EMPLOYEE OCCUPATIONAL INJURY BENEFIT PLAN

OFFICIAL PLAN DOCUMENT

Starr Indemnity Reimbursement Revised 11/13/09

TABLE OF CONTENTS

EMPLOYEE OCCUPATIONAL INJURY BENEFIT PLAN

The Company (and any Participating Employers) desires to establish or update the Employee Occupational Injury Benefit Plan. This Plan is an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The intent of this Plan is to provide non-fringe, wage replacement, death, dismemberment, and medical benefits to eligible Texas employees who sustain a covered injury in the Course and Scope of Employment. The Company has rejected coverage for its Texas employees under the Texas Workers' Compensation Act; and, by execution of the Schedule of Benefits, has established or updated a separate occupational injury benefit plan to apply solely to covered Employees who suffer an eligible Injury on or after the Plan's Effective Date and any beneficiaries, spouse, children, parents, heirs, legal representatives and assigns of such Employee.

ARTICLE I
PARTICIPATION IN THE PLAN

A Covered Employee shall become a Participant in this Plan as of the later of (A) 12:01 a.m. on the Effective Date specified in Item 2(a) of the Schedule of Benefits, (B) the time and date of his or her employment as a Covered Employee, or (C) at such time a Covered Employee receives notice of this Plan after the date specified in item 2(a). In the event the Company sponsored an occupational injury benefit plan immediately prior to the date specified in item 2(a), any Covered Employee who sustains an injury after the date specified in item 2(a), but who has not received notice of this Plan, shall be subject, until such time the Covered Employee is provided notice of this Plan, to the rules and requirements of the former occupational injury benefit plan, including but not limited to any and all policies of mandatory arbitration. Except to the limited extent provided under Article IV regarding the continuation of certain benefit payments, if a Participant ceases to be a Covered Employee under the Plan, he or she shall thereupon cease to participate in this Plan; provided, however, that if such Participant is thereafter reemployed as a Covered Employee, he or she shall resume participating in the Plan as of the time and date of such reemployment.

ARTICLE II
BENEFITS

Any Injury incurred in the Course and Scope of Employment and during the time the employee is deemed to be a Covered Employee under the Plan shall entitle the Participant to the benefits described in this Article II

2.1 Medical Benefits. Subject to Article VI and other provisions of this Plan, the Plan shall pay Medical Benefits to, or with respect to, a Participant for an Injury sustained as a result of an Accident in an amount equal to all Covered Charges incurred during the Maximum Benefit Period, as specified in Item 2(b) of the Schedule of Benefits. The Participant's first Covered Charge must be incurred within 60 days following the date of the Injury. Medical Benefits shall cease upon:

(a) the expiration of the Maximum Benefit Period specified in Item 2(b) of the Schedule of Benefits. This Maximum Benefit Period is calculated continuously from the date of the Occurrence, without regard to whether the Participant regularly requires medical treatment during such period or otherwise receives Medical Benefits continuously throughout such period;

(b) the date the Maximum Benefit Amount is reached;

(c) involuntary termination of employment of the Participant with an Employer for violation of Company policy and/or Gross Misconduct; or

(d) as otherwise provided under Article IV.

2.2 Wage Replacement Benefits.

(a) **Total Disability:** Upon expiration of the Incurral Period as set forth in Item 2(c)(ii) of the Schedule of Benefits, the Plan shall begin payment of Wage Replacement Benefits to an injured Participant identified by an Approved Provider as Totally Disabled during the Maximum Benefit Period as the result of an Accident sustained in the Course and Scope of Employment. Such payment shall be equal to the Participant's Base Annual Salary divided by 52 and multiplied by the Percentage of Average Weekly Earnings specified in Item 2(c)(ii) of the Schedule of Benefits; provided, however, that (1) such benefit payments shall be reduced as described in Article VII, and (2) such benefit payments shall not exceed the Maximum Weekly Wage Replacement Benefit Amount specified in Item 2(c)(iii) of the Schedule of Benefits.

(b) **Partial Disability:** Upon the expiration of the Incurral Period as set forth in Item 2(c)(i) of the Schedule of Benefits, a Participant shall be eligible under the Plan for payment of Partial Disability Benefits if the Approved Provider has imposed work restrictions. Partial Wage Replacement Benefits will be equal to the Participant's Base Annual Salary divided by 52 and multiplied by the Percentage of Average Weekly Earnings specified in Item 2(c)(ii) of the Schedule of Benefits, minus the amount of earnings that the Participant is able to earn.

(1) A Participant released to Modified Duty, Restricted Duty or Transitional Duty shall be considered Totally Disabled if (a) the Company has no Modified Duty, Restricted Duty or Transitional Duty available and, (2) the Approved Provider has not assigned permanent restrictions and released the Participant to any other gainful employment. In this event, the Participant shall receive Wage Replacement Benefits as identified in subsection (a) above.

(2) A Participant released to Modified Duty, Restricted Duty or Transitional Duty shall be considered Totally Disabled if the Approved Provider returns the Participant to a Totally Disabled status after the Participant makes a good faith effort to comply with the Approved Provider's restrictions and carry out the responsibilities of the Modified Duty, Restricted Duty or Transitional Duty position. Upon return to a Totally Disabled status, the Participant shall receive Wage Replacement Benefits as identified in subsection (a) above.

(c) **Wage Replacement Payment Terms:** Wage Replacement Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week shall be prorated. Only the Participant's normal, scheduled workdays shall be considered in calculating benefits (based upon his or her employment status as of the date of Disability). All Wage Replacement Benefits must be incurred during the Maximum Benefit Period specified in 2(b) of the Schedule of Benefits.

(d) **Termination of Wage Replacement Benefits:** Wage Replacement Benefits shall cease upon:

(1) the expiration of the Maximum Benefit Period specified in Item 2(b) of the Schedule of Benefits. This Maximum Benefit Period for Wage Replacement Benefits is calculated continuously from the date of the Occurrence, without regard to whether the Participant qualifies as Disabled at all times during such period or receives Wage Replacement Benefits continuously throughout such period;

(2) the date the Participant is certified by the treating Approved Provider to no longer be Disabled, without regard to whether the Participant returns to regular or Modified Duty, Restricted Duty or Transitional Duty on that date;

(3) the date the Maximum Benefit Amount is reached, as specified in Item 2(f)(i)and (ii) of the Schedule of Benefits;

(4) termination of the Participant's status as a Covered Employee; unless termination of employment is solely due to:

(A) application of a duration limit in the Employer's leave of absence policy, or

(B) elimination of the Participant's employment position;

(5) the date the Participant is placed in jail or has left the local area for an extended period of time, or is similarly unavailable for work unless the Participant provides a "good cause" showing as to reason(s) for their unavailability for work.;

(6) as otherwise provided under Article IV;

(e) If an otherwise Disabled Participant returns to work for the Employer while in Rehabilitation, he or she will be deemed continually Disabled and the Plan will continue to pay Wage Replacement Benefits. Wage Replacement Benefits shall be payable only to the extent that the Participant's total income during the Rehabilitation does not exceed 100% of his or her Pre-Injury Pay.

2.3 Death Benefits. In the event a Participant dies within 365 days from, and as the direct and sole result of, an Injury, then the Plan shall pay the deceased Participant's Beneficiary, as defined in Section 11.5, a Death Benefit equal to the Accidental Death and Dismemberment Benefit Amount specified in Item 2(e) of the Schedule of Benefits; provided, however that this Death Benefit amount shall be reduced to the extent necessary to avoid exceeding the Maximum Benefit Amount. The Death Benefit shall be paid to the Participant's Beneficiary as follows: (a) 15% of the benefit shall be paid in a lump sum cash payment as soon as administratively possible following the death of the Participant and the determination of the proper Beneficiary; and (b) the remainder of the Death Benefit shall be paid in 30 equal monthly installments (without interest), commencing on the first day of the month following the initial lump sum payment.

Death Benefits payable under this Plan shall be in addition to Medical Benefits, Wage Replacement Benefits, and Dismemberment Benefits paid or payable to, or with respect to, the Participant; provided, however, that (1) the Maximum Benefit Amount as specified in Item 2(f) of the Schedule of Benefits shall not be exceeded, (2) the Death Benefits and Dismemberment Benefits paid or payable to and with respect to a Participant shall not exceed the Accidental Death and Dismemberment Benefit Amount specified in Item 2(e) of the Schedule of Benefits, and (3) no interest in future Dismemberment Benefits survives after a Participant's death which results in the payment of benefits under this Section 2.3.

2.4 Dismemberment Benefits. In the event a Participant suffers a loss described in the Schedule of Losses below, within 365 days from, and as the direct and sole result of, an Injury, then the Plan shall pay the Participant an amount equal to the applicable Benefit Percentage from the schedule below times the Accidental Death and Dismemberment Benefit Amount specified in Item 2(e) of the Schedule of Benefits; provided, however, that this Dismemberment Benefit amount shall be reduced to the extent necessary to avoid exceeding the Maximum Benefit Amount. The Dismemberment Benefit shall be paid as follows: (a) 15% of the Dismemberment Benefit shall be paid in a lump sum cash payment as soon as administratively possible following the date of loss;

and (b) the remainder of the Dismemberment Benefit shall be paid in 30 equal monthly installments (without interest), commencing on the first day of the month following the initial lump sum payment.

SCHEDULE OF LOSSES

Loss of:	**Benefit Percentage:**
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
Speech	50%
Hearing	50%
Finger or Toe (two joints)	10%
Finger or Toe (one joint)	5%

(a) In the event a Participant suffers more than one loss, as identified above, from any one Accident, or related series of Accidents, Occupational Disease exposure, or Cumulative Trauma, only the largest single Dismemberment Benefit as set forth above will be payable with respect to such Accident or exposure.

(b) Loss of Hand or Foot means the complete and permanent severance through or above the wrist or ankle joint. Loss of Sight means legally blind. Such loss correctable by surgery or lenses will not result in payment of a Dismemberment Benefit. Loss of Speech means the total and permanent loss of speech. Loss of Hearing means the total and permanent loss of hearing in both ears.

(c) The above-described loss of "Finger or Toe (two joints)" must be at or above the joint at the proximal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the metacarpophalangeal joint. The above-described loss of "Finger or Toe (one joint)" must be at or above the joint at the distal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the joint at the distal end of the proximal phalanx.

(d) Total and permanent loss of use of a member of the body is the same as loss of such member. Prior to payment of the benefit, loss of use must be certified following the care of an Approved Provider for 12 straight months from the date the loss of use began. At the end of this time it must be medically determined by an Approved Provider that the loss of use is total and not reversible. Loss must commence within 365 days from the date of the Injury, and continue without interruption for a period of not less than 365 consecutive days. Loss of use must be total and irrevocable and beyond remedy by surgical or other means.

(e) Dismemberment Benefits shall be in addition to Wage Replacement and Medical Benefits; provided, however, that (1) the Maximum Benefit Amount, as specified in Item 2(f) of the Schedule of Benefits, shall not be exceeded; and (2) payment of Dismemberment Benefits will cease in the event of the death of the Participant which results in the payment of Death Benefits.

ARTICLE III
INITIATING A CLAIM FOR BENEFITS

3.1 Notice of Injury. Notice of any Occurrence or known exposure to an Occupational Disease resulting from an Accident, no matter how minor, which could result, or might reasonably be expected to result, in an Injury must be reported by the Participant (or a person acting on his or her behalf) to his or her supervisor then on duty no later than 24 hours after being injured while in the Course and Scope of Employment. For an actual Injury due to Occupational Disease or Cumulative Trauma which results from an Accident, verbal notice must be provided within the earlier of (1) 24 hours after being medically diagnosed, or (2) 30 days after the Participant should have known of the Injury. Any provision in the Plan to the contrary notwithstanding, no benefits are payable under this Plan unless notice of Injury is provided by the Participant as described above not later than 35 months from the end of the policy period.

3.2 Providing Required Information. An injured Participant (or a person acting on his or her behalf) must complete any and all Injury reporting forms, authorization forms, provide written or recorded statements (whether sworn or unsworn), and provide any and all proof, including records, and demonstrations (relating to the Injury or any prior or subsequent damage or harm suffered by the Participant, in or out of the Course and Scope of Employment), in the manner and timeframes, as the Claims Administrator may from time-to-time direct. **The written incident report must be provided within 24 hours after the Injury is reported.** Unless the Claims Administrator determines that good cause exists for failure to provide such information in a complete and timely manner, a Participant's benefits will be subject to denial or termination.

3.3 Making a Claim for Benefits. At such time a Participant sustains, or reasonably believes he or she may have sustained, an Injury as the result of an Occurrence, the Participant must initiate his or her claim for Medical Benefits, Wage Replacement Benefits, or Dismemberment Benefits under the Plan by complying with the following claim reporting process:

(a) provide notice of such claim in accordance with the notice requirements specified in Section 3.1,

(b) provide all required written information pursuant to Section 3.2, and

(c) submit to medical treatment in accordance with Article VI. A health care professional may directly submit to the Claims Administrator, on the behalf of a Participant, a claim for Medical Benefits. A claim for Death Benefits under the Plan shall be initiated by a Beneficiary providing notice of entitlement thereto to the Claims Administrator within 60 days after the date of the Participant's death.

ARTICLE IV
ELIGIBILITY FOR AND MAINTENANCE OF BENEFITS

A failure to comply with the provisions of the Plan may subject a Participant's benefits to denial, suspension or termination of payment of Plan benefits otherwise due a Participant if:

(a) the Participant refuses to submit to any required drug or alcohol testing, or refuses to provide the Company and its designated representatives with (or access to) drug and alcohol testing information related to an Injury;

(b) the Participant does not receive prior approval for all medical care other than Emergency Care;

(c) the Participant utilizes a non-approved physician or facility other than for Emergency Care;

(d) the Participant refuses to submit to examination by an Approved Provider selected by the Claims Administrator (other than the treating Approved Provider) as required by the Claims Administrator with respect to any surgical procedure or other diagnosis or treatment opinion rendered by the treating Approved Provider for which the Claims Administrator considers a second medical opinion advisable;

(e) the Participant is persistently nonresponsive to treatment, including, but not limited to, behavioral modification(s) recommended by the treating Approved Provider;

(f) the Participant fails to provide accurate information to, or fails to follow the directions (including, but not limited to, any recommended treatment, therapy, course of action, abstinence, or rehabilitation program) of, or ceases to be under the care of, a treating Approved Provider;

(g) the Participant fails to keep, or is late for, a scheduled appointment with an Approved Provider, unless the Claims Administrator is advised prior to the Participant's failure to attend or timely arrive for such an appointment and a "good cause" exception is deemed appropriate based upon the given circumstances;

(h) the Participant engages in conduct following an Injury which is determined by the treating Approved Provider to be an injurious practice that is hindering the Participant's recovery from the Injury;

(i) the Participant fails or refuses to report in to the Participant's supervisor periodically, as directed, until able to return to work, including notice of expected recovery time after each appointment with the treating Approved Provider;

(j) the Participant fails to immediately inform the Participant's supervisor that he or she has been released by an Approved Provider to return to full or Modified Duty, Restricted Duty or Transitional Duty or fails to timely report to work in accordance with such work release;

(k) the Participant receives benefits with respect to the Injury from, or the Occurrence creates any liability for an Employer under, any workers' compensation law (whether or not any coverage for benefits is actually in force under such law), occupational disease law, unemployment compensation law, disability benefits law, or other similar law;

(l) the Participant has been untruthful in regard to any aspect of the required information supplied as part of the injury reporting, on-going treatment, or employment process;

(m) the Participant fails to fully cooperate with the Claims Administrator (including, but not limited to, failure to comply with the provisions of Section 3.2) or demonstrates bad faith in connection with the administration of the Plan, including, but not limited to, subrogation or coordination of benefits procedures; or

(n) the Participant fails or refuses to comply with any of the provisions of the Plan or the rules and procedures adopted by the Claims Administrator for the administration of the Plan.

ARTICLE V
COVERED AND NON-COVERED INJURIES AND INJURY CIRCUMSTANCES

5.1 Covered Injuries. "Covered Injuries" shall mean an Injury that occurs (the "Occurrence") on or after the Effective Date specified in Item 2(a) of the Schedule of Benefits. The Participant's Injury must have resulted directly and solely from an Occurrence in the Course and Scope of Employment that takes place within the United States of America (including its territories and possessions). In the event a Participant sustains an Injury while performing work at the direction of the Company on a temporary basis outside of the United States which is within the Course and Scope of the Participant's employment, such Injury shall be deemed a Covered Injury. All Injuries sustained by a Participant that relate to (a) an Accident, or related series of Accidents, (b) exposure to an environmental or physical hazard that causes an Occupational Disease, or (c) repetitious, physically traumatic activities that result in Cumulative Trauma shall be considered a single Injury for purposes of the Plan.

5.2 Non-Covered Injuries. Any provision of this Plan to the contrary notwithstanding, the term Injury shall not include any damage or harm arising out of:

(a) any stroke, or aneurysm;

(b) heart attack, unless the heart attack was proximately caused by, and arose out of, an Accident during the Course and Scope of Employment;

(c) any mental trauma, emotional distress or similar Injury in the absence of identifiable damage or harm to the physical structure of the body of a Participant;

(d) osteoarthritis, arthritis, and/or other degenerative process of the joints, bones, tendons or ligaments;

(e) ptomaine or bacterial infection, unless occurring as a consequence of an Accident;

(f) hernia, unless such hernia is an inguinal hernia that –

(1) appeared suddenly and immediately following the Injury;

(2) did not exist in any degree prior to the Injury; and

(3) was accompanied by pain;

(g) damage or harm resulting from job stress; or

(h) any Preexisting Condition, except to the limited extent (if any) that an Approved Provider clearly confirms as identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a Preexisting Condition; provided, however that :

(1) coverage for such aggravation will be provided only if and to the extent that the Approved Provider –

(A) confirms that the Preexisting Condition has been previously repaired or rehabilitated, and

(B) prescribes services or supplies that are Medically Necessary to treat such aggravation and likely to return the Participant to pre-Injury status; and

(2) no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury.

5.3 Non-Covered Injury Circumstances. Furthermore, no benefits will be paid under the Plan for an Injury if:

(a) the Injury results from Participant's willful intention and attempt to injure himself or herself or to injure another person, regardless of whether the Participant was sane or insane at the time of the act;

(b) the Injury is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo and the Participant has not availed himself or herself of such treatment;

(c) the Injury results from a Participant's participation as a master or member of the crew of any vessel;

(d)the Injury results from a Participant's -

(1) participation in a riot or act of civil disturbance;

(2) participation in or attempt to commit a crime;

(3) participation in a war or act of war, whether declared or undeclared;

(4) service in the military of any country or any civilian non-combatant unit serving with such forces;

(e) the Injury is directly or indirectly from the consequence of war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, confiscation, nationalization, requisition, destruction of or damage to property, by or under the order of any government or public or local authority;

(f) the Injury is a result of the utilization of nuclear, chemical or biological weapons of mass destruction;

(g) the Injury is caused by nuclear reaction, nuclear radiation or radioactive contamination;

(h) the Injury is sustained by a Participant while traveling on an airplane, helicopter or any device for aerial navigation other than travel on a regularly scheduled commercial airline, or travel on any boat or other device for water navigation;

(i) the Injury occurs while the Participant was deemed to be in a state of intoxication as the term "Intoxication" is defined under the Texas Workers' Compensation Act.;

(j) the Injury occurs while the Participant was under the influence of any chemical substance that was obtained or consumed in violation of the U.S. Controlled Substances Act in force at the time and location of the Occurrence;

(k) the Injury occurred while the Participant was employed in violation of any law;

(l) the Injury is directly or indirectly from the use of or caused by (1) asbestos, asbestos fibers or asbestos products; or (2) the hazardous properties of nuclear material; or

(m) such Injury results from the Participant's voluntary participation in any off-duty recreational, social or athletic activity not constituting part of the Participant's Course and Scope of Employment;

5.4 Additional Non-Covered Causes of Action: In addition to the foregoing, no benefits will be paid under this Plan for any Injury or claim stemming from Participant's assertion of the following common law causes of action:

(a) breach of any contract of employment, whether written, oral or implied;

(b) breach of duty of good faith and fair dealing;

(c) breach of any non-competition agreements;

(d) tortious interference with contractual relations;

(e) negligent or intentional infliction of emotional distress;

(f) claims based on assault and battery, defamation, invasion of privacy, false light publicity, negligent invasion of privacy, misrepresentation, fraud, false imprisonment, false arrest, malicious prosecution, abuse of process, unreasonable search or seizure, and retaliatory discharge;

(g) claims of liability arising out of employment relationships including, without limitation, claims for any type of employment discrimination, wrongful discharge, retaliatory discrimination, coercion, sexual harassment, violation of the U.S. Americans with Disabilities Act or Age Discrimination in Employment Act, and violations of any federal, state or Local Labor Code, and all other claims affecting or arising from the employment relationship whether arising under state or federal statutes or regulations or the common law (except as otherwise specifically covered in this Plan); or

(h) commission of a crime for which Participant has been convicted.

ARTICLE VI
MEDICAL MANAGEMENT

6.1 Use of Approved Provider. A Participant is required under the Plan to utilize the services of Plan Approved Providers. If necessary, the Claims Administrator will assist a Participant in arranging for appropriate medical treatment from an Approved Provider. A Participant does not have the right to select and have the Plan pay for his or her choice of a primary care provider or provider of specialty medical care, even if such a provider is an Approved Provider.

6.2 Pre-Authorization Requirements. The cost of a service or supply shall be a Covered Charge (as further described in Section 6.3) only if:

(a) treatment is pre-approved by the Claims Administrator and furnished by or under the direction of an Approved Provider, acting within the scope of the Approved Provider's license. Such pre-approval may include authorization for multiple visits to an Approved Provider, and may be verbal, in writing, or by electronic notice. The Claims Administrator will not deny a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the Participant; provided, however, that this exception to the pre-approval requirement does not change the requirement that care be provided by or under the direction of an Approved Provider; or

(b) (1) treatment is provided as Emergency Care; and

(2) an Approved Provider is not available or is not within a reasonable distance from the location of the Participant at the time of Injury (taking into account available transportation and the nature of the Injury); and

(3) the Claims Administrator receives notification of such Emergency Care within the later of 24 hours of the Participant's receipt of such care or the next business day; and

(4) after receiving primary Emergency Care, subsequent treatments are provided by, or at the direction of, an Approved Provider in accordance with paragraph (1) above.

6.3 Covered and Non-Covered Charges. The Plan pays 100% of expenses incurred during the Maximum Benefit Period by a Participant for medical or dental services, procedures or supplies prescribed by or provided under the direction of an Approved Provider or for Emergency Care (as described in Section 6.2) that are Medically Necessary (as determined by the Approved Provider), Usual and Customary, and do not exceed the charge specified in any fee schedule approved or adopted by the Claims Administrator. Covered Charges shall include, but not be limited to, confinement within a Hospital or Skilled Nursing Facility and the Usual and Customary cost of Medically Necessary supplies, and ambulance hire, and those expenses incurred for Rehabilitation; but shall not include charges for:

(a) hypnosis, acupuncture, chiropractic treatment or chiropractic therapy; or

(b) the purchase, rental or repair of environmental control devices, including, but not limited to, air conditioners, humidifiers, or air purifiers; or

6.4 Medical Determinations and Treatment. All determinations relating to the physical condition of a Participant, upon which the continued payment of benefits is based (for example, inability to return to work or results of a prior injury), must be made by an Approved Provider. The Participant must follow fully and completely the advice of, and the course of medical treatment prescribed by, the treating Approved Provider, and must keep all scheduled appointments to fulfill the prescribed medical treatment plan. The Claims Administrator may require that the Participant present an authorization and report form to, and submit to any form of drug and alcohol testing by, the treating Approved Provider or Emergency Care provider at the time of primary medical treatment. The Claims Administrator shall have the right to require the Participant to be examined or reexamined by an Approved Provider (including, but not limited to an autopsy, where not prohibited by law) as often as the Claims Administrator determines to be reasonably necessary or appropriate during the pendency of a claim for benefits under the Plan.

6.5 Initial Treatment and Denial. Any provision of this Plan to the contrary notwithstanding, an Employer may render first aid, or the Plan may pay for Emergency Care, Wage Replacement Benefits or for a medical evaluation or treatment of a Participant without waiving the ability to make a subsequent determination that the Participant has not suffered a covered Injury or otherwise deny any or all further benefits under the provisions of this Plan.

6.6 Specialty Provider Referrals. Any Participant eligible for or receiving treatment from an Approved Provider may be referred to a physician specializing in the treatment of the condition from which the Participant suffers. The Approved Provider must notify the Participant and Claims Administrator of the necessity of the referral. The Claims Administrator must approve all referrals in advance of the services being rendered by the specializing physician. Specialist referrals may be rescinded or denied by the Claims Administrator at any time based upon such criteria as the Claims Administrator may determine for the effective administration of the Plan. It is the Participant's responsibility to determine the status of any such approval or disapproval, and the expense of services or supplies relating to any disapproved referral shall be solely the responsibility of the Participant.

6.7 Second Medical Opinions. The Plan reserves the right to require a second medical opinion from an Approved Provider selected by the Claims Administrator for purposes of obtaining an Independent Medical Evaluation (IME) or for any other reason relating to the payment of Medical Benefits, Wage Replacement Benefits, or any other benefits under this Plan. If a Participant refuses to be examined by an Approved Provider selected by the Claims Administrator for the second opinion, all benefits under the Plan shall be suspended. The Claims Administrator will weigh the findings of the treating Approved Provider and the Approved Provider providing the second opinion and make a benefit determination under the Plan. However, if the Participant is in disagreement with the diagnosis or treatment recommended by the Approved Provider whose opinion is accepted by the Claims Administrator ("Physician A"), then the Participant shall have the right to be examined at his or her own expense by another physician ("Physician B"). If the diagnosis and treatment recommended by Physician B is contrary to that of Physician A, then the Claims Administrator shall designate a peer review physician who will evaluate the medical records and advise the Claims Administrator, and who may designate another Approved Provider for a further medical examination. If the Participant refuses to be so examined, all benefits under the Plan may be suspended. The diagnosis and/or recommended treatment of the peer review physician or this last Approved Provider will be controlling. The fees and related expenses of the peer review physician and this last Approved Provider will be paid by the Plan (although the Participant shall have the option of paying up to one-half of such fees and expenses).

6.8 Professional Medical Review and Quality/Efficiency Features. The Claims Administrator shall have the discretion to assign Approved Providers and other healthcare providers or firms to a Participant's case in order to (1) coordinate and expedite medical treatment of the Participant, in consultation with the treating Approved Provider, (2) facilitate such case management, quality, and efficiency measures and procedures as the Claims Administrator deems appropriate, based upon particular facts and circumstances, and (3) review the propriety of any and all treatment, services, and supplies, including charges for such treatment, services, and supplies.

6.9 No Interference with Patient-Provider Relationship. Although benefits under this Plan are conditioned on a Participant's use of only Approved Providers, a Participant remains entitled to seek any medical care he or she deems appropriate from any provider of his or her choice at his or her expense. The Employer, the Plan Administrator, the Claims Administrator, and the Committee, and their respective directors, officers, agents and delegates, possess no responsibility for the actual medical or other healthcare services provided by any Approved Provider or other healthcare service provider. Healthcare providers are not agents of the Plan, Employer, Plan Administrator, Claims Administrator, or Committee, and they are not liable or responsible for the acts or omissions of any healthcare provider. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of the attending Approved Provider and other healthcare providers based on their independent judgment for the provision of health care.

6.10 Use and Disclosure of Protected Health Information. The Plan shall comply with the "Standards for Privacy of Individually Identifiable Health Information" (the "HIPAA Privacy Rules"), as specified under 45 CFR Part 160 and Part 164, Subparts A and E, to the extent that the Department of Health and Human Services ("HHS") determines that these rules apply to the Medical Benefits provided under the Plan. Unless otherwise indicated below, the terms used in this provision shall have the same meanings as defined in the Plan.

(a) **Employer Uses and Disclosures of Protected Health Information ("PHI").** The Employer shall use and disclose PHI provided by the Plan only to the extent such use and disclosure is:

(1) for Treatment, Payment or Health Care Operations, as permitted by and in compliance section 164.506 of the HIPAA Privacy Rules; or

(2) as otherwise permitted or required for group health plans under section 164.502 of the HIPAA Privacy Rules.

(b) **Certification.** The Plan shall not disclose PHI to the Employer unless the Employer provides the Plan with certification that the Employer agrees to comply with the following provisions. The Plan shall also limit the disclosure of PHI to the Employer for plan administration functions that the Employer performs only consistent with such provisions.

(1) The Employer shall not use or further disclose PHI other than as permitted or required by the plan documents for the Plan or as required by law;

(2) The Employer shall require any agents, including a subcontractor, to whom it provides PHI from the Plan to agree to the same restrictions and conditions that apply to the Employer with respect to PHI;

(3) The Employer shall not use or disclose PHI from the Plan for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;

(4) The Employer shall report to the Plan any use or disclosure of PHI provided by the Plan that is inconsistent with the purpose for which the PHI was provided, once the Employer becomes aware of such inconsistent use or disclosure;

(5) The Employer shall provide affected individuals with access to their PHI in accordance with section 164.524 of the HIPAA Privacy Rules;

(6) The Employer shall make PHI available for amendment by the affected individual and shall incorporate any amendments made into such PHI;

(7) The Employer shall make available to affected individuals information required in order to provide an accounting of any disclosures made by the Plan, but only to extent that such disclosures must be accounted for under section 164.528 of the HIPAA Privacy Rules;

(8) The Employer shall make its internal practices, books, and records relating to the use and disclosure of PHI from the Plan available to HHS for determining Plan compliance with HIPAA Privacy Rules;

(9) If feasible, the Employer shall return or destroy all PHI received from the Plan that the Employer still maintains in any form and shall retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. Notwithstanding the foregoing, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures of such PHI to those purposes that make return or destruction of the PHI infeasible; and

(10) The Employer shall ensure that adequate separation has been established between the Employer and the Plan.

(c) **Separation Between Employer and Plan.** The Plan's designated Claims Administrator, the Plan's Committee members and their respective staff members that are designated to perform Plan functions shall be the only Employees or other persons under the direct control of the Employer that shall be given access to PHI for use and disclosure.

(1) Access to and use of PHI by the above-referenced persons shall be restricted to the Plan Administrator functions that the Employer performs for the Plan.

(2) In the event that any of the above-referenced persons fails to comply with the requirements of the HIPAA Privacy Rules and this Appendix, an affected individual may bring a claim to resolve the noncompliance by contacting the Plan's HIPAA privacy contact person specified in the Plan's Notice of Privacy Practices.

(A) The Plan shall respond to such claim within 30 days, subject to a 30-day extension. If the Plan disagrees with the complaint or the claim is otherwise denied in whole or in part, the Plan shall provide the affected individual with a written denial that explains the basis for the denial. The affected individual may then provide the Plan with a written statement of disagreement and/or take such further action provided in the Plan's Notice of Privacy Practices or by law.

(B) The Employer shall ensure that this process provides appropriate sanctions for noncompliance and otherwise serves as an appropriate mechanism for noncompliance disputes.

(d) **Exceptions to Employer Uses and Disclosures.** Notwithstanding the foregoing, the Plan may disclose the following information to the Employer:

(1) PHI to the extent specified in an authorization that complies with section 164.508 of the HIPAA Privacy Rules;

(2) Summary Health Information, if the Employer requests Summary Health Information for the limited purpose of either (1) obtaining premium bids for insurance coverage related to the Plan, or (2) modifying, amending or terminating the Plan; or

(3) information on whether an affected individual is participating in the Plan.

(e) **Definitions.** The following definitions shall apply to this Appendix:

(1) "Health Care Operations" shall mean any of the following activities that relate to functions covered under the HIPAA Privacy Rules:

(A) conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients about Treatment alternatives, and related functions that do not include Treatment;

(B) reviewing the competence or qualifications of health care professionals, evaluating provider performance, health plan performance, conducting training programs related to improving health care provider skills, accreditation, certification, licensing or credentialing activities;

(C) underwriting, premium rating and other activities related to creation, renewal or replacement of health insurance or Medical Benefits (including excess loss insurance);

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

(E) business planning and development, such as conducting cost-management analyses for managing and operating the Plan;

(F) business management and general administrative activities of the Plan, including (i) compliance with the HIPAA Privacy Rules, (ii) customer service, (iii) resolution of internal grievances, or (iv) the sale, transfer, merger or consolidation of all or part of a Plan with another entity that is (or will be) covered by the HIPAA Privacy Rules (including due diligence related to such activity); and

(G) creating de-identified health information or a limited data set.

(2) **"Payment"** means Plan activities to determine (or fulfill its responsibility for) coverage and provision of benefits under the Plan, or obtain or provide reimbursement for the provision of health care. These activities must relate to the individual receiving health care, including, but not limited to:

(A) Eligibility or coverage determinations (including coordination of benefits) and adjudication or subrogation of Medical Benefit claims;

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

(C) Billing, claims management, collection activities, obtaining payment under a reinsurance contract and related health care data processing;

(D) Review of health care services with respect to medical necessity, Plan coverage, appropriateness of care or justification of charges;

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

(F) Subject to the HIPAA Privacy Rules, disclosure to consumer reporting agencies related to premium or reimbursement collection.

(3) **"Protected Health Information" or "PHI"** means the individually identifiable health information (including demographics) that is transmitted or maintained by electronic or any other form or medium and that:

(A) is created or received by the Plan or an Employer;

(B) relates to 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 health care for the individual; and

(C) identifies the individual (or there is a reasonable basis to believe that the information can be used to identify the individual).

As specified under the HIPAA Privacy Rules, PHI excludes individually identifiable health information contained in education records and employment records held by an Employer.

(4) **"Summary Health Information"** means individually identifiable health information:

(A) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided Medical Benefits under the Plan; and

(B) from which the certain information that identifies the individual (as described in section 164.514(b)(2)(i) of the HIPAA Privacy Rules) has been deleted, except that geographic information need only be aggregated to the level of a five digit zip code.

(5) **"Treatment"** shall mean the provision, coordination or management of health care and related services by one or more health care providers, including 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.

ARTICLE VII
OTHER LIMITATIONS ON BENEFITS

7.1 Reduction in Benefit Payments. Benefit payments under this Plan shall be reduced by:

(a) the amount of any applicable federal or state income, employment, or other taxes that are required by law to be withheld;

(b) the Participant's earnings from any employer after disability begins, amounts legally garnished, and Participant contributions (through salary reduction or otherwise) to a 401(k) or a 403(b) plan, cafeteria plan, or other pre-tax salary deferral employee benefit plan;

(c) except as specified under Section 7.2(c), any amount paid or available with respect to the Participant's Injury under the following: Social Security Act, the Railroad Retirement Act, workers' compensation law, unemployment compensation law, occupational disease law or any other government program or similar law. The Plan shall deduct from Plan benefits the estimated benefit amounts for which the Participant is likely to be eligible under such other deductible sources of income, regardless of whether the Participant actually applies for such other deductible source of income.

7.2 Coordination Of Benefits. If a Participant is covered under this Plan and one or more other benefit plans, then (unless otherwise subject to Section 9.2) any Medical Benefits and Wage Replacement Benefits payable under this Plan will be either regular benefits or reduced benefits that, when added to the benefits of the other plan(s), will not exceed 100% of the amount described herein. The purpose of this provision is to prevent duplicate payments under plans that would exceed 100% of the benefits described in this Plan. In the coordination of benefits, one of the plans will be designated as the primary plan and the other plans will be designated as secondary. The primary plan will pay its full benefits first, then the secondary plan(s) will pay, but payments will be coordinated so that the total from all plans will not be more than the benefits described in this Plan.

(a) For purposes of this Section 7.2, "other benefit plans" shall mean any health or disability-type benefits provided under (1) any individual, group, blanket or franchise plan, (2) other prepaid coverage under service plan contracts, or under group or individual plans, policies or a practice, (3) uninsured arrangements of group or group-type coverage, (4) labor-management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans, (5) benefits coverage in a group, group-type and individual policy or policies of automobile coverage (including, but not limited to medical payment coverage, personal injury protection coverage, uninsured motorists coverage and underinsured motorists coverage, and (6) any other group-type contracts – that is, those contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

(b) Except as specified under Section 7.2(c), if a person is covered by more than one plan to which this coordination of benefits provision applies, then the following rules will determine which plan will be primary:

(1) With respect to health benefits only, when only one of the plans has a coordination of benefits provision, then the plan without such a provision will be the primary plan;

(2) The plan under which the person is covered other than as a dependent (for example, active employee, former employee, inactive employee, COBRA employee or retiree) will be the primary plan over a plan which covers the person as a dependent;

(3) The plan under which the person is covered as an active employee will be the primary plan over a plan which covers the person as former employee, inactive employee, COBRA employee or retiree;

(4) If none of these rules establish an order of benefit determination, then the plan that has covered the person for the longer period of time will be the primary plan.

(c) Any provision herein to the contrary notwithstanding, Medical Benefits payable under this Plan to or with respect to any Participant who is in "current employment status" as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be primary and shall not be reduced by the amount of benefits payable to or with respect to such Participant under Medicare, which will be considered the secondary plan. However, Medical Benefits payable under this Plan to or with respect to any Participant who is not in "current employment status," as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be secondary and reduced by the amount of all benefits payable to or with respect to such Participant under Medicare, which will be the primary plan. In addition, the fact that a Participant is eligible for or provided medical assistance under a state plan will not be taken into account in making payments under the Plan.

(d) The Participant must notify the Claims Administrator of such other benefit plans and cooperate with the Claims Administrator in (1) furnishing copies of other policies, coverages or plans which may be applicable to the Injury, and in (2) completing and returning to such Claims Administrator any questionnaire or forms inquiring about, or assigning rights to recover under, other policies, coverages or plans which may cover or be applicable to such Participant.

ARTICLE VIII
CLAIMS FILING AND APPEAL PROCEDURES

8.1 What is a Claim. Each (i) medical service or supply for which payment is requested, (ii) Wage Replacement Benefit for a particular payroll period, or (iii) claim for Death Benefits or Dismemberment Benefits, shall be deemed a separate "claim" for benefits that is subject to a Determination under the Plan. The Plan's payment of a particular claim (for example, payment for an initial medical evaluation, even on a claim that may have been reported late) does not waive or otherwise prejudice the Claims Administrator's or Committee's right to deny another particular claim or all future claims for benefits under the Plan. As stated above, any failure by the Claims Administrator or Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Committee's authority to apply such provisions thereafter.

8.2 Who is a Claimant. A claimant or a claimant's authorized representative may file a claim for benefits under the Plan, as well as an appeal of an Adverse Benefit Determination. References in this Article VIII to "claimant" shall include a Participant, a medical provider seeking payment for a service or supply, a Beneficiary, or a claimant's authorized representative, as applicable. The Plan shall have the right to establish reasonable procedures for determining whether and to what extent an individual has been authorized to act on behalf of a claimant. However, with respect to an Urgent Care Claim, a physician or other health care provider licensed, accredited and certified to perform specified health services consistent with state law and with knowledge of a Participant's medical condition shall be permitted to act as the authorized representative of the Participant.

8.3 Information to Submit. Claims must include the information required by this Section, Section 3.2 and such other reasonable information requested by the Claims Administrator, such as medical records or a written statement from an independent service provider evidencing the date, type of services rendered, and the total cost of such services. In addition, the Claims Administrator may require the claimant to provide a written and signed statement which provides that the Covered Charge has not been reimbursed, or is not reimbursable under any other plan or program. Further, the Claims Administrator may also request that the claimant file all appropriate claims and requests for payment from any other plan or program maintained by the claimant prior to making any payments under this Plan. The Claims Administrator may rely upon all such information furnished by the claimant, including the claimant's current mailing address, and shall have no obligation or duty to locate a claimant.

8.4 Submission of Medical Bills for Payment. Approved Providers will be requested to invoice all health care-related charges directly to the Claims Administrator (or an Employer, which shall immediately transmit such invoice to the Claims Administrator). However, in the event that a Participant receives such an invoice or pays such a charge, all requests for payment or reimbursement of Covered Charge must be filed with the Claims Administrator within 30 days from the date such expenses are incurred or, if later, the date such Participant receives an invoice from an Approved Provider or other health care provider (in the case of Emergency Care) for such expenses not to exceed the Maximum Benefit Period.

8.5 Incomplete Claim Submissions. In the event that a claim, as originally submitted, is not complete, the Claims Administrator shall notify the claimant in the manner described below, and the claimant shall have the responsibility for providing the missing information. Notwithstanding the foregoing, the period of time within which a benefit Determination must be made shall begin at the time that a claim is filed in accordance with this Plan, without regard to whether all the information necessary to make a benefit Determination accompanies the claimant's filing. In the event that the period of time for a particular claim is extended in accordance with the applicable provisions of this Article VIII due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be suspended from the date on which the notification of the extension is sent to the claimant until the date on which the Claims Administrator receives the claimant's response to the request for additional information not to exceed the Maximum Benefit Period.

8.6 Claims Review.

(a) **Notice of Initial Benefit Determination** - The Claims Administrator shall provide notice to the claimant of its initial benefit Determination as follows:

(1) **Urgent Care, Pre-Service Medical Claims** – In the case of a Pre-Service Claim for Medical Benefits that is an Urgent Care Claim, the Claims Administrator shall notify the claimant of the Plan's initial Determination (whether adverse or not) as soon as possible, taking into account the medical exigencies of the particular claim, but not later than 72 hours after receipt of the claim. A Determination that such claim will be covered can be communicated to the claimant verbally, in writing, or by electronic notice; but an Adverse Benefit Determination must be provided in writing or by electronic notice as described further in Section 8.6 (b)(1)below. If the claimant (i) fails to follow the Plan's procedures for filing an Urgent Care Claim, or (ii) otherwise fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan on an Urgent Care Claim, then:

(A) The Claims Administrator shall notify the claimant as soon as possible, but not later than 24 hours after its receipt of the claim, of the procedure to follow or the specific information necessary to complete the claim. Notification may be oral, unless the claimant requests a written notice. This notice requirement shall only apply to the extent that such failure is a communication

by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

(B) The claimant shall then be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to correct such failure.

(C) The Claims Administrator shall then notify the claimant of the Plan's initial benefit Determination as soon as possible, but not later than 48 hours after the earlier of (i) the Claims Administrator's receipt of the specified information necessary to complete the claim, or (ii) the end of the time period given the claimant to provide such information.

(2) **Concurrent Medical Care Decisions** – If the Claims Administrator has approved an ongoing course of medical treatment to be provided over a period of time or number of treatments not to exceed the Maximum Benefit Period:

(A) The Claims Administrator shall notify the claimant of any reduction or termination by the Plan of such course of treatment. Such reduction or termination shall be considered an Adverse Benefit Determination and the Claims Administrator shall, in accordance with this Article VIII, notify the claimant sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a benefit Determination on review before the course of treatment is actually reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is an Urgent Care Claim shall be decided as soon as possible, taking into account the medical exigencies of the claim. The Claims Administrator shall make an initial benefit Determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If such claim is not made Plan within such 24-hour period, the request shall be treated as an Urgent Care Claim and be decided within the normal Urgent Care Claim timeframes (i.e., as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after receipt).

(C) Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is not an Urgent Care Claim shall be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (i.e., as a Pre-Service Claim or a Post-Service Claim).

Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, shall be made in accordance with the provisions of this Section.

(3) **Non-Urgent Care, Pre-Service Medical Claims** – In the case of a Pre-Service Claim for Medical Benefits that is not an Urgent Care Claim, the Claims Administrator shall notify the claimant of the Plan's benefit Determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after its receipt of the claim. A Determination that such claim will be covered can be communicated to the claimant verbally, in writing, or by electronic notice; but an Adverse Benefit Determination must be provided in writing or by electronic notice as described further below.

(A) If the claimant fails to follow the Plan's procedures for filing a non-urgent care, Pre-Service Claim, then the Claims Administrator shall notify the claimant as soon as possible, but not later than 5 days after its receipt of the claim, of the procedures to follow. Notification may be oral, unless the claimant requests a written notice. This notice requirement shall only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

(B) The Claims Administrator may extend the 15-day benefit Determination period up to an additional 15 days if it determines that, due to matters beyond the control of the Plan, an initial benefit Determination cannot be made within the first 15-day period, and notifies the claimant of the special circumstances requiring the extension and the date by which the Plan expects to render a decision. If the extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the extension notice shall specifically describe the required information and the claimant shall then be given at least 45 days to provide the specified information. However, the Claims Administrator's timeframe for making a benefit Determination shall be suspended until the date upon which the claimant responds to the request for additional information.

(4) **Post-Service Medical Benefit, Wage Replacement Benefit, Death Benefit, and Dismemberment Benefit Claims** – In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, Death Benefits or Dismemberment Benefits, the Claims Administrator shall notify the claimant of the Plan's benefit Determination (whether adverse or not) within 30 days after its receipt of the claim. A Determination that such claim will be covered can be communicated to the claimant verbally, in writing, or by electronic notice; but an Adverse Benefit Determination must be provided in writing or by electronic notice as described further in 8.6(b) below. The Claims Administrator may extend this period up to an additional 15 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan. Notice of such extension must be provided to the claimant prior to the expiration of the initial 30-day period and state (i) the special circumstances requiring the extension, and (ii) the date by which the Plan expects to render a decision. If the extension relates to a claim for Wage Replacement Benefits, such notice shall also state (i) the standards on which entitlement to benefits is based, and (ii) unresolved issues that prevent a benefit Determination on the claim and what additional information is needed to resolve those issues. If additional information is requested with the extension notice, the claimant shall have 45 days from the date of the notice of extension in order to provide the specified information.

(b) **Manner and Content of Adverse Benefit Determinations** – If the initial benefit Determination is an Adverse Benefit Determination, the Claims Administrator shall provide a written or electronic notice to the claimant that satisfies the following requirements:

(1) Any electronic notice shall satisfy ERISA regulations that specify the standards for electronic disclosure of benefit plan information;

(2) The notice shall be written in a manner calculated to be understood by the claimant;

(3) The notice shall set forth the specific reason or reasons for the Adverse Benefit Determination, making reference to the specific Plan provisions on which the Adverse Benefit Determination is based;

(4) If an internal rule, guideline, protocol or other similar criterion was relied upon in making an Adverse Benefit Determination on a claim for Medical Benefits or Wage Replacement Benefits, the notice shall state that such rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy thereof shall be provided free of charge to the claimant upon request;

(5) If the Adverse Benefit Determination of a Medical or Wage Replacement Benefits claim is based upon medical necessity, an experimental treatment or similar exclusion or limit, the notice shall provide either an explanation of the scientific or clinical judgment for the Adverse Benefit 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;

(6) The notice shall include a statement that in the case of an Adverse Benefit Determination on review by the Committee, the Plan offers no further voluntary levels of appeal and that the claimant can pursue his or her right to bring an action under ERISA section 502(a);

(7) If the initial Adverse Benefit Determination involves an Urgent Care Claim, the notice shall provide a description of the expedited review process applicable to such claims. Notification of an Adverse Benefit Determination that involves an Urgent Care Claim may be provided to the claimant orally within the time frames specified above, provided that the oral notification satisfies the requirements of this subsection and that a written or electronic notice satisfying the requirements of this subsection is furnished to the claimant not later than 3 days after the oral notification;

(8) The notice shall describe any additional materials or information necessary for the claimant to perfect the claim and explain why such material or information is necessary; and

(9) The notice shall provide a description of the Plan's review procedures (including the time limits applicable to these review procedures).

(c) **Appeal of Adverse Benefit Determinations** -- The claimant may appeal in writing an Adverse Benefit Determination to the Committee within the following number of days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator:

(1) 180 days for a Medical Benefits or Wage Replacement Benefits claim; or

(2) 60 days for a Death Benefit or Dismemberment Benefit claim.

If the Adverse Benefit Determination involves an Urgent Care Claim for Medical Benefits, the claimant may request orally or in writing for an expedited review of the Adverse Benefit Determination and all necessary information, including the Plan's benefit Determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available expeditious method.

(d) **Committee Consideration** -- When reviewing the appeal of an Adverse Benefit Determination, the Committee shall comply with the following requirements:

(1) The claimant may submit written comments, documents, records, and other information relating to the claim for benefits, and the Committee shall take all of such information into account when reviewing such claim, without regard to whether such information was submitted or considered in the initial benefit Determination;

(2) The claimant may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information that is Relevant to the claimant's claim for benefits (as determined by the Committee);

(3) The review of an Adverse Benefit Determination on a claim for Medical Benefits or Wage Replacement Benefits shall not give any deference to the initial Adverse Benefit Determination.

(4) If the appeal request on a Medical Benefits or Wage Replacement Benefits claim is based in whole or in part on a medical judgment, including Determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate, the Committee shall consult with an Approved Provider who has appropriate training and experience in the field of medicine involved in the medical judgment. This Approved Provider shall not be an individual who was consulted in connection with the initial Adverse Benefit Determination or a subordinate of such individual.

(5) Upon request of a claimant, the Committee shall identify the individual names of any medical or vocational experts whose advice was obtained in connection with an initial Adverse Benefit Determination, without regard to whether the advice of such experts was relied upon in making the benefit Determination.

(e) **Timing of Notice of Benefit Determination on Review** – The Committee shall provide notice to the claimant, as described in subsection (f) below, of the Plan's benefit Determination on review in accordance with the following timeframes:

(1) **Urgent Care, Pre-Service Medical Claims** – In the case of a Pre-Service Claim for Medical Benefits that is an Urgent Care Claim, the Committee shall notify the claimant of the Plan's benefit Determination on review as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after its receipt of the claimant's appeal request. No extension of time is available for Committee Determinations on the review of claims for Medical Benefits.

(2) **Non-Urgent Care, Pre-Service Medical Claims** – In the case of a Pre-Service Claim for Medical Benefits that is not an Urgent Care Claim, the Committee shall notify the claimant of the Plan's benefit Determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after its receipt of the appeal request. No extension of time is available for Committee Determinations on the review of claims for Medical Benefits.

(3) **Post-Service Medical Benefit, Wage Replacement Benefit, Death Benefit, and Dismemberment Benefit Claims** – In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, Death Benefits or Dismemberment Benefits, the Committee shall notify the claimant of the Plan's benefit Determination on review within 45 days after its receipt of the appeal request. The Committee may extend this period up to an additional 45 days on a claim for Wage Replacement Benefits, Death Benefits, or Dismemberment Benefits if the Committee determines that an extension is necessary due to matters beyond the control of the Plan. Written or electronic notification of an extension must be provided to the claimant prior to the expiration of the initial 45-day period and indicate the special circumstances requiring the extension and the date by which the Plan expects to render a decision.

(f) **Manner and Content of Benefit Determination on Review** – The Committee shall provide a claimant with written or electronic notification of the Plan's benefit Determination on review. If the decision on review is an Adverse Benefit Determination, the notice must satisfy all the requirements set forth in subsection (b)(1) through (6) above, and also state that the claimant is entitled to receive, upon request and free of charge, reasonable access

to, and copies of, all documents, records, and other information Relevant to the claimant's claim for Plan benefits.

(g) **Extension of Time Frames Allowed by Law or Agreement** – In the event that ERISA rules and regulations permit additional time for decisions or actions by the Claims Administrator or Committee, the Claims Administrator or Committee may exercise their discretion to utilize (but not exceed) those extended time frames; provided, however, that this discretion shall only be exercised when necessary to provide a full and fair review of a claimant's right to benefits in accordance with the terms of this Plan (e.g., additional time needed to obtain an appointment and results of a medical examination). Upon request by the Plan, a claimant may also voluntarily agree to an extension or further extension of any time period within which the Plan must decide a claim.

(h) **Exhaustion of Administrative Remedies:** No legal action can be brought by or with respect to a Participant to recover benefits under the Plan before the foregoing claims procedure has been exhausted.

ARTICLE IX
NATURE OF PAYMENTS AND SUBROGATION

9.1 Nature of Payments.

(a) **No Admission of Liability:** The Plan has been established and is maintained by the Employer to protect themselves from certain liabilities as nonsubscribers to the Texas workers' compensation insurance system. Payments made under this Plan by an Employer shall not in any way constitute an admission of liability or responsibility by an Employer for an Injury and any such liability or responsibility is specifically denied.

(b) **No Collateral Source:** Benefit payments made under or on behalf of the Plan, however made, shall be considered to be made by the Employer of a Participant and shall not be considered payment from a "collateral source" as that term has been defined under any applicable rule, statute, judicial decision, or directive. All benefits paid under this Plan shall be offset against any alleged liability of the Employer, its officers, directors, or agents to a Participant or Participant's Beneficiaries, heirs, or assigns due to an Injury.

9.2 Subrogation and Excess Payments. For purposes of Section 9.2, 9.3, and 9.4 of this Plan, the term "Payee" means a Participant or Beneficiary or their family members, heirs, estate, or other representative (in their individual or representative capacity), singularly or collectively as the context may require to give the Plan the broadest possible rights of recovery. If a Payee becomes entitled to or directly or indirectly receives Plan benefits for any Injury caused by the negligence or other act or omission of any person or organization (including, but not limited to, an Employer), and is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury (including, but not limited to, damages for negligence, survival, wrongful death or other legal or equitable action), whether by insurance, litigation, settlement or other proceeding, the Payee shall automatically be required to (i) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation to the extent of the Plan benefits paid to, or with respect to, the Payee and (ii) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation for all medical management, investigation, attorneys' fees, costs of recovery, and other expenses related to the claim for benefits (including any subrogation proceeding). The subrogation rights of this Plan even apply with respect to a Payee who is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury but has not and will not receive any Plan benefits if such person's claim for damages or other compensation is dependent on whether the Participant had or has a valid claim against a third party. Upon request of the Plan, the Payee shall provide the Plan written confirmation of this subrogation right, including execution of any assignment, lien form or other document

requested by the Claims Administrator to enable the Plan to recover such Plan benefits and related expenses. Any failure of a Payee to give written confirmation of the Plan's subrogation rights does not adversely affect its rights of subrogation because the Plan's right of subrogation arises automatically once payment under this Plan is made to or on behalf of the Payee. If (i) a Payee fails, refuses or neglects to reimburse the Plan or otherwise comply with the provisions of this Section, or (ii) payments are made under the Plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the Plan, then the Plan shall still have all remedies and rights of recovery specified herein. The Plan shall also have the right to terminate or suspend benefit payments and/or recover the reimbursement of all amounts above due to the Plan by withholding, offsetting and recovering such amounts out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such Payee. The Plan shall have the first lien recovery against any benefits paid or to be paid by the Plan. The Plan shall also have the right to bring a lawsuit and assert a constructive trust or other interest against any and all persons that have assets that the Plan can claim rights to. The Plan has the right of first recovery from any judgment, settlement or other payment, regardless of whether the Payee has been "made whole." The Plan's subrogation rights and first lien will not be reduced by attorneys' fees or expenses incurred by any party in pursuing recovery against a third party and the "common fund" doctrine shall not apply. Any attorneys' fees and/or expenses incurred by or at the request of the Payee or his, her or its attorneys in a third party or other action shall be the sole responsibility of such party.

9.3 Notice Of Legal Proceedings. A Payee shall provide the Claims Administrator with prior written notice of the involvement of such party in any lawsuit, settlement discussion or other proceeding, one of the principal purposes of which is recovering, from any person or organization, damages or other compensation in any way related to any Injury for which such Payee has received (or may in the future file a claim to receive) Plan benefits. The Plan shall have the right to intervene for itself and on behalf of a Payee in any such lawsuit, settlement discussion or other proceeding. If a Payee neglects, fails or refuses to seek a recovery from any person or organization for any Injury caused by the negligence or other act or omission of such person or organization, the Plan shall have the right to institute a lawsuit or other proceeding or do any other act that in the opinion of the Claims Administrator may be necessary or desirable to recover the Plan benefits paid (and to be paid in the future) to the Payee, plus any costs and expenses incurred by the Plan in pursuing such recovery.

9.4 Assignment Of Rights. By participating in this Plan, a Participant obligates himself or herself, as well as all other Payees (in both their individual and representative capacities), to the provisions of this Plan, including, without limitation, Sections 9.2, 9.3, and 9.4 hereof. Upon the request of the Claims Administrator, a Payee shall assign to the Plan the right to intervene in or institute any lawsuit, settlement discussion, or other proceeding described in Section 9.2 and/or 9.3, and to use the name of such party for such purpose. The Plan shall have the right to select legal counsel of its own choice and such counsel shall have complete control over the conduct of any such lawsuit, settlement discussion, or other proceeding without the consent or participation of any such Payee. Whenever the Plan shall intervene in or institute any lawsuit or other proceeding as permitted by the provisions of this Section, the Plan may pursue same to a final determination and the Plan expressly reserves the right to appeal from any adverse judgment or decision. The Payee shall give the Plan all reasonable aid in any such lawsuit, settlement discussion, or other proceeding in effecting settlement, in securing evidence, in obtaining witnesses, or as may otherwise be requested by the Claims Administrator. The Payee shall release the Plan, the Employer, the Plan Administrator, the Claims Administrator, the Committee, and their respective directors, officers, agents, attorneys, and employees from all claims, causes of action, damages and liabilities of whatever kind or character that may directly or indirectly arise out of the pursuit or handling by the Plan of any such lawsuit, settlement discussion or other proceeding.

9.5 Final Compromise And Settlement. At the Claims Administrator's option within five years after the date of the Occurrence, and at any time thereafter if the Claims Administrator elects to extend such five-year period after the date of the Occurrence, the Claims Administrator may notify the Participant of the Plan's intention to be released from any further known and unknown benefit

and all other injury-related claims by such Participant and pay a final claim settlement to, or with respect to, such Participant in exchange for the Participant's agreement to a release of liability in favor of the Plan, Employers, Claims Administrator, Committee, and other interested parties with respect to such claims. In that event, the Claims Administrator may appoint an actuary, appraiser, and/or Approved Provider to investigate, determine, and capitalize such claims. The payment by the Plan and/or Employer of the value of such claims (as finally determined by the Claims Administrator) shall be made in such manner as the Claims Administrator may determine. No additional claims will be subsequently accepted with respect to such Injury. Any actuary or appraiser shall apply such rules, standards, and assumptions (present value discount, inflation, and mortality rates, etc.) as the Claims Administrator may reasonably determine. The Participant must cooperate and provide all information, sign such forms and agreements, and submit to all medical examinations as may be requested by the Claims Administrator to arrive at a valuation and settlement of the Participant's claims. No further benefits will be payable to, or with respect to, a Participant who fails or refuses to accept the Claims Administrator's claim valuation, sign the release agreement presented by the Claims Administrator, or otherwise comply with the requirements of this Section or other provisions of the Plan. Prior or subsequent to the Claims Administrator's evaluation and determination of the value of a Participant's claims, the Claims Administrator may determine to not capitalize and satisfy any such claim as described above and to instead continue eligibility for benefit payments and defer the above valuation and settlement.

ARTICLE X
ADMINISTRATION

10.1 Plan Administrator.

(a) **Administrator:** The Company shall be the Plan Administrator of the Plan. The Plan shall be administered on behalf of the Company and all other Employers by the Claims Administrator and Committee. Each Claims Administrator or member of the Committee so appointed shall serve in such office until his or her death, resignation, or removal by the Company. The Company may remove any Claims Administrator or member of the Committee with or without cause at any time, and may fill any vacancies in the Claims Administrator position or with respect to Committee membership or add additional Claims Administrators or members to the Committee at any time and from time to time. The Committee shall act by a majority of its members at the time in office. The Committee may by such majority action authorize any one or more of its members to execute any document or documents on behalf of the Committee. The Claims Administrator and Committee shall keep such records of their proceedings and acts as they deem to be necessary or appropriate for the purposes of the Plan. The Claims Administrator and Committee shall cause such information, documents or reports to be prepared, provided and/or filed as may be necessary to comply with the provisions of ERISA, or any other applicable law. Members of the Committee shall receive no remuneration from the Plan for their services as Committee members. The Plan shall operate and keep its records on the basis of the Plan Year.

(b) **Administrative Authority:** Subject to the Plan claims procedures, the Claims Administrator and Committee shall have discretionary and final authority to interpret and implement the provisions of the Plan, including, but not limited to, making all factual and legal determinations, correcting any defect, reconciling any inconsistency and supplying any omission, and making any and all determinations that may impact a claim for benefits hereunder. The Claims Administrator and Committee shall perform all of the duties and may exercise all of the powers and discretion that the Claims Administrator and Committee deem necessary or appropriate for the proper administration of the Plan, and shall do so in a uniform, nondiscriminatory manner. Any failure by the Claims Administrator or Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Committee's authority to apply such provisions thereafter. Every interpretation, choice, determination or other exercise by the Claims Administrator or Committee of any power or discretion given either expressly or by implication to it shall be

conclusive and binding upon all parties having or claiming to have an interest under the Plan or otherwise directly or indirectly affected by such action, without restriction, however, on the right of the Claims Administrator or Committee to reconsider and redetermine such action. There shall be no *de novo* review by any arbitrator or court of any decision rendered by the Committee and any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion. The Claims Administrator and/or Committee may adopt such rules and procedures for the administration of the Plan as are consistent with the terms hereof.

(c) **Delegation of Responsibilities:** The Claims Administrator's and Committee's authority shall include, but not be limited to, the power to allocate or delegate fiduciary and non-fiduciary responsibilities or duties among the members of the Committee or to Employees or third persons, including any insurer or contract administrator, and, except as is otherwise provided by applicable law, those persons to whom such responsibilities and duties have not been allocated or delegated shall not be liable for any act or omission of those persons to whom such responsibilities and duties have been allocated or delegated. Except as otherwise provided under ERISA, neither an Employer, the directors, officers, partners, managers, or supervisors of an Employer, the Plan Administrator, the Claims Administrator or the Committee nor any person designated to carry out fiduciary responsibilities pursuant to this Plan shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of the Plan.

10.2 Claims Administrator and Committee Indemnity. The Employers shall indemnify and hold harmless the actual Claims Administrator and the actual Committee, each actual member thereof, and any other Employee of an Employer to whom the Claims Administrator or Committee has delegated administrative authority with respect to the Plan against any claim, cost, expense (including reasonable attorneys' fees), judgment or liability (including any sum paid in settlement of a claim with the approval of the Company) arising out of any act or omission to act of the Claims Administrator or Committee or such a member or Employee under this Plan, except in the case of willful misconduct. The Employers shall be jointly and severally liable for any amounts owed pursuant to this Section.

10.3 Funding. All benefits payable to or with respect to a Participant under this Plan shall be paid or provided for by the Employer who was the employer of such Participant at the time of his or her Injury. Said benefits shall be paid by or on behalf of such Employer at the direction of the Claims Administrator or Committee or its designated representative solely out of the general assets of such Employer or its insurer. The Employers shall have no obligation to establish any fund or trust for the payment of benefits under this Plan. The Employers shall obtain an insurance contract that may (depending upon the terms of such policy) provide funds to reimburse or pay on behalf of an Employer for a benefit payable under this Plan. **Benefits under this Plan shall not be payable or shall immediately cease in the event that such insurance coverage is not available (for reasons other than the need to satisfy a self-insured retention) or ceases under such policy for any reason.** Any such insurance policy proceeds shall not be considered "plan assets" for purposes of ERISA. Payments by an Employer shall be from its general assets. The Employer that applied for the contract shall own any such insurance contract. If any insurance benefits are paid directly by an insurance company to a Participant or beneficiary with respect to an Injury covered under this Plan, such payments shall be deemed to be made under this Plan by an Employer or shall otherwise be subject to the provisions of Section 7.2 or Article VIII, as determined by the Claims Administrator.

10.4 Participating Employers. With the consent of the Company, any incorporated or unincorporated trade or business which is a member of a control group (within the meaning of Section 3(40) of ERISA) with respect to which the Company is also a member may adopt and become an Employer under this Plan.

ARTICLE XI
DEFINITIONS

11.1 "Accident" or "Accidental" means an external, sudden event which (1) was unforeseen, unplanned, unexpected, unintended, and abrupt; (2) occurred at a specifically identifiable time and place in the Course and Scope of Employment; (3) occurred by chance or from unknown causes; (4) resulted solely and independently of all other causes, and (5) results in physical Injury to the Participant. Accidental bodily Injury does not include Occupational Disease or Cumulative Trauma unless it results directly from an Accident.

11.2 "Adverse Benefit Determination" means a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit.

11.3 "Approved Provider" means a person duly licensed under Texas law as a Medical Doctor or Doctor of Osteopathy and either expressly approved by the Claims Administrator or included on an approved list of physicians adopted by the Claims Administrator. "Approved Provider" also includes a hospital, other medical care facility or medical service or supply provider either expressly approved by the Claims Administrator or included on an approved list of facilities adopted by the Claims Administrator. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any designation or list of Approved Providers at any time.

11.4 "Base Annual Salary" means the total amount of annual compensation that is paid to a Participant, including overtime, bonuses, commission, pay for holidays, vacations or periods of sickness as reported to the Internal Revenue Service. For Participants receiving payment by commission, Base Annual Salary shall be the average annual earnings over the three-year period immediately preceding the date of loss. If the Participant has not been employed for a period of three years, the Base Annual Salary shall be determined by calculating the average monthly earnings and multiplying by 12. For Participants employed less than three months, Base Annual Salary shall be determined by utilizing the Base Annual Salary of an employee in the same or similar position.

11.5 "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. If an Eligible Child has predeceased the Participant, Death Benefits that would have been paid to that child if he or she had survived the Participant shall be paid in equal shares per stirpes to the children of such deceased child.

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

(2) "Eligible Child" means a surviving child of the deceased Participant, whether by blood, marriage, or legal adoption, 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 25 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.

11.6 "Claims Administrator" means the individual or individuals or entity appointed by the Company to make initial Determinations of benefit claims under this Plan on behalf of the Company and all other Employers.

11.7 "Committee" means the individual or individuals appointed by the Company to make Determinations on appeal of benefit claims. The Claims Administrator cannot serve as the Committee or as a member of the Committee, and no individual who is a subordinate of the Claims Administrator can serve as the Committee or as a member of the Committee.

11.8 "Company" means the entity named in Item 1(a) of the Schedule of Benefits or any successor thereto.

11.9 "Course and Scope of Employment" means an activity of any kind or character that has to do with and originates in the work, business, trade or profession of an Employer, and that is performed by a Participant while engaged in or about the furtherance of the business of an Employer, including activities conducted on the premises of an Employer or at other locations designated by the Employer. This term does not include a Participant's transportation to and from his or her place of employment, unless:

(a) the transportation is furnished as part of the employment arrangement or is paid for by an Employer, or the means of the transportation are under the control of an Employer; or

(b) the Participant is directed in his or her employment to proceed from one place to another place.

11.10 "Covered Charge" means the cost to a Participant of a service or supply described in this Plan below, which service or supply is Medically Necessary, based on the nature of the Injury, as and when provided, and (i) cures or relieves the effects naturally resulting from the Injury; (ii) promotes recovery; or (iii) enhances the ability of the Participant to return to or retain employment. Such services and supplies are also subject to the medical management provisions of Article VI. For purposes of this Plan, the words "service" or "supply" include, but are not limited to, any related treatment, medication, technique or method.

(a) The first Covered Charge must be incurred within 60 days following the date of the Injury; and

(b) No further amount shall be considered a Covered Charge if the Participant does not receive medical treatment from an Approved Provider (or scheduled treatment with an Approved Provider has not been approved by the Claims Administrator) for a period of more than 120 days. This subsection (2), however, shall not apply to any Covered Charge for testing and any follow up vaccination with respect to an Injury that involves a potential occupational exposure to a bloodborne pathogen.

11.11 "Covered Employee" means an Employee whose employment with the Employer is principally located within the State of Texas.

11.12 "Cumulative Trauma" means an Injury to a Participant that is caused by the combined effect of rapid, repetitive physical activities extending over a period of time in the Course and Scope of Employment. For coverage under the Plan, Cumulative Trauma must have occurred as the result of an Accident.

11.13 "Death Benefits" means any benefit payable under Section 2.3.

11.14 "Determination" means a decision of the Claims Administrator or Committee on whether benefits are payable to or with respect to a claimant under the Plan.

11.15 "Disabled" or "Disability" means a Total Disability or a Partial Disability.

11.16 "Dismemberment Benefits" means a dismemberment benefit payable under Section 2.4.

11.17 "Emergency Care" means a service or supply provided with respect to a medical condition manifesting itself by a sudden and unexpected onset of acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably be expected to (i) result in death, disfigurement, or permanent disability, or (ii) result in substantial impairment of any bodily organ, part, or function of a Participant. **This Emergency Care determination solely relates to satisfaction of the Plan's approved medical provider requirements, and the exception for Emergency Care. Urgent Care Claims may not arise to the level of involving Emergency Care. A Participant's decision to seek treatment from an urgent care clinic or hospital emergency room does not necessarily result in an Urgent Care Claim or involve Emergency Care. That determination shall be made within the sole administrative discretion of the Claims Administrator or Committee, with such advice and consultation from an Approved Provider as the Claims Administrator or Committee deems appropriate.**

11.18 "Employee" means a person who is employed in the regular business of, and receives his or her pay by means of a salary, wage or commission directly from, an Employer and for whom an Employer files a Form W-2 with the Internal Revenue Service. The term does not include an independent contractor, sub-contractor, day laborer, or third-party agent.

11.19 "Employer" means the Company and any other related trade or business that adopts the Plan pursuant to Section 10.4 by signing the Schedule of Benefits as a Participating Employer.

11.20 "Gross Misconduct" means the Employee's gross misconduct within the meaning of Section 4980B of the Internal Revenue Code, or any successor provision of law.

11.21 "Hospital" means a facility that:

(a) is licensed and operated in accordance with applicable public health laws;

(b) has organized facilities for diagnosis and treatment of injured persons on its premises or facilities available to it on a prearranged basis;

(c) has 24-hour nursing services by registered nurses (RNs); and

(d) is supervised by one or more state licensed medical doctors.

A Hospital does not include (1) a nursing convalescent or geriatric unit of a Hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged, nor does it include any ward, room, wing or other section of the Hospital that is used for such purposes; or (3) any military or veterans Hospital

or soldiers home or any Hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

11.22 "Incurral Period" means the initial number of days of a Participant's disability from an Injury, as defined in Item 2(c)(i) of the Schedule of Benefits during which the Company is open for purposes of operating its business or enterprise unless the disability shall last for longer than fourteen days pursuant to Section 2.2 above.

11.23 "Injury" means an identifiable damage or harm to the physical structure of the body resulting from an Occurrence in the Course and Scope of Employment and caused solely as the result of either (1) an Accident, (2) Cumulative Trauma, or (3) an Occupational Disease. The Plan provisions for Covered Injuries or non-Covered Injuries are described in Article V. The term Injury, as used herein, shall have the same meaning as Covered Injuries described in Article V.

11.24 "Maximum Benefit Amount" means the maximum amounts of all benefits payable under the Plan. Payments made for each form of benefit shall be counted towards the applicable Maximum Benefit Amount, and benefit payments to or with respect to a Participant shall cease or be reduced in such manner as the Claims Administrator or Committee may determine when a Maximum Benefit Amount is reached. The Maximum Benefit Amount for this Plan is as follows:

(a) "Maximum Any One Employee Per Occurrence" as specified in Item 2(f)(i) of the Schedule of Benefits.

(b) "Maximum All Employees Per Occurrence" as specified in Item 2(f)(ii) of the Schedule of Benefits. This is the aggregate limit of all benefits payable to or with respect to all Participant Injury claims arising out of a single Occurrence.

(c) "Annual Aggregate" as specified in Item 2(f)(iii) on the Schedule of Benefits. This is the aggregate limit of all benefits payable to or with respect to all Participant Injury claims occurring during each 12-month period beginning on the Effective Date specified in Item 2(a) of the Schedule of Benefits or any anniversary thereof.

11.25 "Maximum Benefit Period" or "Maximum Medical Benefit Period" means the maximum amount of time any form of benefits expense is incurred under this Plan as specified in Item 2(b) of the Schedule of Benefits. Such period is calculated continuously from the date of the Occurrence. The Claims Administrator shall have discretion to determine the computation and timing of all expense incurrals and payments hereunder.

11.26 "Medical Benefits" means any benefit payable under Section 2.1.

11.27 "Medically Necessary" means the medical services, procedures or supplies, which are:

(a) required, recognized, and professionally accepted nationally by physicians as the usual, customary and effective means of diagnosing or treating the condition;

(b) the most economical supplies or levels of service that are appropriate and available for the safe and effective treatment of the Participant; and

(c) not primarily for the convenience of a Participant, the Participant's family, an Approved Provider or other provider of medical services, supplies or procedures.

Even if the service, supply or procedure is Medically Necessary or may have been prescribed by an Approved Provider, this Plan will not cover services, supplies or procedures excluded from coverage under the terms of this Plan.

11.28 "Modified Duty, Restricted Duty or Transitional Duty" means work which is either (a) a temporary accommodation that allows an Employee to perform his or her regular job; or (b) an alternate, temporary job that complies with the Employee's work restrictions and Employer needs.

11.29 "Occupational Disease" means a disease arising solely out of the Course and Scope of Employment that causes damage or harm to the physical structure of the body. Occupational Disease includes other diseases or infections that naturally result from the work-related diseases. Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of a Participant's assigned duties in their Course and Scope of Employment or a disease resulting from an Accident or Cumulative Trauma.

11.30 "Occurrence" means an Accident or related series of Accidents arising out of one event or incident while the Participant is in the Course and Scope of their employment. In addition, Injury by Occupational Disease or Cumulative Trauma must be caused or aggravated by the conditions of employment and shall be deemed to have occurred on the last day of last exposure to those conditions of employment causing or aggravating such Injury by Occupational Disease or Cumulative Trauma. Any provision of this Plan to the contrary notwithstanding, in order to be subject to this Plan document:

(a) the date of such Occurrence must be during the policy period on an insurance policy referred to in Section 10.3; and

(b) a claim for benefits on an Injury due to Occupational Disease or Cumulative Trauma must in all events be made in accordance with Section 3.1 and not later than 36 months from the end of the policy period. In no event will benefits for such a claim extend beyond (i.e., they must be incurred within) the Maximum Benefit Period.

11.31 "Partial Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury that results in the Participant being (a) unable to perform the normal duties for which he or she was employed; (b) under the regular care of an Approved Provider; (c) released to Modified Duty, Restricted Duty or Transitional Duty by such Approved Provider; and (d) working for the Employer in such a Modified Duty, Restricted Duty or Transitional Duty position approved by the Employer.

11.32 "Participant" or "Plan Participant" means a Covered Employee who becomes eligible for benefits in accordance with Article I.

11.33 "Plan" means the employee injury benefit plan established or continued by the Employers in the form of this document, including the Schedule of Benefits. The name of the Plan is set forth at the top of the Schedule of Benefits. The Plan created by each adopting Employer is a separate Plan, independent from the plan of any other employer adopting this document, unless the adopting Employer is adopting the same Plan sponsored by a related member of a control group (within the meaning of Section 3(40) of ERISA), as provided in Section 10.4.

11.34 "Plan Administrator" means the Company.

11.35 "Plan Year" means a 12 calendar month period beginning on the Effective Date in Item 2(a) of the Schedule of Benefits and each anniversary thereafter; provided, however, that the Company may specify a different Plan Year for past, current, or future years by formal written action of a representative authorized to act on behalf of the Company and communicated to Participants in writing.

11.36 "Post-Service Claim" means any claim for a Medical Benefit that is not a Pre-Service Claim.

11.37 "Preexisting Condition" means any Participant illness, injury, disease, or other physical or mental condition, whether or not work-related, which originated or existed prior to the date of Injury.

11.38 "Pre-Service Claim" means any claim for Medical Benefits with respect to which this Plan requires Claims Administrator approval in advance of obtaining medical care (i.e., any such claim that does not involve Emergency Care).

11.39 "Rehabilitation" means only those procedures which are performed for the purpose of restoring the function of motion, speech or vision lost as a result of a covered Accidental bodily Injury, Occupational Disease or Cumulative Trauma.

11.40 "Relevant" shall mean, with respect to the relation of a document, record or other information to a Participant's or beneficiary's claim, that such document, record or other information:

(a) was relied upon in making a benefit Determination on the claimant's claim;

(b) 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 actual benefit Determination;

(c) demonstrates compliance with the Plan's administrative processes and safeguards required for making the benefit Determination.

(d) 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.

The individual records or information specific to the resolution of one claimant's claim shall not be considered relevant to another claimant's claim.

11.41 "Schedule of Benefits" means the page(s) attached to the front of this Plan document, setting forth certain Company information and benefit limits, and signed by the Company. The Schedule of Benefits and the other terms of this Plan shall be construed as a single document. Each provision of the Schedule of Benefits corresponds to the referencing provisions in this Plan and the related Summary Plan Description booklet.

11.42 "Skilled Nursing Facility" means a section, ward, or wing of a hospital, or a free-standing healthcare facility, which:

(a) provides room and board;

(b) provides nursing care by or under the supervision of a nurse;

(c) provides physical, occupational, and speech therapy furnished by the facility or by others under arrangements made by the facility;

(d) provides medical social services;

(e) provides drugs, biologicals, supplies, appliances and equipment ordinarily furnished for use in such a facility;

(f) provides medical services by staff physicians;

(g) has an agreement with a Hospital for diagnostic and therapeutic services, the transfer of patients, and exchange of clinical records;

(h) provides other services necessary to the health and care of patients that are generally provided by such facilities; and

(i) is licensed or registered in accordance with local and state laws and regulations.

11.43 "Totally Disabled" or "Total Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury that (a) causes the Participant to be unable to perform the normal duties for which he or she was employed; (b) causes the Participant to be under the regular care of an Approved Provider; and (c) causes the Participant to be unable to engage in Modified Duty, Restricted Duty, or Transitional Duty or any other occupation for wage or profit. A Total Disability must commence within:

(a) 90 days from the date of the Injury; or

(b) six months from the date of the Injury; provided

(1) the Participant received medical care with 30 days from the date of the Injury; and

(2) the Participant has remained under the continuous care and treatment of an Approved Provider.

11.44 "Urgent Care Claim" shall mean any claim for medical care or treatment with respect to which application of the time periods for making non-urgent Pre-Service Claim Determinations (i.e., generally, 15 days after the Claims Administrator's receipt of the claim):

(a) could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function; or

(b) in the opinion of a physician with knowledge of the Participant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim within the meaning of subsection (a) above shall be made by the Claims Administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the Participant's medical condition determines that a claim is an Urgent Care Claim and clearly communicates such determination to the Claims Administrator, such claim shall be treated as an Urgent Care Claim for purposes of this Plan. **The characterization of a claim as being an Urgent Care Claim solely impacts the timeframes and other procedures for claims processing under Article VIII, and in no way changes this Plan's approved medical provider, pre-authorization, or other medical management requirements. These requirements generally provide that (1) except in the case of Emergency Care, no amount shall be considered a Covered Charge unless treatment is pre-approved by the Claims Administrator and furnished by or under the direction of an Approved Provider, and (2) all determinations relating to the physical condition of a Participant, upon which the payment of benefits is based, must be made by an Approved Provider. Urgent Care Claims may not arise to the level of involving Emergency Care. A Participant's decision to seek treatment from an urgent care clinic or hospital emergency room does not necessarily result in an Urgent Care Claim or involve Emergency Care. The determination of whether a claim involves Emergency Care shall be made within the sole administrative discretion of the Claims Administrator or Committee, with such advice and consultation from an Approved Provider as the Claims Administrator or Committee deems appropriate.**

11.45 "Usual and Customary" means the usual charge made by a physician or other provider of services, supplies, medication or equipment that does not exceed the general level

of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" means a county or such other area as is necessary to obtain a representative cross-section of such charges.

11.46 "Wage Replacement Benefits" means any benefit payable under Section 2.2.

ARTICLE XII
GENERAL PROVISIONS

12.1 Termination and Amendment. The Company shall have the right and power at any time and from time to time to amend this Plan, in whole or in part, on behalf of all Employers, and at any time to terminate this Plan or any Employer's participation hereunder; provided, however, that no such amendment or termination shall reduce the amount of any benefit then due and payable to, or with respect to, a Participant under the Plan in connection with an Injury occurring prior to the date of such amendment or termination. Any such amendment or termination shall be pursuant to formal written action of a representative authorized to act on behalf of the Company.

12.2 Spendthrift Provision. Except as expressly provided for in this Plan, no right or interest of any Participant or Beneficiary under this Plan may be assigned, transferred or alienated, in whole or in part, either directly or by operation of law, and no such right or interest shall be liable for or subject to any debt, obligation or liability of such Participant or Beneficiary.

12.3 Employment Noncontractual. The establishment of this Plan shall not enlarge or otherwise affect an Employee's "at will" employment by an Employer, and an Employer may terminate the employment of any Employee at any time and/or modify the Employee's working relationship as desired, at-will for any or no reason (with or without cause), as freely and with the same effect as if this Plan had not been established.

12.4 Plan Documents Control. This written Plan document constitutes the entire Plan, and no oral or written representation or promise concerning the Plan, which is inconsistent with the provisions of this Plan document, shall have any effect. The provisions of this Plan document shall be the sole source of all legally enforceable rights with respect to the benefits herein provided.

12.5 Construction. The titles to the Articles and the headings of the Sections in this Plan are placed herein for convenience of reference only and in case of any conflict the text of this instrument, rather than such titles or headings, shall control. Whenever a noun or pronoun is used in this Plan in plural form and there be only one person or entity within the scope of the word so used, or in singular form and there be more than one person or entity within the scope of the word so used, such word or pronoun shall have a plural or singular meaning as appropriate under the circumstance.

12.6 Separability. If for any reason any provision of this Plan is determined to be invalid or contrary to applicable law, such invalidity shall not impair the operation of or otherwise affect the remaining provisions of this Plan.

12.7 Applicable Law. This Plan shall be governed and construed in accordance with the provisions of ERISA and, except where superseded by federal law, the laws of the State of Texas.

ARTICLE XIII
ARBITRATION OF INJURY-RELATED DISPUTES

The Employer hereby adopts a mandatory company policy requiring that the following claims or disputes must be submitted to final and binding arbitration under this Article XIII: (A) any legal or equitable claim or dispute relating to enforcement or interpretation of the arbitration provisions

in a Receipt and Arbitration Acknowledgement form or this Article XIII; and (B) any legal or equitable claim by or with respect to an Employee for any form of physical or psychological damage, harm or death which relates to an accident, occupational disease, or cumulative trauma (including, but not limited to, claims of negligence or gross negligence or discrimination; claims for intentional acts, assault, battery, negligent hiring/training/supervision/retention, emotional distress, retaliatory discharge, or violation of any other noncriminal federal, state or other governmental common law, statute, regulation or ordinance in connection with a job-related injury, regardless of whether the common law doctrine was recognized or whether the statute, regulation or ordinance was enacted before or after the effective date of this Article XIII). This includes all claims listed above that an Employee has now or in the future against an Employer, its officers, directors, owners, employees, representatives, agents, subsidiaries, affiliates, successors, or assigns.

This does not, however, include any legal or equitable claim under ERISA for benefits, fiduciary breach, or other problem or relief solely relating to benefits payable under this Plan. If an Employee wishes to appeal a denial of benefits under the Plan, such Employee must follow the process described in ARTICLE VIII of the Plan. After exhausting the appeal process outlined in ARTICLE VIII of the Plan, any action challenging a Plan decision, or any other ERISA right of action, must be brought in the United States District Court for the Northern District of Texas, Dallas Division.

The determination of whether a claim is covered by this Section shall also be subject to arbitration under this Section. Neither an Employee nor an Employer shall be entitled to a bench or jury trial on any claim covered by this Section. This Section applies to all Employees without regard to whether they have completed and signed a Receipt and Arbitration Acknowledgement form. These provisions also apply to any claims that may be brought by an Employee spouse, children, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns. This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.

13.1 Required Notice of All Claims: When a party seeks arbitration, such party must give written notice of any claim to the American Arbitration Association **and** the other party within the applicable statute of limitations. The day the act complained of occurred will be counted for purposes of determining the applicable period. If such notice is not given, the claim shall be void and deemed waived. The party requesting arbitration must send written notice in triplicate to the American Arbitration Association, Attention: Regional Claims Administrator, at 13455 Noel Road, Two Galleria Tower, Suite 1750, Dallas, Texas, 75240-6620. If an Employee wishes to invoke arbitration, the Employee must also send written notice to the Employer, in care of the contact person and address listed in Item 1(f) and Item 1(b) of the Schedule of Benefits (or such other person or address as the Employer may specify). If the Employer wishes to invoke arbitration, the Employer must also give written notice to the Employee at the last address recorded in the Employee's personnel file. The party requesting arbitration must specifically identify and describe in the written notice all claims asserted and the facts on which the claims are based. This written notice shall be sent certified or registered mail, return receipt requested. The responding party shall have the ability to file special exceptions with the arbitrator on the basis that the written notice does not satisfy the requirements of this arbitration requirement.

13.2 Arbitration Procedures: Any arbitration under this Section will be administered by the American Arbitration Association ("AAA") under its then-current Employment Arbitration Rules and Mediation Procedures.

(a) Unless otherwise agreed to in writing by the parties, the arbitrator selected by the parties in accordance with those rules (1) shall be an attorney licensed to practice in the State of Texas with experience in personal injury litigation, and (2) shall be selected from a panel of arbitrators located in Dallas County, Texas. If the arbitrator so selected becomes unable to serve for any reason, the parties shall again go through the same selection process.

(b) The arbitrator will apply the substantive law of Texas (other than the Texas General Arbitration Act), or federal law, or both, depending upon the claims asserted. The arbitrator will provide brief findings of fact and conclusions of law. The arbitrator will have the authority to consider and grant motions consistent with the Texas Rules of Civil Procedure (or Federal Rules of Civil Procedure, if applicable), including, but not limited to, motions for summary judgment. The arbitrator is authorized only to rule on the claims set forth in the original written notice, any counterclaim(s), and the answer(s) made to such claims and counterclaims. The arbitrator is not authorized to modify the powers granted to him or her under this arbitration requirement or to make any award merely on the basis of what he or she determined to be just or fair. **The arbitrator shall also not commingle the standards for state law determinations and remedies (for example negligence claims and special damage awards) with the standards for federal law determinations and remedies that may or may not be subject to this arbitration requirement (for example, ERISA benefit eligibility and ERISA damage awards).**

(c) The final decision and the arbitration award, if any, shall be made consistent with the remedies available under the state or federal statute, common law, code or regulation that is the subject of the claim. All decisions rendered by an arbitrator under this Section will be kept confidential by all parties, and shall not serve as binding, legal precedent with respect to subsequent claims or disputes under this Section. **An arbitrator's decision can be challenged in a state or federal court of law only on such basis as available under the Federal Arbitration Act.**

13.3 <u>Payment of Fees and Expenses</u>:

(a) The Employee shall pay a nonrefundable arbitration filing fee equal to the standard employee filing fee specified under then-current AAA Employment Arbitration Rules and Mediation Procedures. The Employee's filing fee must be paid when he or she submits a request for arbitration (or, if this process is challenged by an Employee, when arbitration is compelled by court order). The Employer shall pay a nonrefundable arbitration filing fee equal to the standard employer filing fee specified under then-current AAA Employment Arbitration Rules and Mediation Procedures. The Employer will also pay the arbitrator's entire fee and any other AAA administrative expenses; provided, however, that an employee may elect to also pay up to one-half of these fees and expenses.

(b) If the arbitrator finds completely in favor of the Employee on all claims, the Employer will reimburse the Employee for his or her share of the filing fee.

(c) If the Employer initiates the arbitration (by means other than a motion in court to compel arbitration), the Employee will pay no portion of the AAA or arbitrator fees.

(d) Either party may arrange for, and pay the cost of, a court reporter to provide a stenographic record of the proceedings.

(e) Each party shall also be responsible for their own attorney's fees, if any. However, if any party prevails on a statutory claim which allows the prevailing party to be awarded attorney's fees, or if there is a written agreement providing for such fees, the arbitrator may award reasonable attorney's fees to the prevailing party.

(f) Notwithstanding the above provisions, the arbitrator shall assess the AAA filing fee, arbitrator fees and expenses, and attorney's fees against a party upon a showing by the other party that the first party's claim is frivolous, or unreasonable, or factually or legally groundless.

(g) If either party pursues a claim covered by this Section by any means other than arbitration, the responding party shall be entitled to dismissal of such action, and the recovery of all costs and attorney's fees and expenses related to such action.

13.4 Interstate Commerce and Venue: The Employer is engaged in transactions involving interstate commerce and the Employee's employment involves such commerce. The Federal Arbitration Act shall govern the interpretation, enforcement, and proceedings under the arbitration provisions of this Plan. Unless contrary to applicable law, any lawsuits seeking to enforce or vacate an arbitration award shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

13.5 Binding Effect: This provision for resolving claims by arbitration is equally binding upon, and applies to any such claims that may be brought by, an Employer and each Employee and his/her spouse, children, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns. This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.

(a) This Section applies to all Employees without regard to whether they have completed and signed a Receipt and Arbitration Acknowledgement form. Adequate consideration for this arbitration provision is represented by, among other things, eligibility for (and not necessarily any receipt of) benefits under this Plan and the fact that it is mutually binding on both the Employers and Employees. Any actual payment of benefits under this Plan to or with respect to an Employee shall serve as further consideration for and represent the further agreement of such Employee to the provisions of this Section. This arbitration provision shall remain in effect with respect to the Employers and all Employees, without regard to any Employee refusal of benefits under this Plan, return of benefit payments under this Plan to an Employer, ineligibility for or cessation of benefits under this Plan in accordance with its terms, or any voluntary or involuntary termination of an Employee's employment with an Employer.

(b) This arbitration provision is not subject to ERISA requirements or otherwise dependent upon the benefit provisions of this Plan in any way, and is included herein strictly as a matter of convenience in documentation. This Plan and arbitration requirement also in no way changes the "at will" employment status of any Employee not covered by a collective bargaining agreement.