

"Home Health Care Plan" means a program for continued care and treatment of the Participant established and approved in writing by the Participant's Approved Provider within seven (7) days following termination of a Hospital confinement as a resident patient, and is for the same or related condition for which he or she was hospitalized. The Approved Provider must certify that the proper treatment of the Injury would require continued confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

"Hospital" means an institution which meets all of the following conditions:

A. It is engaged primarily in providing medical care and treatment to the injured person on an Inpatient basis at the patient's expense;

B. It is constituted, licensed and operated in accordance with the laws of jurisdiction in which it is located which pertain to Hospitals;

C. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Injury;

D. Such treatment is provided for compensation by or under the supervision of physicians with continuous 24 hour nursing services;

E. It is a provider of services under Medicare; and

F. It charges patients for its services.

A Hospital is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

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“Indemnity Benefits” means certain wage replacement benefits payable to a Participant who is Disabled as defined in this Plan.

“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.

“Inpatient” means a patient who is confined to a Hospital, hospice or Convalescent Nursing Facility for treatment, and charges are made for Room And Board to the patient as a result of such treatment.

“Intensive Care Unit” means a section, ward or wing within the Hospital which is separated from other facilities and:

A. Is operated exclusively for the purpose of providing professional medical treatment for critically ill or critically injured patients;

B. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and

C. Provides constant observation and treatment by a nurse or other highly trained Hospital personnel.

“Intoxicated” means testing positive for any amount of drugs or alcohol, regardless of the cause of the Accident or Occurrence.

“Loss of Use” means the total loss of movement or total feeling in the arm (including the hand) and/or leg (including the foot). The loss must be determined by an Approved Provider to be complete and irreversible. Loss of use must commence within 365 days of the date of the Accident and continue without interruption for a period of not less than 365 consecutive days. The Loss Of Use must be total and irreversible and beyond remedy by surgical or other means.

“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.

“Manifest” means when an Occupational Disease is reasonably capable of diagnosis by an Approved Provider or, in the opinion of the Approved Provider, the Participant could reasonably be expected to be aware of its existence.

“Medical Care Claim” means a Pre-Service Claim, a Post-Service Claim, a Concurrent Care Decision or an Urgent Care Claim.

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"Medical Expense" an expense, incurred by a Participant as a direct result of a Bodily Injury due to an Accident or Occurrence, for medical or dental services, procedures, supplies, or prescription drugs, provided the expense is Medically Necessary, Usual and Customary, and prescribed by an Approved Provider acting within the scope of his or her license.

"Medically Necessary" or "Medical Necessity" means that a service, procedure, medicine, prescription drug, or supply is necessary and appropriate for the diagnosis or treatment of an Accidental Bodily Injury based on generally accepted current medical practice. A service, medicine or supply will not be considered Medically Necessary if it:

A. Is provided only as a convenience to a Participant or a provider;

B. Is not appropriate treatment for a Participant's diagnosis or symptoms; or

C. 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 any particular 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 final determination of whether a service, procedure, medicine, prescription drug, or supply is Medically Necessary will be made by the Claims Administrator, or its delegate.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the United States Social Security Amendments of 1985, as then constituted or later amended.

"Minor Emergency Medical Clinic" means a freestanding facility which is engaged primarily in providing minor emergency and episodic medical care to a Participant. A board-certified physician, a registered nurse, and a registered X-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include X-ray and laboratory equipment and a life support system. For the purposes of the Plan, a clinic otherwise meeting these requirements but is, in any way, part of a regular Hospital, shall be excluded from the terms of this definition.

"New Injury" with respect to a Preexisting Condition means a medically diagnosed change in the physical structure of the body caused by an Accident or Occurrence.

"Non-Health Claim" means a Claim other than a Disability Claim or a Medical Care Claim.

"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.

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"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.

"Other Income Benefits" means any amounts that a Participant or a Participant's dependents receive (or are assumed to receive) under:

A. Any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary Indemnity Benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted. If paid as a lump sum, these benefits will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over a five year period. If no specific allocation of a lump sum is made, then the total sum will be an Other Income Benefit.

B. Any Social Security or retirement benefits the Participant receive or any third party receives (or is assumed to receive) on the Participant's behalf or for the Participant's dependents; or, if applicable, that the Participant's dependents receive (or are assumed to receive) because of the Participant's entitlement to such benefits.

C. Any proceeds payable under any Company group health or welfare plan, group insurance or similar plan. If there is other coverage or insurance that applies to the same claim for Benefits under this Plan, and contains the same or similar provision for reduction because of other coverage or insurance, this Plan will pay its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit under this Plan that the amount payable without other benefits, coverage or insurance, bears to the total benefits under all such sources.

"Outpatient" refers to a patient who receives medical care, treatment, services or supplies at a clinic, a physician's office, or at a Hospital if the patient is not a registered bed patient at that Hospital.

"Partially Disabled" refers to a Participant who remains Disabled from working full time, but is able to return to work on a part-time basis or earns less than his or her pre-Injury wage.

"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.

"Plan" means the Employee Injury Benefit Plan of the entity identified in the Schedule of Benefits, Appendix B, as it may be amended from time to time, including all subsequent amendments.

"Plan Administrator" means the Plan Sponsor or its designee.

"Plan Sponsor" means the Company.

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“Post-Service Claim” means a Medical Care Claim under the Plan for reimbursement or consideration of payment for the cost of medical care that has already been rendered. A Post-Service Claim is a Medical Care Claim that is neither a Pre-Service Claim nor an Urgent Care Claim.

“Pre-Certification” means a program whereby 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, the Participant or an Approved Provider will obtain authorization from the Claims Administrator.

“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.

“Pre-Service Claim” means a medical care claim for benefits under the Plan that, under the terms of the Plan, conditions the receipt of the benefit, in whole or in part, on pre-approval of the benefit in advance of obtaining medical care.

“Principal Residence” means the legal domicile of the Participant.

“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. Company. “Scope of Employment” does not include a Participant’s transportation to and from the Participant’s residence and the Participant’s workplace. Employee 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.”

“Spouse” means a Participant’s legal spouse or domestic partner as defined in the Company’s domestic partner policy, as it may be amended from time to time.

“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

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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.

"Usual and Customary Charge" means the usual charge made by a licensed health care provider acting within the scope of his or her license; a provider of treatment, services, procedures, supplies, medicine or prescription drugs that does not exceed the general level of charges made by other Approved Providers rendering or furnishing such care or treatment within the same geographic area. The final 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, or its delegate.

"Waiting Period" means the number of days after the Participant has suffered an Accidental Injury and the Participant is Totally Disabled, but for which no benefits are payable.

III. PARTICIPATION, REPORTING, AND REQUIREMENTS

A. Commencement of Participant

An individual who becomes an Employee coded in the Company's payroll system as residing in the State of Texas after the Effective Date of the Plan shall become a Participant on the date the Employee is first in Active Service in the State of Texas. No enrollment forms are necessary.

B. Cessation of Participation

Participation in the Plan ceases on the earliest of the following:

- Participant's voluntary separation of employment or termination for cause;
- The date the Participant is determine to have not complied with their obligations under the Plan;
- The date the Company terminates the Plan;
- The date the Participant is no longer eligible to participate in the Plan; or
- The date the Participant is released to Maximum Rehabilitative Capacity.

C. Reporting Requirements

A Participant must immediately report any Accidental Injury or Occupational Disease from a known cause or exposure to his or her manager or other person designated by the Company, and no later than 24 hours after the date of injury. The Participant must report every Accidental Injury, regardless of the nature or severity. Further, Participant 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

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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 the Participant's 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.

D. Drug and Alcohol Screen

In the event of an Accident requiring medical care, Employee 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 of a Participant to submit to a drug and alcohol screen upon request within 24 hours of management's request will result in a denial of benefits under this Plan.

E. Medical Treatment

The Participant will be sent to an Approved Provider. The Participant must seek initial medical treatment with an Approved Provider within 14 days of an Accident or Occurrence. Participant will be required to accept referral to an Approved Provider. If a Participant chooses to go to a physician of his choice without prior approval, the Plan will not be responsible for the expenses incurred by the Participant in so doing. In addition, the Plan Administrator reserves the right to require that a Participant undergo an initial and subsequent evaluation by an Approved Provider prior to allowing the Participant to return to work after an Accident or Occurrence. The Participant must attend scheduled appointments. If a Participant misses one scheduled appointment, benefits may be suspended or terminated, at the Plan's discretion. If a Participant misses a second scheduled appointment, benefits can be terminated at the Plan's discretion. Benefits will terminate if Participant goes 60 or more consecutive days without treatment with an Approved Provider after initial treatment.

The Claims procedures applicable to Claims made for benefits under the Plan do not include casual or general inquiries regarding eligibility or particular benefits that may be provided under the Plan. In order for an "inquiry" to constitute a Claim for benefits or an appeal of an Adverse Benefit Determination, a Participant must follow the Claim procedures set forth in this Plan.

F. Medical Advice

The Plan will provide for the continuing medical care of an injured or ill Participant as described in this Plan only if the Participant follows fully and completely the advice of and/or the course of treatment prescribed by the Approved Provider including, but not limited to, keeping all scheduled appointments and fulfilling the recommended treatment plan. The failure by a Participant to satisfy these (and all other) Plan conditions shall relieve the Plan, Plan Administrator, and/or Company of any obligation to provide continuing benefits under this Plan.

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G. Second Opinion

Additional medical opinions relating to any Injury may be required prior to benefits being paid or benefits being continued. Failure of a Participant to submit to an additional opinion upon request may result in denial of benefits under this Plan.

If Participant disagrees with the diagnosis or treatment recommended by an Approved Provider whose opinion is accepted by the Claims Administrator, then Participant may request a second, medical opinion. Participant must notify the Claims Administrator of the request for a second, medical opinion within 30 days of the diagnosis from an Approved Provider. The Participant shall have the right to a one-time examination at his or her **own expense** by another physician ("Second Physician"). The Participant shall have the right to select the Second Physician who will examine Participant solely for the purpose of evaluating the Participant's 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.

After initial treatment, the Approved Provider may instruct the Participant 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, Participant must report that change of work status immediately, but no later than 24 hours following Participant's appointment with the Second Physician, to his or her supervisor. Participant must report to work when directed by their supervisor.

H. Incapacity and Return to Work.

After initial treatment, the Approved Provider may instruct the Participant 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, Participant must report that change of work status immediately to his or her supervisor. Participant must report to work when directed by their supervisor.

I. Weekly Contact.

A Participant must contact the Claims Administrator or Plan Administrator weekly while receiving benefits to report on his progress and expected recovery time. Failure to do so may cause the Participant's entitlement to continuing benefits under the Plan to be discontinued. Participant must promptly respond if contacted by Company or Claims Administrator or Plan Administrator.

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J. Failure to Return to Work.

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

K. Covered Locations.

The list of Company locations covered by the Plan is contained in the Company's DWC 005 annual filing with the Texas Department of Insurance and is available for review upon request from the location where Participant works.

IV. BENEFITS, ELIGIBILITY, AND EXCLUSIONS

A. General Provisions

This Plan shall apply to Accidents, Occurrences, Cumulative Trauma and Occupational Disease sustained by Participants in the furtherance of the business of the Company by a Participant who is in Active Service of the Company and is subject to all terms and conditions of the Plan. The Plan specifies the only benefits for which a Participant is eligible in the event of such Accident, Occurrence, Cumulative Trauma or Occupational Disease. The Plan document shall govern in all cases concerning eligibility and benefits, including limitations and exclusions. Provision of benefits to a Participant pursuant to this Plan shall not constitute an admission of liability on the part of the Company. The Plan Administrator reserves the right to condition payment of any benefits hereunder on the Participant (or his estate or beneficiary) executing an acknowledgment to this effect.

B. Benefits Provided

Plan Benefits shall consist of the payment of Medical Expenses for eligible medical treatment rendered by an Approved Provider, Indemnity Benefits for periods of disability resulting from Injury, and applicable Accidental Death and Dismemberment Benefits.

C. Eligibility

Every Participant is eligible to receive benefits under this Plan. The initial receipt and continuing receipt of benefits is contingent upon compliance with the terms and conditions of this Plan. A participant who fails to comply with the conditions and requirements herein shall not be entitled to receive or continue to receive benefits.

D. Payment of Medical Expenses Arising From an Accident

If a Participant incurs Covered Charges as a result of Injury due to an Accident or Occurrence, the Plan will reimburse Covered Charges up to the Combined Benefit Amount Per Occurrence, Per

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Participant or the Combined Benefit Amount Per Occurrence, that are the result of the same Accident or Occurrence. The Covered Charges must be the direct result of an Injury. The first Covered Charges that are caused by the Accident or Occurrence must occur within 14 days of the Accident or Occurrence. Benefits will terminate if Participant does not receive treatment from an Approved Provider for a period of 60 or more consecutive days after initial treatment from the date of the Accident or Occurrence.

1. <u>The Plan will reimburse Covered Charges provided that</u>:

- Covered Charges for Injury are incurred within Combined Benefit Period Coverage;
- Such Covered Charges are Medically Necessary and are Usual and Customary Charges; for such services in the Geographic Area where the service was performed;
- The total amount paid on behalf of any one Participant or Participants as a result of one Accident or Occurrence for all Injuries does not exceed the maximum Combined Benefit Amount or the Combined Benefit Amount Per Occurrence;
- Such Covered Charges have not been covered or reimbursed by another medical expense coverage plan or policy; and
- Such Covered Charges do not exceed the Combined Benefit Amount, less any payments made for any other benefits under the Plan that are payable as a result of the same Accident.

2. <u>Payment of Medical Expenses shall cease upon the earliest of</u>:

- The date Maximum Medical Improvement is achieved;
- The expiration of Combined Benefit Period found in the Schedule of Benefits, Appendix B;
- Any other limitation or terminating event in this Plan;
- If Participant leaves employment for some reason other than the Employer not having suitable light duty; or
- If Participant leaves employment solely because of inability to work because of his/her Injury.

E. Payment of Indemnity Benefits Arising from an Accident

A Participant is eligible for the Indemnity Benefits provided that the Participant is disabled from performing his or her usual work for the Employer by an Accidental Injury, Occupational Disease and/or Cumulative Trauma. Said Disability must be diagnosed by an Approved Provider. If these, as well as the other conditions and limitations contained in this Plan are met, the Plan will pay Disability Benefit payments as specified in the Schedule of Benefits, Appendix B. Indemnity Benefits are payable on the regularly scheduled pay period for each location. The Waiting Period

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for the receipt of Indemnity Benefits following and Accidental Injury is identified in the Schedule of Benefits, Appendix B. Indemnity Benefits payments are subject to the following limitations:

1. Duties of a Participant

- Participant must provide the Claims Administrator with satisfactory proof of Disability and of being under the care of an Approved Provider.
- Participant must be under the continuous care of an Approved Provider.
- The Plan may require the Participant to submit proof of continued Disability as often as the Claims or Plan Administrator, in its sole discretion, considers necessary and reasonable. Failure to submit the required proof will cause the Plan to suspend reimbursement until such proof is received.

2. Reduction of Indemnity Benefits

- If the Participant remains Disabled from working full time, but is able to return to work on a part-time basis or earns less than his or her hourly wage, he or she will be deemed Partially Disabled and the Disability Benefit will be reduced by the amount of the Participant's earnings during the period of partial disability.
- The Indemnity Benefits shall be reduced by any amount for which the Participant is 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 Participant's employer; or (e) Any other amounts Participant receives outside of the Plan.

3. Termination of Indemnity Benefits

- If the Participant is released to return to work without restriction or to Maximum Medical Improvement by an Approved Provider, but the Participant does not return to work for any reason Indemnity Benefits shall cease.
- If Participant goes 60 or more consecutive days between visits to an Approved Provider, Indemnity Benefits will cease.
- Indemnity Benefits cease on the date the Participant returns to his or her regular work with the Employer.
- Indemnity Benefits cease on the date the Participant dies.
- Indemnity Benefits cease on the date the Participant leaves employment for a reason other than inability to work solely because of the Injury or Employer not having suitable light duty.
- Indemnity Benefits cease on the date the Participant is released from care by an Approved Provider or refuses to participate in any medically recommended rehabilitation program or if the Disability is treatable by medical care that is

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reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo and the Participant has not availed himself or herself of the treatment.

- Indemnity Benefits cease on the date any applicable limit stated in this Plan is reached.
- Indemnity Benefits are subject to any other limitation or exclusion contained in the Plan.

4. Other Terms and Conditions

- 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 the Participant is not Disabled.
- The amount reimbursed under this Indemnity Benefits count toward the Combined Benefit Amount Per Participant and the Combined Benefit Amount Per Occurrence. If an Injury due to an Accident or Occurrence results in the Disability of a Participant, the Plan will reimburse amounts up to the Combined Benefit Amount Per Participant or the Combined Benefit Amount Per Occurrence.

F. Payment of Accidental Death and Dismemberment Benefits Arising from an Accident

If Accidental Injury to the Participant results in any of the losses shown below within 365 days of the Occurrence or Accident, the Participant (or his designated Beneficiary in the case of death) is eligible for Accidental Death and Dismemberment Benefits in the amount specified in the Schedule of Benefits, Appendix B. 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%

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Loss	Benefit Amount
Four Fingers of the Same Hand	25%
Single Finger or Toe	10%

1. Definitions

- "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.

- "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 "Loss 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.

2. Schedule of Payments

   - An initial lump sum payment of 25% of the Accidental Death and Dismemberment Benefit due.

   - Equal, monthly installments of the remaining Accidental Death and Dismemberment Benefit due will be paid out over 12 months.

Accidental Death and Dismemberment Benefits are subject to all terms and limitations contained in the Plan, including but not limited to the Combined Benefit Limit Per Participant and the

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Combined Benefits Limit Per Occurrence. Accidental Death and Dismemberment Benefits are reduced by any other Benefits paid to the Participant arising out of the Occurrence.

G. Maximum Benefit Amount Per Participant, Per Occurrence

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 shall not exceed the amount identified in the Schedule of Benefits, Appendix B, per Occurrence. 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, shall not exceed the amount identified in the Schedule of Benefits, Appendix B.

H. Covered Charges for Medical Expenses Arising From an Accident

For purposes of this Section, Covered Charges means the charges actually incurred by a Participant for the Inpatient or Outpatient medical care and treatments listed below. 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 in excess of the Usual and Customary charge for the service, the supplies or the equipment which are needed for such care and treatment. Covered Charges include:

1. Approved Provider fees

   - Medical care and/or surgical treatments including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.
   - Nurse performing private duty nursing.
   - Licensed physical therapist in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Injury.
   - Qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Injury or due to surgery performed on account of an Injury.
   - Additional Visits to or treatments must be approved in writing in advance by the Claims Administrator.

2. Convalescent nursing facility

   - Room And Board including any charges made by the facility as a condition of occupancy. The daily Room And Board charge allowed will not exceed the facility's average semi-private charges or an average semi-private rate made by a representative cross section of similar institutions in the area.

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- Medical services customarily provided by the convalescent nursing facility, with the exception of private duty or special nursing services and an Approved Provider's fees.
- Drugs, biological solutions, dressings and casts furnished for use during the convalescent period, but no other supplies.
- Only charges incurred in connection with convalescence from the Injury, for which the Participant is confined, will be eligible for Benefits.

3. Home Health Care Agency

- Part-time or intermittent nursing care by a nurse who is under the direct supervision of a registered nurse.
- Home health aides.
- Medical supplies, drugs and medicines prescribed by an Approved Provider and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the Participant had remained in the Hospital.
- Covered Charges for care in accordance with the Home Health Care Plan are covered up to a maximum of sixty (60) days.

4. Hospital Charges

- Daily semi-private room and board; for Hospitals having only private rooms, Hospital will be reimbursed at 125% of the Usual and Customary charge for a semi-private room.
- Confinement in an Intensive Care Unit.
- Necessary services and supplies including Inpatient miscellaneous services and supplies, Outpatient Hospital treatments for chronic-conditions, and emergency room use, physical therapy treatments, hemodialysis, X-ray, and linear therapy.

5. Medical Equipment

- Wheelchair rental, Hospital bed or iron lung or other durable medical equipment required for temporary therapeutic use, or for purchase of this equipment if economically justified, whichever is less.
- Charges for artificial limbs, eyes, larynx, or Orthotic Appliances but not the subsequent replacement of such items.
- Dressings, sutures, casts, splints, trusses, crutches, braces, initial pair of corrective shoes or other necessary medical supplies with the exception of dental braces.

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6. Miscellaneous

- Professional ground ambulance services to the nearest facility where emergency care or treatment is rendered.
- Charges made by a Minor Emergency Medical Clinic or an Ambulatory Surgical Center when treatment has been rendered.
- Drugs requiring the written prescription of an Approved Provider if such drugs are necessary for the direct treatment of an Injury.
- The cost of any drug screen.
- Radiation therapy or treatment.
- Processing and administration of blood or blood components.
- Oxygen and other gases and their administration.
- Electrocardiograms, electroencephalograms, basal metabolism tests, pneuma-encephalograms, X-rays, microscopic tests and laboratory tests, or similar well-established tests generally approved by an Approved Provider and Medically Necessary.
- Cost and administration of an anesthetic.

I. Pre-Certification Requirements for Medical Expenses resulting From an Accident

Pre-Certification is designed to assure that Hospital admissions and lengths of stay, surgery and other medical services are Medically Necessary by having the Claims Administrator refer the Participant's claim file to an Approved Provider to determine Medical Necessity. The Participant's Approved Provider 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:

- Within twenty-four (24) hours after the Occurrence or Accident occurs; or
- On the first business day after admission or treatment on a weekend or legal holiday; or
- The earliest possible time thereafter.

The Claims Administrator may consult with the Approved Provider, 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 the Participant requires could be provided just as effectively through a less expensive treatment plan, the Participant will be notified of the decision. If the Participant proceeds with the treatment plan without asking for Pre-Certification or being given a Pre-Certification notice, the Participant's Medical Expense Benefit will be denied entirely.

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J. Forfeiture of Benefits

A Participant's entitlement to Benefits, however provided for, under this Plan may be forfeited, suspended, or discontinued if the Participant fails to comply with or satisfy any of the requirements or provisions of this Plan. For example, a Participant shall not be entitled to the Benefits under this Plan if:

1. The Participant utilizes a health care provider for an Injury other than an Approved Provider;
2. The Participant fails to follow the treatment and advice prescribed by the Approved Provider;
3. The Participant does not obtain treatment within 14 days of an on-the-job Injury or Accident or 60 consecutive days elapses between treatments;
4. The Participant refuses or fails to obtain a second opinion prior to surgery, if requested to do so;
5. The Participant fails to give the Company, Plan Administrator or Claims Administrator a weekly progress report by contacting the Company, either verbally or in writing, once each week while receiving benefits;
6. The Participant fails to report to his or her supervisor for work immediately upon being released in whole or in part by the Approved Provider to return to work;
7. It is determined that the Participant has any amount of illegal drugs or alcohol in his or her system at the time of the Accident;
8. It is determined the Injury is the resulted from an intentional or willful act of the Participant;
9. It is determined the Injury is the result of the Participant's violation of the Company's written safety policy;
10. The Accident arises from, or is aggravated by, a Pre-Existing Condition;
11. The Participant becomes employed by another employer while receiving Benefits under the Plan;
12. The Participant fails to provide a complete statement, affidavit, or deposition upon request concerning the incident that the Participant believes resulted in an Injury;
13. The Participant was untruthful in regard to 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; or
14. The Participant refuses to submit to drug and alcohol testing.

K. Coordination of Benefits when a Participant is Covered by Multiple Plans

If a Participant is covered under one or more other plans including, but not limited to, automobile or health insurance (excluding the Company group health insurance program), the Benefits under

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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 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:

1. When only one of the plans has a coordination of benefits provision, then the plan without such a provision will be primary.

2. If both plans have such a provision, the plan under which the Participant is covered as an Employee will be the primary plan.

3. 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.

L. Exclusions.

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:

1. Non-Covered Injuries

- Repetitive motion and Cumulative Trauma Injuries unless the Participant has worked in the job position which Participant claims caused the Injury for at least 180 days.
- Pre-existing conditions unless the Pre-Existing Condition satisfies the requirements for a “covered” Pre-Existing Condition contained in the definition of “Pre-Existing Condition” as defined in this Plan.
- Hernia, unless such hernia is an inguinal or umbilical hernia that: (a) appeared suddenly and immediately following the Accidental Injury; (b) did not exist in any degree prior to the Accidental Injury; and (c) is accompanied by pain.
- Stress, anxiety, depression, insomnia, or other similar emotional and mental disorders, even if associated with a Bodily Injury.
- Hemorrhoids.
- Hearing Loss.
- Hearing loss unless it falls under the definition of an Accidental Injury or is diagnosed by an Approved Provider as resulting solely from Participant’s job with the Employer.
- The following exposure related items: (a) asbestos, asbestos fibers or asbestos products; (b) lead or lead based products; (c) the hazardous properties, including radioactive, toxic or explosive properties, of nuclear materials; or (d) mold.
- 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

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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.

- 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.

2. Non-Covered Accidents

- A Participant's participation in (a) an assault or a felony, except an assault committed in defense of the Employer's business or property; (b) any illegal act; or (c) horseplay.
- Accidental Injury, Occupational Disease or Cumulative Trauma occurring while the Participant has in his 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 in force at the time and location of the occurrence, or if Participant has in her or her 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 Employer's Alcohol and Drug Policy.
- Accidental Injury, Occupational Disease or Cumulative Trauma to a Participant while employed in violation of law.
- A Participant's participation in any recreational, social or athletic activity not constituting part of the Participant's Scope of Employment, whether or not such participation occurs on the Employer's premises or during normal business hours.

3. Other Non-Covered Conditions

- Liability arising out of employment relationships including, without limitation, claims for any type of discrimination, discharge, coercion, criticism, demotion, reassignment, discipline, defamation, harassment, humiliation, sexual harassment, claims arising under the U .S. Americans with Disabilities Act, claims arising out of the Texas Labor Code and all other claims affecting or arising out of the employment relationship whether rising out of state or federal statues or regulations or the common law.
- 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: (a) 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

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de jure or de facto, martial law; (b) riots, strikes, or civil commotion; or (c) an act of God.

- Any diagnostic procedure, treatment, service or supply which is not Medically Necessary.
- That part of any medical expense that is in excess of the Usual and Customary Charge for that good or service.

M. Immediate Medical Assistance

The provision of immediate medical assistance is not an admission of negligence or liability of the Company nor shall it constitute a determination that the Participant is entitled to further Benefits under this Plan.

N. Acceptance of Medical Treatment

The acceptance of medical treatment by a Participant shall not obligate the Plan, Plan Administrator or Company to pay any or all related medical expenses if it is determined that the injury or illness is not an Accidental Injury, Cumulative Trauma or Occupational Disease as provided herein or is otherwise excluded or not covered by this Plan.

O. Subrogation

This provision shall apply to all Benefits provided under any section of this Plan. A Participant may incur medical or other charges related to injuries or illness 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 injuries or illness. If so, the Participant 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 will be Subrogated to all rights the Participant 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 the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures or may be entitled to procure regardless of whether the Participant has received compensation for any of his damages or expenses, including any of his 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, the Participant agrees that acceptance of Benefits is constructive notice of this provision.

1. A Participant's Obligations:

a) Execute and deliver a Subrogation and Reimbursement Agreement;

b) Authorize the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of Medical Expense or other Benefits paid for the injuries or illness

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under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Participant's rights to Recovery when this provision applies;

c) Immediate Reimbursement of Plan, out of any Recovery made from Another Party, 100% of the amount of Medical Expense or other Benefits paid for the injuries or illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

d) Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

e) Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future Benefits for other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any Medical Expense or other Benefits will be paid by the Plan for the injuries or illness. If the Plan pays any Medical Expense or other Benefits for the injuries or illness before these papers are signed, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

2. Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of Medical Expense or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

3. When a Participant Retains an Attorney

If the Participant retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of Benefits and as a condition to any payment of future Benefits for other illnesses or injuries. Additionally, the Participant's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Participant's attorneys' fees and costs

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associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

4. <u>When a Participant Receives a Recovery</u>

A Participant or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Participant or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Participant or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

5. <u>When the Participant is Deceased</u>

These provisions apply to the parents, trustee, guardian or other representative of a minor Participant and to the heir or personal representative of the estate of a deceased Participant, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

6. <u>When a Participant Does Not Comply</u>

When a Participant does not comply with the provisions of this Section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Participant and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce this provision, then that Participant agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

7. <u>Subrogation Definitions</u>

a) "Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Participant's injuries or illness. "Another Party" shall include the party or parties who caused the injuries or illness; the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Participant's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the injuries or illness.

b) "Recovery" shall mean any and all monies paid to the Participant by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

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c) “Subrogation” shall mean the Plan’s right to pursue the Participant’s claims for medical or other charges paid by the Plan against Another Party.

d) “Reimbursement” shall mean repayment to the Plan for Medical Expense or other Benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this Benefit amount.

V. ADMINISTRATION OF THE PLAN

A. Plan Administrator

The Company is the Plan Administrator who administers this Plan. The Plan Administrator may appoint a Claims Administrator to handle claims made under this Plan.

B. Discretionary Rights and Duties

The Plan Administrator is a fiduciary. The Plan Administrator has the exclusive responsibility for the general administration of the Plan and has the discretionary power and authority necessary to accomplish that purpose including, but not limited to, the following rights, powers, and authorities: (i) to make rules for administering the Plan; (ii) to construe all provisions of the Plan; (iii) to correct any defect, supply, any omission, or reconcile any inconsistency that may appear in the Plan; (iv) to determine all questions relating to eligibility and all other matters relating to entitlement to benefits; (v) to resolve all controversies relating to the administration of the Plan and to ask any questions he believes are advisable for the proper administration of the Plan; (vi) direct the Claims Administrator, if any, in all matters relating to the processing of claims and payment of Plan benefits; provided, however, such matters delegated to the Claims Administrator shall constitute ministerial or non-discretionary responsibilities; (vii) delegate any clerical or recordation duties of the Plan Administrator as the Plan Administrator believes is advisable to properly administer the Plan; (viii) the Plan Administrator (or its delegate) may investigate all accidents, injuries, and illnesses, and promulgate, implement, and enforce workplace safety rules and standards; and (ix) appoint a Claims Administrator or Claims Administrator to assist with the administration of claims under this plan.

The action of the Plan Administrator in exercising all of the rights, powers, and authorities set out in this Article IV, when performed in good faith and in its sole judgment, shall be final, conclusive, and binding upon all parties.

C. Documents

The Plan Administrator shall make available to each Participant for his or her examination those records, documents, and other data required under ERISA, but only at reasonable times during business hours. No Participant has the right to examine any data or records reflecting information pertaining to any other Participant. The Plan Administrator is not required to make any other data or records available other than those required by ERISA.

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D. Indemnification

The Plan Administrator shall not be liable for any act or omission of its own unless required by ERISA or another applicable state or federal law under which liability cannot be waived. The Company shall indemnify the Plan Administrator from any and all losses, costs, expenses, and damages arising out of the Plan Administrator's administration of this Plan, unless the Plan Administrator is determined by a non-appealable final order of a court of competent jurisdiction to have been guilty of gross negligence or willful misconduct.

VI. CLAIMS AND APPEAL PROCEDURES

A. Claim Procedure

When a Benefit is due, the Participant should submit a Claim to the Claims Administrator. If a claim is denied during the claims period, the Claims Administrator must notify the Participant in writing. The Notice of Adverse Benefit Determination must include the specific reasons for it, the Plan provisions upon which the denial is based, and the claims review procedure. If no action is taken during the claims period, the claim is treated as if it were denied on the last day of the claims period.

The Plan will be deemed to have received a claim for benefits if a Participant or a Participant's representative makes 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.

B. Claims Management and Related Deadlines

1. 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 Participant of the Plan's Benefit Determination, as follows:

a) Pre-Service Claim. The Claims Administrator will render a Benefit Determination and provide notice to the Participant of such Benefit Determination (whether or not adverse) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (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 fifteen (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 Participant, prior to the expiration of the initial fifteen (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 Participant's failure to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Participant shall be afforded at least forty-five (45) days from the receipt of the notice within which to provide the specified information.

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In the event that the Participant fails to follow the Plan's procedures for filing a Pre-Service Claim, the Participant 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 Participant as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Participant. 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 Participant 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 Participant of any such Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the Post-Service Claim. This period may be extended one time by the Plan for up to fifteen (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 Participant, prior to the expiration of the initial thirty (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 Participant to submit the information necessary to decide the Post-Service Claim, the notice of extension shall specifically describe the required information, and the Participant shall be afforded at least forty-five (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.

2. Disability Claims

If a Disability Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Participant of any Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the Disability Claim (the "Initial Period"). The Initial Period may be extended by the Plan for up to thirty (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 Participant, prior to the 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 Participant, 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.

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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 Participant shall be afforded at least forty-five (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.

3. 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 Participant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Participant 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 Participant 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 Participant of the Benefit Determination, whether or not adverse, within twenty-four (24) hours after receipt of the Claim by the Plan, provided that any such Claim is made to the Plan at least twenty-four (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.

C. Notice of Adverse Benefit Determination

In the event that a claim for benefits is to be denied in whole or in part, then the Plan Administrator shall provide the Participant or the Participant's representative with written or electronic notification of the Plan's Adverse Benefit Determination.

Except as otherwise provided, the Claims Administrator shall provide Participant or Participant's representative 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(1)(i), (iii), and (iv). The notification shall set forth in a manner calculated to be understood by the Participant:

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 Participant to perfect the Claim and an explanation of why such material or information is necessary;

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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 Participant's 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 Participant 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.

In the case 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 Participant not later than 3 days after the oral notification is provided.

D. Deadlines for Providing an Adverse Benefit Determination

The deadline for providing the notice of an Adverse Benefit Determination 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 Participant or the Participant's representative did not follow the Plan's procedure for submitting the claim, the Plan Administrator must notify the Participant or the Participant's representative 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 Participant or the Participant's representative followed Plan procedures but did not submit sufficient information for the Plan Administrator to determine whether the claim is covered or payable by the Plan, the Plan Administrator shall notify the Participant or the Participant's representative of the additional information needed within five days after receipt of the claim, and the Participant or the Participant's representative shall be given 45 days after the date the notice is received to provide the missing information. The Plan Administrator shall then review the additional information and notify the Participant or the Participant's representative 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 Plan Administrator shall send a notice of claim denial within 15 days after the end of the 45-day period. Exception for Urgent Care: If the claim is for urgent care, the Plan Administrator shall notify the Participant or the Participant's representative of the additional information needed within 24 hours after the claim

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is received, and the Participant or the Participant's representative shall be given 48 hours to provide the missing information. The Plan Administrator shall then review the additional information and notify the Participant or the Participant's representative 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 Plan Administrator shall provide a notice of denial of the claim within 48 hours after the end of the response period.

3. If the Participant or the Participant's representative 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.

E. Appeal Procedures

1. Filing an Appeal. If a Participant disagrees with an Adverse Benefit Determination the Participant shall file an appeal of an Adverse Benefit Determination to the Claims Administrator within 180 days following receipt of notification of an Adverse Benefit Determination. The Participant shall be provided a reasonable opportunity for full and fair review of an Adverse Benefit Determination, in accordance with the provisions of this Section.

2. General Review Procedures. The following are general review procedures:

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

c) The appeal shall take into account all comments, documents, records, and other information submitted by the Participant 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 Participant, along with a notice to the Participant of his/her right to respond to the new information.

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

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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.

e) 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 Participant, and all necessary information, including the Plan's Benefit Determination on Review, shall be transmitted between the Plan and the Participant by telephone, facsimile, or other available similarly expeditious method.

F. Benefit Determination on Appeal

1. Timing of Notification on Appeal

a) Urgent Care Claim. In the case of an Urgent Care Claim, the Claims Administrator shall notify the Participant 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 Participant's appeal of an Adverse Benefit Determination by the Plan.

b) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall notify the Participant 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 thirty (30) days after receipt by the Plan of the Participant's appeal of an Adverse Benefit Determination.

c) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall notify the Participant of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Participant's appeal of an Adverse Benefit Determination.

d) Disability Claims. In the case of a Disability Claim, the Claims Administrator shall notify the Participant of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than forty-five (45) days after receipt by the Plan of the Participant's appeal of an Adverse Benefit Determination, unless the Claims Administrator determines that special circumstances require an extension of time for processing the Claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Participant prior to the termination of the initial forty-five (45) day period. In no event shall such extension exceed a period of forty-five (45) days from the

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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.

e) Non-Health Claims. In the case of a Non-Health Claim, the Claims Administrator shall notify the Participant of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Participant's appeal of an Adverse Benefit Determination, unless the Claims Administrator determines that special circumstances require an extension of time for processing the Claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Participant prior to the termination of the initial sixty (60) day period. In no event shall such extension exceed a period of sixty (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.

G. Notification of Benefit Determination On Appeal

The Claims Administrator shall provide a Participant 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(1)(i), (iii), and (iv). In the case of an Adverse Benefit Determination On Review, the notification shall set forth in a manner calculated to be understood by the Participant:

1. The specific reason or reasons for the Adverse Benefit Determination On Review;

2. Reference to the specific Plan provisions upon which the Adverse Benefit Determination On Review is based;

3. A statement that the Participant 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 Participant's Claim for benefits under the Plan.

4. A statement of the Participant's right to bring an action under Section 502(a) of ERISA;

5. 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 Participant 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

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Plan to the Participant's medical circumstances, or a statement that such explanation will be provided, free of charge, upon request.

H. Procedures Specific to Department of Labor Regulations

1. If applicable, all adverse benefit and appeal determinations will contain an explanation of the basis for, and disagreement with, the opinions provided by an Approved Physician.

2. All adverse benefit and appeal determinations will provide a citation to the guidelines, protocols, standards, and plan terms relied on in the determination.

3. Before making an adverse appeal determination, the Plan will disclose any new or additional evidence or information considered, relied upon or generated by the Plan in connection with the claim as well as the rationale behind consideration of the new or additional evidence. In this situation, the claimant will have a reasonable opportunity to supplement their claim with any new information or evidence.

4. Appeal decision letters with describe any applicable, contractual or statutory limitations period that applies to the claimant's right to bring an action related to the claim. This includes the calendar date on which the contractual or statutory limitations period expires for the claim.

I. Calculating Time Periods

For the purposes of this Section, the period of time within which a Benefit Determination or a Benefit Determination on Review is required to be made shall begin at the time a Claim or appeal, as the case may be, is filed in accordance with the procedures of the Plan, without regard to whether all information necessary to make a Benefit Determination or a Benefit Determination on Review, as the case may be, accompanies the filing. In the event that a period of time is properly extended due to a Participant's failure to submit information necessary to decide a Claim or the appeal, the period for making the Benefit Determination or the Benefit Determination on Review shall be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

J. Relevance

For the purposes of this Section, a document, record, or other information shall be considered "relevant" to a Participant'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;

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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.

K. Rights of Recovery

Whenever Benefit payments have been made in excess of the maximum amount of payment required under the Plan, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

L. Exhaustion of Administrative Remedies

No action at law or in equity may be brought to recover Benefits under the Plan until all administrative remedies, including the appeal procedures, have been exhausted. If a Participant fails to file a timely claim, or if the Participant fails to request a review in accordance with the reasonable claim procedures, such Participant shall have no right of review and shall have no right to bring any action in any court. The denial of the Claim shall become final and binding on all persons for all purposes.

M. Procedures Specific to Department of Labor Regulations

1. If applicable, all adverse benefit and appeal determinations will contain an explanation of the basis for, and disagreement with, the opinions provided by an Approved Physician.

2. All adverse benefit and appeal determinations will provide a citation to the guidelines, protocols, standards, and plan terms relied on in the determination.

3. Before making an adverse appeal determination, the Plan will disclose any new or additional evidence or information considered, relied upon or generated by the Plan in connection with the claim as well as the rationale behind consideration of the new or additional evidence. In this situation, the claimant will have a reasonable opportunity to supplement their claim with any new information or evidence.

4. Appeal decision letters with describe any applicable, contractual or statutory limitations period that applies to the claimant's right to bring an action related to the claim. This includes the calendar date on which the contractual or statutory limitations period expires for the claim.

N. Failure to Timely Respond to an Appeal

If the Claim Administrator fails to timely response to a Participant's Appeal of an Adverse Benefit Denial, the Claim Administrator is presumed to have upheld the original Adverse Benefit Determination.

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O. Participant's Responsibilities

Each Participant shall be responsible for providing the Claims Administrator and/or Company with the Participant'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 and mailed by regular United States mail or by electronic means as specified in 29 CFR 2520.104b-1 of ERISA. The Claims Administrator and Company shall not have any obligation or duty to locate a Participant. In the event that a Participant becomes entitled to a payment under the Plan and such payment is delayed or cannot be made:

1. Because the current address according to the Administrator's records is incorrect;
2. Because the Participant fails to respond to the notice sent to the current address according to the Administrator's records;
3. Because of conflicting claims to such payments; or
4. 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.

VII. AMENDMENT AND TERMINATION

A. Amendment

The Plan Sponsor has the sole right to amend this Plan. An amendment may be made by (i) a certified resolution or consent of the Company, or (ii) by an instrument in writing executed by the appropriate officer or employee of the Plan Sponsor. The amendment must describe the nature of the amendment and its effective date.

B. Termination

The Plan Sponsor may terminate this Plan by executing and delivering to the Plan Administrator a notice of termination specifying the date of termination.

VIII. ARTICLE VIII – MISCELLANEOUS

A. Creditors

None of the payments, Benefits, proceeds, claims or other rights afforded to any Employee, Participant or Beneficiary under this Plan shall be subject to any claim of any creditor, and, in particular, to the fullest extent permitted by law, all such payments, Benefits, and rights shall be free from attachment, garnishment, trustee's process, or any other legal or equitable process available to any creditor of such Employee or Participant or Beneficiary. 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 he or she may be entitled or expect to receive or assert under this Plan.

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B. No Contract of Employment

Neither the establishment of this Plan nor any modification hereof, nor the creation of any fund, trust, or account, nor the maintenance of the Plan, nor the payment of any Benefit hereunder, shall be construed as giving any Participant or Employee, or any person, the right to be retained in the service of the Company, and all Participants and other Employees shall remain subject to discharge at will, to the same extent as if this Plan had never been adopted and the Plan never obtained.

C. Heirs

This Plan shall be binding upon the heirs, executors, administrators, successors, and assigns of the parties including each Participant, estate of a Participant, and beneficiary of a Participant, present and future.

D. Headings

The headings and captions herein are provided for reference and convenience only, and shall not be considered part of this Plan, and shall not be used in construction of this Plan.

E. Gender

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

F. Controlling Law

This Plan is an "employee welfare benefit plan" as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as a Plan maintained for the purpose of providing one or more of medical, surgical, or hospital care, disability, death, or dismemberment benefits in the event of an injury. This Plan shall be governed, construed, and enforced according to Federal law to the maximum extent available.

G. Assets

No Participant shall have as a result of the adoption of this Plan any right to, or interest in, any assets of this Plan or Company, upon termination of his employment or otherwise.

H. Expenses

All expenses for management and administration of this Plan shall be paid by the Company and/or participating Employers.

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I. Offset

The purpose of the Plan is to provide wage, disability and medical benefits to eligible Participants. Additionally, the purpose of the Plan is to reduce any damage award which may result from a work place injury. All Benefits shall be construed as an offset against any damage award by a court of law with respect to any claim related to a work place injury against the Company, Employer or its respective officers, directors or employees. Benefits paid under this Plan shall not be considered payment from a collateral source as that term is defined by statute or case law.

J. No Admission of Liability

Payments made under this Plan shall not in any way constitute an admission of liability or responsibility by the Company or its respective officers, directors or employees for an injury.

K. Severance

If any provision herein is found unenforceable by a court of law, it shall not affect the enforceability of the remainder of the Plan.

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APPENDIX A – PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

Federal legislation requires that the Plan comply with certain federal regulations promulgated pursuant to the law known as the Health Information Portability and Accountability Act of 1996 (“HIPAA”). Specifically, the Plan must comply with the applicable provisions of 45 C.F.R. Part 164, known as the “Standards for the Protection of Electronic Protected Health Information” and the “Standards for Privacy of Individually Identifiable Health Information” (collectively, the “HIPAA Regulations”). The paragraphs provided herein describe how medical information about the Participants may be used and disclosed by the Plan Administrator. References to § numbers throughout this document refer to the HIPAA Regulations, unless otherwise noted.

1. Definitions: Unless otherwise provided in this paragraph, the terms defined in the Plan shall have the same meaning in this Appendix.

a. “Group Health Plan” means an employee welfare benefit plan that provides medical care, including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise.

b. “Health Care” means care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following:

(i) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

(ii) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

c. “Health Care Operations” means any of the following activities of the Plan Administrator to the extent that the activities are related to functions covered by the HIPAA Regulations:

(i) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(ii) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(iii) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of § 164.514(g) are met, if applicable;

(iv) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(v) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

(vi) Business management and general administrative activities of the Employer, including, but not limited to: (A) management activities relating to implementation of and compliance with the requirements of the HIPAA Privacy Rules; (B) customer service; (C) resolution of internal grievances; (D) the sale, transfer, merger, or consolidation of all or part of the Employer with another entity, and due diligence related to such activity; and (E) consistent with the applicable requirements of § 164.514, creating de-identified health information or a limited data set.

d. “Payment” means activities undertaken by the Plan Administrator to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. These activities must relate to the individual to

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whom health care is provided and include, but are not limited to:

(i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

(iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(v) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

(vi) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: (A) name and address; (B) date of birth; (C) social security number; (D) payment history; (E) account number; and (F) name and address of the health care provider and/or health plan.

e. “Protected Health Information” (or “PHI”) means any information whether oral or recorded in any form or medium, that:

(i) Is created or received by a health care provider, health plan, public health authority, employer, or life insurer; and

(ii) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care of an individual.

f. “Electronic Protected Health Information” means PHI which is transmitted by, or maintained in, electronic media.

g. “Security Incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

h. “Summary Health Information” means information that may be individually identifiable health information, and:

(i) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

(ii) From which the information described at § 164.514(b)(2)(I) has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

i. “Treatment” means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

2. Permitted uses and disclosures: The Plan is permitted to use or disclose Protected Health Information as follows:

a. To the individual who is the subject of the PHI;

b. For treatment, payment, or health care operations, as permitted by and in compliance with § 164.506;

c. Incident to a use or disclosure otherwise permitted or required by HIPAA, provided that the Employer has complied with the applicable requirements of § 164.502(b), § 164.514(d), and § 164.530(c) with respect to such otherwise permitted or required use or disclosure;

d. Pursuant to and in compliance with a valid authorization under § 164.508; and

e. Pursuant to an agreement under, or as otherwise permitted by, § 164.510.

3. Required disclosures: The Plan is required to disclose Protected Health Information:

a. To an individual, when requested under, and required by § 164.524 or § 164.528; and

b. When required by the Secretary of Health and Human Services under subpart C of part 160 to investigate or determine the Employer’s compliance with HIPAA.

4. Employer Certification: The Plan will disclose Protected Health Information to the Employer because the Employer certifies that the Employer agrees to:

a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law;

b. Ensure that any agents, including a subcontractor, to whom it provides Protected Health

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Information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such Protected Health Information;

c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

d. Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

e. Make available Protected Health Information in accordance with § 164.524;

f. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with § 164.526;

g. Make available the Protected Health Information required to provide an accounting of disclosures in accordance with § 164.528;

h. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Regulations;

i. If feasible, return or destroy all Protected Health Information received from the Plan that the sponsor still maintains in any form and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

j. Ensure that the adequate separation required in the following paragraph is established.

5. Separation between the Plan and Employer:

a. The only employees or other persons under the control of the Employer who shall be given access to Protected Health Information for use and disclosure are:

(i) The Plan's designated Claim's Administrator;

(ii) The Plan's Committee Members; and

(iii) Those staff members designated to perform Plan functions.

b. The Employer must restrict the access to and use by such persons to the plan administration functions that the Employer performs for the Plan; and

c. If any of the persons described in a.(i), (ii), and (iii) above violate the requirements of this paragraph, the Employer must resolve any issues of noncompliance in accordance with the mechanisms provided in the Notice of Privacy Practices distributed to all Plan Participants.

6. Exception: Notwithstanding the above requirements, the Plan may disclose summary health information to the Employer if the Employer requests such information for the purpose of:

a. Obtaining premium bids from health plans for providing health insurance coverage under the Plan;

b. Modifying, amending, or terminating the Plan; or

c. Determining whether the individual is participating in the Plan.

7. Security Requirements: The Plan will reasonably and appropriately safeguard Electronic Protected Health Information created, received, maintained or transmitted to or by the Employer on behalf of the Plan. Further, the Employer will:

a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that the Employer creates, receives, maintains, or transmits on behalf of the Plan;

b. Ensure that the adequate separation required by Section 5 above is supported by reasonable and appropriate security measures;

c. Ensure that any agent to whom the Employer provides Electronic Health Information agrees to implement reasonable and appropriate security measures to protect the information; and

d. Report to the Plan any Security Incident of which the Employer becomes aware.

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