TAOS Staffing Corporation
Employee Injury Benefit Plan

A Summary of Your Benefits

This document is a Summary Plan Description of your rights and responsibilities under your employer's occupational injury benefit plan (the "PLAN").

For complete details of the PLAN, refer to the official PLAN document available from your employer. In any case, the official PLAN document will govern the benefits available under the PLAN.

This Summary Plan Description contains a provision requiring "Binding Arbitration" in the event of a legal dispute. Please review the Summary Plan Description and the PLAN document for details of the Binding Arbitration feature and its applicability to you and your employer.

May 1, 2019

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SECTION 1 INTRODUCTION

This booklet, "**A SUMMARY OF YOUR BENEFITS"**, and the attached Schedule of Benefits and SPD Highlights ("Schedule") summarize the provisions of your employer's official Occupational Injury Benefit Plan ("Plan"). It replaces and supersedes all previous Summary Plan Descriptions and summaries of material modifications of the Plan. The Plan is hereby effective or amended and entirely restated for Injuries sustained from an Occurrence on or after 12:01 a.m., **May 1, 2019**, (the **"Effective Date"**) to provide the Participants with limited Benefits due to Bodily Injury or Occupational Disease that occur within the Scope of Employment on or after the Plan's Effective Date.

This booklet is the official Summary Plan Description of the Plan required under the Employee Retirement Income Security Act of 1974 (ERISA). It explains the major provisions of the Plan in simplified language. The summary is intended to help you understand the Plan and, where applicable, fulfill disclosure requirements under ERISA. If the language in this booklet results in a misunderstanding or inconsistency with the official legal Plan document (including any insurance policy incorporated by reference into the official Plan document), the Plan document will govern.

For complete details about the Plan, you should refer to the official legal Plan document and insurance policy(s). Copies of the legal Plan document and policy(s) are available for a reasonable photocopying charge by contacting the Company at the Name and address shown in the Summary. See "Your Rights Under the Law" (Section 15) for more details.

Although at the present time the Company expects to continue the Plan described in this booklet, the Plan can be amended or terminated at any time, with or without prior notice or approval by a Participant or anyone claiming benefits through a Participant. The right to amend or terminate includes the right to reduce or eliminate coverage for any treatment, procedure, or service; but will not reduce any Plan benefit then due a Participant because of an injury or death that occurred *prior* to the effective date of the amendment or termination. Maximum benefit limits and all other provisions regarding benefits are applicable.

The benefits set forth below are "excepted benefits" under the terms of certain statutes, including without limitation, the Public Health Service Act (42 U.S.C. § 300gg-91) and the Health Insurance Portability and Accountability Act of 1996 (sec. 706(c)). Participants and Plan beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the plan and, if the employer is a plan sponsor, the sponsor's address.

(A) This booklet "**A Summary of Your Benefits"** is your reference source to find information needed to:

- Understand the Plan benefits available to you;
- Understand enrollment procedures;

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- Claim benefits;
- Understand your rights under the Plan; and
- Understand your responsibilities.

(B) Your Responsibilities: You and your Authorized Representative have the responsibility to**:**

- Review information contained in this booklet regarding eligibility and enrollment procedures
- Review and understand the claims procedures, **including prompt notification** of a covered Injury as outlined in Section 4.
- Provide your Employer, Physician and Designated Healthcare Provider, to degree possible, with information needed to provide care and administer your claim.
- Follow treatment plans and care instructions as agreed upon with your Physician and Designated Healthcare Provider. Actively participate, to degree possible, in understanding and improving your own medical health condition and develop mutually agreed upon medical treatment goals pursuant to the provisions of the Plan
- Understand the arbitration procedures and your rights under the law, which provide recourse for resolution of disputes related to the Plan.

SECTION 2 ELIGIBILITY REQUIREMENTS FOR THE PLAN

Every Texas Employee is **eligible** to participate in the Plan. In order actually to **participate** in the Plan, however, an Employee must make a written election to become a **Participant** in the Plan by executing and agreeing to the terms of an "Election and Arbitration Agreement" in the form attached to this Summary as Exhibit "B".

If you receive Plan benefits or have Plan benefits paid to a medical provider on your behalf, you agree that by such action you have agreed to, ratified , and affirmed your participation in the Plan and requirements of the Election and Arbitration Agreement just as though you had executed the Election and Arbitration Agreement on or before the earliest date you were eligible to participate in the Plan.

An Employee is a person who is employed in the regular business of, and who receives pay directly from, the Sponsoring Employer or an employer adopting the Plan and for whom the employer files a Form W-2 with the Internal Revenue Service. An Employee becomes a Participant by the action of the two paragraphs immediately preceding this paragraph.

(A) Loss of Eligibility

You will lose your Participant status and become ineligible for Plan coverage as of the earlier of the:

- date and time the Plan is terminated; or

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- date and time your Employee status is terminated for any reason including, without limitation, suspension, layoff, leave of absence, and termination of employment.

Subject to the provisions of the Plan, if you were a Participant and previously awarded Benefits under the Plan for Bodily Injury or Occupational Disease that occurred while you were eligible for Plan benefits, these benefits will not be discontinued due to termination of employment or leave of absence unless separation from the employment relationship was For Cause.

(B) Reinstatement of Eligibility

If you lose eligibility and no longer are a Participant in the Plan, you may regain eligibility when you again satisfy all Plan eligibility requirements.

(C) No COBRA Continuation Coverage

The purpose of the Plan is to provide Benefits in the event of an Occurrence while you are employed and in Active Duty. Except for Benefits payable due to injury while an active Participant in the Plan and prior to your termination, no post-employment Benefits are available. Therefore, no COBRA continuation coverage is available at time of termination.

(D) Participant Eligibility Claims Procedures

Your claim should be submitted to the Plan Administrator. The Plan Administrator will make a timely determination of Participant's eligibility status . Note: If the eligibility claim arises in connection with a demand claim for benefits under the Plan, the timeframes outlined in the Schedule will apply, unless due to special circumstances an extension of time is needed.

The Plan Administrator can notify you before the end of the initial claim period that an extension is needed to review your claim. An extension can be up to 60 days. If your claim for eligibility to be a Participant in the Plan is denied, the Plan Administrator will provide reasons for the denial and advise you of any additional information needed to overturn your denial. The denial will also advise you of the appeal rights. If you do not request an appeal of a denied claim for Participant eligibility within 60 days after you receive notice of your denied claim for eligibility, no further action will be taken and you cannot request an appeal at a later date.

If you or your Authorized Representative believes your eligibility in the Plan has been wrongfully denied by the Plan Administrator, you or your Authorized Representative should file an appeal in writing with the Plan Committee within 60 days after receiving the denial.

(E) Non-Discrimination

All Participants will be treated under the Plan's administrative procedure and Committee action on a non-discriminatory basis without regard to their race, color, religion, national origin, ancestry, sex, disability, age or veteran status.

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SECTION 3 COST OF COVERAGE UNDER THE PLAN

Your Employer pays 100% of the costs associated with the Plan as well as all administrative costs of the Plan, except those costs noted in the Arbitration Procedure (Section 14).

Except for a death beneficiary, there is no dependent or beneficiary coverage under the Plan. Dependents of Participants are ineligible for any Plan benefits. Participants do not have the option of paying a premium for dependent coverage or electing dependent coverage.

SECTION 4 PROMPT NOTICE OF INJURY

You or a person acting on your behalf must promptly report each incident (no matter how minor) that you reasonably believe resulted in an on-the-job Accident or might later result in Bodily Injury. You must report an Occupational Disease as soon as symptoms of the disease are detected.

No benefits will be paid if you fail to comply with the Plan's notification and information requirements, unless the Plan's Committee determines that good cause exists for failure to comply.

A) Oral Notice of Injury

You must immediately (and no later than the end of your work shift), orally report every occupational incident or fact that is an Accident or may result in Bodily Injury under the Plan. The oral report should be made to your supervisor, manager or other person in charge.

B) Written Employee Incident Report

You are required to follow up any oral notice of injury by completing a written Employee Incident Report ("Report"). All information requested on the Report form must be provided. The completed Report must be signed and dated by you and delivered to your supervisor by the end of the work shift on date of the incident for an Accident or as soon as you suspect or have knowledge of an Occupational Disease.

C) Reporting Treatment

You must report to your supervisor within twenty-four (24) hours after receiving Emergency Treatment and after each appointment or treatment session with a Designated Healthcare Provider or at a Facility.

D) Ongoing Communication and Cooperation

You or your Authorized Representative must cooperate with and provide the Committee, as requested, with written or sworn statements, information, proof and account for details of the Accident or Occupational Disease. Such information is

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required before Pre-Service Medical Benefits, Post-Service Medical Benefits, Disability Benefits, Dismemberment Benefits and Death Benefits are approved for payment and/or for any continuation of Benefits.

E) You Must Submit to Medical Treatment Pursuant to the Provisions in the Plan
In order to make a claim under the Plan, you must receive timely medical care for the Bodily Injury or Occupational Disease from a Designated Healthcare Provider. Except for Emergency Treatment, Physicians and Facilities approved by the Committee, (i.e., Designated Healthcare Provider) must provide all medical care. If medical care is not received within 30 days of the Accident or detection of the Occupational Disease, no Benefits will be paid under the Plan.

The Plan or Committee will not intervene in the patient-provider relationship. The treatment of a Bodily Injury or Occupational Disease remains under the control and responsibility of the attending Physician and other providers. Neither the Company nor the Plan shall be responsible or liable for the quality of the health care services provided pursuant to the Plan.

SECTION 5 OCCUPATIONAL INJURIES and DISEASES

The Plan provides certain Benefits for occupational injuries sustained by you while in the Course and Scope of Employment and are considered a Plan Participant. The following information explains Covered Injuries as well as excluded injuries under the Plan.

A) Covered Injuries
Subject to the terms and conditions of the Plan, the Plan pays Benefits for any Injury (including Bodily Injury, Cumulative Trauma and Occupational Disease) to the physical structure of the Participant's body incurred in the Scope of Employment, which is caused by an Occurrence during his or her participation in the Plan.

B) Definitions. Key terms are defined below:

(1) "Accident": Means an event which was sudden, unforeseen, unplanned, unintended, unexpected by the Participant and which occurred while the Plan was in effect at a specifically identifiable time and place, by chance or from unknown causes, independent of all other causes, and that directly resulted in Bodily Injury to the Participant, who at the time of the Accident was in Active Duty within the Scope of Employment. An Accident is deemed to end 72 hours after the event commences. Each subsequent 72 hours is deemed to be a separate Accident.

(2) "Occurrence": Means an Accident or series of Accidents, which results in Bodily Injury or Occupational Disease to one or more Participants, arising out of one event or incident after the Effective Date. With respect to Occupational Disease, Occurrence means the Participant's last day of last exposure, after the

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Effective Date, to the conditions causing or aggravating such Occupational Disease.

(3) "Bodily Injury": Means an identifiable physical injury to a Participant, including resulting death, caused by an Accident. Bodily Injury does not include Cumulative Trauma or Occupational Disease unless it results directly from an Accident.

(4) "Cumulative Trauma": Means an identifiable damage to the physical structure of the Participant's body occurring as a result of physically traumatic activities that occur in the Participant's Scope of Employment but only if, the Participant's last day of exposure to the conditions causing or aggravating such damage took place while in Active Duty and while covered under the Plan. Cumulative Trauma does not include Bodily Injury.

(5) "Occupational Disease": Means an unhealthy condition of the body (but not including ordinary diseases of life to which the general public is exposed) arising out of a Participant's assigned duties while in Scope of Employment at a Company owned location, which causes damage or harm to the physical structure of the body but only if, the Participant's last day of last exposure to the conditions causing or aggravating such damage or harm took place while in Active Duty and while covered under the Plan. Occupational Disease includes Cumulative Trauma. The condition must not have been caused by an Accident and must be generally accepted by the National Center of Diseases to be a disease. Occupational Disease does not include Bodily Injury.

(6) "Scope of Employment": Means an activity of any kind or character that has to do with and originates in the Company's work, business, trade or profession and that is performed by a Participant while engaged in or about the furtherance of the Company's business, including activities conducted on the Company's premises or at other locations. "Scope of Employment" does <u>not</u> include, under any circumstances, a Participant's commuting to or from the place of employment or an injury occurring on a parking lot or other premises in close proximity to the Company before or after the employee has begun or ceased work.

(7) "Injury": Means Bodily Injury or Occupational Disease to the physical structure of the Participant's body incurred in the Scope of Employment and sustained from an Occurrence. All Bodily Injury or Occupational Disease suffered in a single Accident or Occurrence shall be considered a single injury.

C) Excluded Injuries: The term "Injury" shall not include and *the Plan will not pay benefits for:*

1. an injury that occurred before or after the Participant was eligible for Benefits;

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2. an injury when the first Medical Expense was not incurred within thirty (30) days of the Accident or discovery of an Occupational Disease;

3. any mental trauma, emotional distress, chronic fatigue syndrome or similar injury which is not identifiable as damage or impairment to the physical structure of the body, including without limitation, any mental or physical manifestation resulting from or emotional damage or harm that arises primarily from an act of violence or a personnel action, including, but not limited to, a transfer, promotion, demotion or termination of employment;

4. an injury that is a disease of ptomaine or bacterial infection (except pyogenic infection occurring with and through an injury), unless otherwise eligible for Benefits as an Occupational Disease;

5. an injury that occurred as the result of an incident that cannot be identified as proximately caused by or arising out of an Occupational Accident, including but not limited to, heart attack, stroke, seizure, or aneurysm;

6. any injury arising out of an act of God, unless the employment with the Company exposes the Participant to a greater risk of injury from an act of God than ordinarily applies to the general public;

7. an injury that arose from or has progressed to a state that treatment by a Physician has not been required for a period of sixty (60) days;

8. an injury that is a hernia, unless such hernia is an inguinal hernia that appeared immediately following the Accident and was not a Pre-Existing Condition;

9. any injury, damages, fines, assessments or penalties resulting from, relating to or connected in any way with a cause of action or claim; (1) against the Company and/or the Plan for liability assumed under any written, oral or implied contract, agreement, representation, warranty or indemnity of any kind; (2) arising from the Participant's employment relationship with the Company (such as employment discrimination, wrongful discharge, retaliatory discharge, coercion, sexual harassment, claims under Title VII of the Civil Rights Act of 1964, Civil Rights Act of 1991, Civil Rights Act of 1866, Age Discrimination in Employment Act, Americans with Disability Act, Fair Labor Standards Act, Railway Labor Act, National Labor Relations Act, Family and Medical Leave Act, Texas Commission on Human Rights Act, and claims under the Texas Labor Code); (3) arising from alleged or actual violations of any federal or state statute; and/or (4) arising under the common law;

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10. the care or treatment of alcoholism or drug abuse or other substance abuse treatment;

11. treatment or service that may be performed safely and reasonably by a person not medically skilled or that is designed to assist the patient with daily living activities unless such expense is approved by the Committee;

12. an injury that occurred while driving or testing a vehicle, boat, or aircraft in/for any race or speed contest.

13. an injury that is not an Injury defined in the Plan.

14. arising from statutory causes of action including, without limitation, claims for any type of employment discrimination, wrongful discharge, retaliatory discharge, coercion, sexual harassment, claims under Title VII of the Civil Rights Act of 1964, Civil Rights Act of 1991, Civil Rights Act of 1866, Age Discrimination in Employment Act, Americans with Disability Act, Medicare, Medicaid, SCHIP Extension Act of 2007, Fair Labor Standards Act, Bankruptcy Code, Internal Revenue Code, Railway Labor Act, National Labor Relations Act, Family and Medical Leave Act, Texas Commission on Human Rights Act, Texas 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. (this exclusion does not apply to negligence claims under Texas common law seeking damages for Injury otherwise covered by SECTION 2: INSURING AGREEMENT nor does it apply to the defense of non-separable allegations of claims listed in this paragraph A when there is a demonstrable Injury. That portion of damages, settlements, awards, judgments, punitive or otherwise, for non-separable claims included in this paragraph A are excluded from indemnification).

17. arising under the Federal Employers Liability Act, United States Longshore & Harbor Workers Compensation Act, the Jones Act, Non-Appropriated Fund Instrumentality's Act, Defense Bases Act, Outer Continental Shelf Lands Act, Federal Coal Mine Health and Safety Act of 1969 or the Migrant and Seasonal Agricultural Worker Protection Act, the Employee Retirement Income Security Act of 1974 (this exclusion does not apply to claims for benefits under Your Injury Benefit Plan) or any other federal or State workers' compensation law, unemployment compensation law, disabilities law, occupational disease law or other similar law or any amendments to those laws.

18. any fines, assessments or penalties, whether arising under federal or State statute, regulation, or procedural rule.

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19. an intentionally self-inflicted Injury while either sane or insane by the Employee, or Injury intentionally caused or intentionally aggravated.

20. any injury arising out of an Employee's participation in:
    1. a riot or act of civil disturbance;
    2. a felony or an assault, except an assault committed in defense of Your business or property;

21. an injury directly or indirectly, contributed by, caused by, resulting from, or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence of the Injury:
    1. a war, (declared or undeclared) invasion, acts of foreign enemies, hostilities, civil war, mutiny, revolution, rebellion, insurrection, uprising, military or usurped power, confiscation by order of any public authority or government dejure or de facto, martial law; or
    2. service in the military of any country or any civilian non-combatant unit serving with such forces.
    3. all actual or alleged Loss, defense costs, costs or expenses directly or indirectly arising out of, contributed by, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, retaliating against, or responding to 1. and/or 2. above.

22. any injury arising out of travel to and from work, except when:

    1. the transportation is furnished as a part of the contract of employment or is paid for by the Company; or
    2. the Employee is directed in his Scope of Employment to proceed from one place to another place by the Company;

23. any injury arising out of an act of a third person intended to injure the Employee because of personal reasons and not directed at the Employee as an employee or because of his employment with Company;

24. any injury arising out of voluntary participation in an off-duty recreational, social, or athletic activity not constituting part of the Employee's work-related duties;

25. any injury arising out of any diagnostic procedures, treatment, service or supply that is not Medically Necessary;

26. any injury arising out of that part of any charge which exceeds the Usual and Customary charge for that good or service;

27. any injury occurring while the Employee tests positive for alcohol or any chemical substance not lawfully available or consumed in violation of the Controlled Substances Act in force at the time and location of the injury;

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28. the use of or caused or contributed by:

    1. asbestos, asbestos fibers, silica, sand blasting or asbestos products; or
    2. the hazardous properties of nuclear material.

29. with regard to aircraft, this Plan does not cover any injury arising out of:

    1. boarding, alighting from, or being on any aircraft owned, operated or leased by Company, the Employee or a member of the Employee's household;
    2. an Employee who is a member of the flying crew of any aircraft;
    3. flying in any aircraft that is rocket propelled;
    4. flying in any aircraft being used for aerobatics, racing or an endurance test, crop dusting, seeding, fertilizing or spraying, fighting a fire, any exploration or pipe or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting or any test of experimental aircraft; or
    5. flying when a special permit or waiver from the proper authority has to be issued.

30. injury to a master or member of the crew of any vessel.

SECTION 6 BENEFITS AVAILABLE TO PLAN PARTICIPANTS

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Any Benefits shall be payable to a Participant after the claim has been approved by the Committee or its designee. The Company may provide Emergency Treatment at the time of your Injury. However, the provision of initial medical treatment does not obligate the Plan in any way nor does it mean that additional Benefits will be approved or paid by the Plan. The Committee retains the right at any time to award, discontinue or reduce Benefits of a Participant based upon the terms and conditions of the Plan.

The combined aggregate of all possible benefits under this Plan (including, but not limited to, Medical Benefits, Disability Benefits, Death and Dismemberment Benefits) payable to a Participant or on his behalf shall not exceed $1,000,000.00. The combined aggregate of all possible benefits under this Plan (including, but not limited to, Medical Benefits, Disability Benefits, Death and Dismemberment Benefits) payable because of an Occurrence, regardless of the number of Participants, shall not exceed $10,000,000.00 The combined aggregate of all possible benefits under this Plan (including, but not limited to, Medical Benefits, Disability Benefits, Death and Dismemberment Benefits) payable regardless of the number of Occurrences or the number of Participants shall not exceed $25,000,000.00 All benefits must be for Occurrences after May 1, 2019. The maximum duration of any benefit for any Occurrence is 110 weeks.

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A) Medical Benefits

Subject to the terms and conditions of the Plan, a Participant is entitled to receive Medical Benefits for Medical Expenses incurred as result of an Injury up to $250,000.00. "Medical Benefits" means any benefit payable under this Section. Medical Expenses are covered at 100%, provided (1) the Participant follows the procedures in Section 4 of this booklet; and (2) the first Medical Expense was incurred within 30 days of the Injury or Occupational Disease or the discovery of an Occupational Disease; and (3) the Medical Expense is incurred within 60 days of the last treatment of the Injury by an approved Physician.

Medical Benefits terminate upon the earliest of (1) the date of the Participant's death; (2) the date that the Participant reaches Maximum Rehabilitative Capacity; (3) the date of any termination For Cause of the Participant's employment with the Company; (4) the date a Maximum Benefit has been paid or (5) the expiration of **110** weeks from the date of injury or (6) as provided in Section VI of the Plan document.

(1) Definitions Key terms are defined below:

(i) "Designated Medical Provider": Refers to a Designated Physician or Designated Medical Facility, which is a physician or facility expressly approved by the Claims Administrator and on a list of Designated Medical Providers or otherwise approved in writing by the Claims Administrator. The list of Designated Medical Providers is available from the Plan Administrator. Unless otherwise determined by the Committee, only the services of a "Designated Medical Provider" are covered under the Plan.

(ii) **"Maximum Rehabilitative Capacity"** also referred to as maximum medical improvement, is the point at which a Physician determines that the injured Participant will not likely improve substantially as a result of additional medical treatment or physical therapy.

(iii) **"Medical Expenses"** are expenses incurred by a Participant for the treatment of an Injury and paid by the Plan for medical or dental services, procedures or supplies, provided that the expense is Medically necessary and within the scope of his or her license. Medical Expenses include confinement in a Facility or skilled nursing facility and the cost of Medically Necessary supplies, appliances, prescription drugs and emergency ground ambulance hire.

(iv) **"Medically Necessary"** means medical services, procedures or supplies which are necessary and appropriate for the diagnosis or treatment of a Participant's Injury and are: (1) required, recognized and professionally accepted nationally by Physicians as the usual, customary and effective means of diagnosing or treating the condition; (2) the most economical supplies or levels of service that are appropriate and available for the safe and effective treatment of the condition; (3) not primarily for the convenience of the

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Participant, the Participant's family or the Participant's Physician or other provider of medical services, supplies or procedures; (4) services or supplies that could not have been omitted without adversely affecting the Participant's condition or quality of the medical care rendered; *however, the fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Medically Necessary or make the expense an allowable Medical Expense.*

(v) **"Usual and Customary Charge"** means the Medical Expense is: (1) usual when it is the fee regularly charged (and which the patient is responsible to pay in the absence of insurance or other third party reimbursement), by a health care provider or physician for a given treatment, service or supply; and (2) customary in relation to what other physicians and health care providers in the same geographic area are charging for the same or similar treatment, service or supply.

(2) Exclusions from Coverage under "Medical Expenses". Unless approved by the Plan's Committee, Medical Expenses do **not** include expenses incurred for:

(i) biofeedback (and other forms of self-care or self-help training or any related diagnostic testing), hypnosis, acupuncture or air purifiers,

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

(iii) services performed by the Participant or by a person who normally lives with the Participant, the spouse of the Participant, the parents of the Participant or the Participant's spouse, a child of the Participant or the Participant's spouse, or a brother or sister of the Participant or of the Participant's spouse;

(iv) any diagnostic or preventive procedure, treatment, service or supply which is not Medical Necessary as determined by the Committee;

(v) that part of any Medical Expense which is in excess of the Usual And Customary Charge for it;

(vi) any request for payment or reimbursement of Medical Expenses not filed with the Committee or its designee within sixty (60) days from the date such expense is incurred or, if later, the date the Participant received the invoice from the Designated Healthcare Provider for the treatment;

(vii) a missed appointment with a health care provider:

(viii) any Medical Expense that is reimbursable by any local, state, federal or other governmental agency or is incurred while confined in a hospital owned or operated by the United States Government or an agency thereof for the treatment of a military services-related disability;

(ix) any Medical Expense that would not be legally required to be paid or would not be made absent the Plan;

(x) that part of any Medical Expense that is in excess of the maximum Benefit limitations of the Plan;

(xi) Any Medical Expense that is incurred for the treatment of any and all types of herpes, simplex type 2 genital herpes, syphilis, and/or gonorrhea;

(xii) Charges rendered after your Medical Benefits under this Plan terminate.

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(B) Medical Benefit Claim Procedures

There are three kinds of Medical Benefit claims (defined below) and each category is handled differently as described in this Section. You should become familiar with this Section as it explains the benefit claim procedures as well as your appeal rights.

(1) "Emergency Medical Benefit Claims"

Includes those Medical Necessary healthcare treatments, services or supplies that are provided for the repair or treatment of a Bodily Injury or Occupational Disease which, if not immediately diagnosed and treated, could reasonably be expected to result in loss of life or limb, disfigurement, serious impairment to bodily functions, an organ or a body part or the Participant's ability to regain maximum function, or a physician's diagnosis that Participant's medical condition would subject Participant to severe pain unless the care or treatment is provided that is the subject of the claim. These claims do not require pre-approval from the Committee (or its designee) and the emergency services do not need to be provided by an approved Physician or Facility. A physician or other health professional licensed, accredited or certified to perform the health services under applicable state law and who has knowledge of the Participant's medical condition is permitted to act as the Authorized Representative for purposes of an Emergency Medical Benefit Claim.

(2) "Pre-Service Medical Benefit Claims"

Includes those Medically Necessary healthcare treatments, services or supplies that are provided for the treatment of a Bodily Injury or Occupational Disease which can be scheduled in advance without adverse consequences. These services and supplies must be pre-approved by the Committee (or its designee) and provided by a Designated Healthcare Provider.

(3) "Post-Service Medical Benefit Claims"

Refers to the regular ongoing Medically Necessary treatments of a Bodily Injury or Occupational Disease which are provided for the ongoing treatment of a Bodily Injury or Occupational Disease previously approved under the above-noted Paragraph (2) ("Pre-Service Medical Benefit Claims). These services do not need to be pre-approved by the Committee (or its designee) but must be performed by a Designated Healthcare Provider

.

(4) Eligible Medical Benefit Claims

To be an eligible claim for Medical Benefits or Pre- and Post-Service Medical Benefits, the Participant or the Participant's Authorized Representative must have complied with the notice requirements in Section 4 of this booklet (if medically possible). Pre-Service Medical care must also be pre-approved and provided by a Designated Healthcare Provider to be an eligible claim. Post-Service Medical

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Benefits also must have been provided by a Designated Healthcare Provider to be an eligible claim.

(5) Open Medical Benefit Claims

When a Participant or Authorized Representative fails to follow the Plan's claim filing, reporting and/or communication procedures for Emergency or Pre-Service Medical Benefit Claims, the Committee or its designee shall notify the Participant or Authorized Representative as soon as possible, but not later than five (5) days (twenty-four [24] hours for Emergency Medical Benefit Claims) of the failure and the information or proper procedures required to process the claim or approve the treatment. This notification shall be telephonic or oral, unless written communication is requested by the Participant or Authorized Representative. This notification of a failure to follow the Plan's claims filing procedures shall only apply in the case of a failure which (a) is a communication by a Participant or Authorized Representative that is received by the Committee's designated claim administrator and (b) is a communication that identifies a specific Participant; identifies a specific medical condition or symptom; and references a specific treatment, service or product for which approval is requested. The open medical claim shall be approved or denied within the timelines noted in this Paragraph and Section 6(C)1, 6(C)2, and 6(C)3, below independent of the required information necessary to accept the claim accompanying the filing.

(C) Filing a Medical Benefit Claim

To be eligible to file a Medical Benefit claim (other than Emergency Treatment) under the Plan, a Participant or Authorized Representative must first comply with the reporting, communication, and treatment requirements of Section 4 of this booklet. The handling of Emergency Medical Benefit Claims, Pre-Service Medical Benefit Claims, and Post-Service Medical Benefit Claims are detailed in this Section.

(1) Claims for Emergency Medical Benefit

(i) **(i)Timing of Actions** – The Committee's designated representative will contact the Participant or Authorized Representative (the **"Claimant"**) with notice of acceptance or denial of the claim as soon as possible, but not later than 72 hours after receipt of notice of any occupational injury requiring Emergency Treatment. When additional information is required of Claimant to determine if Emergency Medical Benefits are payable under the Plan, the Committee's designated representative will notify the Claimant of the information required as soon as possible, but no later than 24 hours after receipt of the claim. The Claimant will be allowed a reasonable time to respond, but not less than 48 hours to provide the needed information. The Committee's designated representative will notify the Claimant of the acceptance or denial of Benefits as soon as possible, but not later than 48 hours after the earlier of the receipt of the clarifying information or the expiration of the time period given to the Claimant to respond with the clarifying information.

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(ii) Method of Notice – The Committee's designated representative will attempt to notify the Claimant orally of a denial of Benefits, with written notice provided no later than three days after the oral notice. The written notice shall: (1) itemize the specific reason for the adverse determination; (2) refer to the specific Plan criteria on which the determination is based; (3) detail any additional specific information required for the Claimant to complete the claim and explain why the additional specific information is needed; (4) outline the Plan's appeal procedures and the time frames for the procedures, including a statement of the Participant's right to bring a civil action under Section 502(a) of ERISA, and after any adverse determination on the appeal; (5) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, state that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and a copy of it will be provided free of charge to the Claimant upon request; (6) if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, state that an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Claimant's medical circumstances, will be provided free of charge upon request; and (7) notify the Claimant that he or she may make an expedited appeal of the denial orally or in writing and that if an expedited appeal is requested, all necessary information, including the Committee's benefit determination on the expedited appeal will be transmitted to the Claimant by telephone, facsimile, electronic or other expeditious means.

(iii) Appeal of a Claim Denial – A Claimant requesting Emergency Medical Benefits may appeal an adverse benefit determination by the Committee's designated representative. The appeal will be made to the Committee and processed in accordance with the Plan's appeal procedures and rules, which include: (1) Claimant will have 180 days after receipt of the notification of the adverse benefit determination by the Committee's designated representative to appeal the decision to the Committee; (2) the Claimant will have the opportunity to present written comments, documents, records and other specific additional information relative to the claim; (3) the Claimant will be provided upon request and free of charge, reasonable access to, and copies of all information relevant to the individual's claim; (4) the Committee will take into account all comments, documents, records and other specific information submitted by the Claimant relating to the claim, even if such items were submitted or considered in the initial benefit determination by the Committee's designated representative; (5) the Committee's review shall be independent of and not afford deference to the initial adverse benefit determination by its designated representatives, and the designated representative, if a Committee member, will not be permitted to vote on the Claimant's appeal of the negative benefit determination by the designated representative; (6) if the appeal is of any adverse benefit determination that was based in whole or in part on a medical judgment (including determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or

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appropriate), the Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment leading to the negative benefit determination; (7) the Committee will identify medical or vocational experts whose advice was obtained by its designated representatives in connection with the adverse benefit determination, even if the advice was not relied upon in making the negative benefit determination; and (8) when the Committee consults with a health care professional under number (6) above, such individual may not have been the same individual or the subordinate of the same individual who was consulted in making the designated representative's adverse determination under appeal

(iv) Notification of Appeal Determination – As soon as possible but not later than 72 hours after receipt of the Claimant's appeal to the Committee for review of the adverse benefit determination for Emergency Treatment Benefits, the Committee will notify the Claimant of the Plan's final decision on the Claim. The Committee will provide the Claimant with written notice of its determination on the Claimant's appeal of the Claim for Emergency Treatment Benefits. If the determination is adverse to the Claimant, the notice will (1) set forth the specific reason for the adverse determination; (2) detail the specific Plan provision on which the determination is based; (3) notify the Claimant that upon request and free of charge, the Claimant shall be provided reasonable access to, and copies of, all information relevant to the claim; (4) state the Claimant's right to bring a civil action under Section 502(a) of ERISA; (5) if an internal rule, guideline, protocol or other similar criterion was relied upon in rendering the adverse determination, state that such rule, guideline, protocol or other similar criterion was relied upon in rendering the adverse determination and that a copy of it will be provided free of charge to the Claimant upon request; (6) if the adverse determination is based upon medical necessity or experimental treatment or similar exclusion or limit, state that an explanation of the scientific or clinical judgment for the determination, applying the Plan's provision to the Claimant's medical circumstances, will be provided free of charge upon request; and (7) state: "You and the Plan may have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor or the Plan Committee."

(2) Claims for Pre-Service Medical Benefit and Post-Service Medical Benefit

(i) Timing of Action – The Committee's designated representative will contact the Claimant of the acceptance or denial of the claim within a reasonable time based on the medical condition, but not later than fifteen (15) days after receipt of a claim for Pre-Service Medical Benefits or thirty (30) days after the receipt of a Post-Service Medical Benefit claim (unless special circumstances necessitate an extension of handling time.) If special circumstances cause additional time for handling the claim, the Claimant will be notified in writing that an extension of no more than fifteen days is required. The written notice will be made prior

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to the end of the initial fifteen or thirty day handling period. The notice of extension will specify the special circumstances causing the extension, the date by which a final decision will be reached, specify the standards on which acceptance of the claim is based, detail the unresolved issues that created the delay, and specify the additional information required to resolve the issues. The Claimant has forty-five (45) days to provide the specified additional information. If the fifteen (15) day extension is created by the Claimant's failure to submit the information required to adjudicate the claim, the period for making the benefit determination is suspended from the date the fifteen (15) day extension notice was mailed until the date the Claimant responds with the requested information. The Committee's designated representative will notify the Claimant in writing of any adverse benefit determination on Pre-Service Medical Benefits or Post-Service Medical Benefit Claims. The notice will include the "Method of Notice" information described in Section 6.

(ii) Appeal of a Claim Denial – A Claimant for Pre-Service and/or Post-Service Medical Benefits will be afforded a reasonable opportunity for a full and fair appeal of a claim that was denied or negatively impacted by the Committee's designated representative. The appeal will be to the Committee to review the negative determination under the rules in Section 6 and others the Committee deems appropriate.

(iii) Notification of Appeal Determination – Within a reasonable time, but not later than 30 days after the receipt of an appeal to the Committee of an adverse benefit determination of Pre-Service Medical Benefits and no later than 60 days after the receipt of an appeal to the Committee of an adverse benefit determination on Post-Service Medical Benefits the Committee will notify the appealing Claimant of the Plan's final decision on the claim. The Committee will provide the Claimant with written notification of its final decision on the Claimant's appeal of the negative determination. If the determination is adverse to the Claimant, the notice will include the items in Section 6.

(3) Claims for Concurrent Care Medical Benefit

i. Timing of Action – If the Committee has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Committee's designated representative will contact the Claimant of such adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical situations, and the Committee shall notify the Claimant of the benefit

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determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with Section 6 and appeal shall be governed by Section 6 above.

(D) Disability Income Benefits

Subject to the terms and conditions of the Plan, a Participant who is Disabled as the result of an Injury shall be entitled to a Disability Benefit equal to the Disability Income Percent of pre-disability pay as shown in the Schedule. **"**Disability Benefit" means any benefit payable under this Section 6. **"**Disabled" means a Participant's partial or total inability (whether temporary or permanent) because of an Injury, commencing within 12 months from the date of the Injury, to: (1) perform the material and substantial duties of his or her regular occupation, and (2) earn the equivalent wages the Participant was receiving at the time of the Injury in his or her regular duties for the Company, as determined by the Committee with advice from a Designated Healthcare Provider.

The Disability Benefit will begin on the scheduled workday immediately following the end of the Elimination Period shown in the Schedule that, pursuant to the Designated Healthcare Provider, the Participant is continuously disabled from Active Duty as a result of the Injury ("lost time"). In any case no Participant shall receive Disability Benefits in excess of **Disability Maximum per week shown in the Schedule.**

The Committee or its designee shall determine: (1) if the Participant is entitled to Disability Benefits; (2) the amount and frequency of any payments of Disability Benefits, (3) the length of time the Disability Benefits shall be paid. The Committee or its designee will require the Participant to periodically report his or her health status to the Committee.

(1) "Pre-Disability Pay" means:

i. for a Participant paid an **hourly wage** by the Company, the Participant's average regular rate of pay for the average hours worked per week (up to forty [40] hours per week) for the six consecutive weeks immediately before he or she became Disabled, but if an hourly Participant has not worked for the Company for six weeks or his or her rate of pay cannot otherwise be reasonably determined by the Committee (in its sole discretion), then the six-week average weekly rate of pay (in turn divided by the average hours worked per week to determine hourly rate of pay) shall be based on the rate of pay of a similar Employee, as determined by the Committee in its sole discretion;

ii. for a Participant paid a **salary** by the Company, the Participant's total regular weekly salary on the date he or she became Disabled (in turn divided by the average hours worked per week, regardless of the number of hours normally worked by the salaried Participant in a week, to determine hourly rate of pay);

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iii. for a Participant paid a **commission** by the Company, the Participant's average weekly commissions for the six consecutive weeks immediately before he or she became Disabled, but if a commission-paid Participant has not worked for the Company for six weeks or his or her rate of pay cannot otherwise be reasonably determined by the Committee (in its sole discretion), then the six-week average weekly rate of pay (in turn divided by the average hours worked per week to determine hourly rate of pay) shall be based on the rate of pay of a similar Employee, as determined by the Committee in its sole discretion.

Pre-Disability Pay is calculated using the appropriate foregoing weekly rate of pay and corresponding hourly rate of pay, and is paid to a Disabled Participant on a weekly basis, and excludes any overtime, bonuses, benefits, tips, or other extraordinary remuneration. Pre-Disability Pay shall include a Participant's contributions made in the form of an authorized salary reduction, which is diverted by the Participant for payment, by the Company, into a savings plan such as a Salary Reduction Plan, Cafeteria Plan or Flexible Benefit Plan.

Disability Benefits shall continue to be paid only while the Participant remains Disabled as the result of an Injury, but shall terminate, in any event, at the earliest of: (1) the expiration of the Disability Maximum Number of Weeks shown in the Schedule from the date of the Bodily Injury; (2) the expiration of the Disability Maximum Number of Weeks shown in the Schedule from the date such Disability Benefits began to accrue as the result of Occupational Disease; (3) the date of the Participant's death; (4) the date that the Participant reaches Maximum Rehabilitative Capacity; (5) the date of any termination For Cause of the Participant's employment with the Company; (6) the date a Maximum Benefit has been paid, or (7) as provided in Section 9.

(2) Benefit Reductions

The Plan shall not provide duplicate payments to or on behalf of the Participant. Disability Benefits otherwise payable to a Participant shall be reduced by the Committee dollar-for-dollar by the amount of any:

(i) absent-time pay paid by the Company;

(ii) salary contributions paid by the Company;

(iii) salary or wages paid to the Participant for services rendered in modified-duty or restricted capacity;

(iv) compensation or benefits received or payable to the Participant under the Social Security Act, a workers' compensation act, unemployment compensation law, occupational injury or disease law, or another law providing disability benefits; and

(v) benefits payable under any short-term or long-term disability insurance policy or employee benefit program provided by the Company for the Participant.

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Any amount to which the Participant is entitled under the terms of any insurance policy which is maintained by the Employer and covers the Participant shall be primary to any Benefits payable under the Plan, and the amount due under any such insurance policy shall reduce or offset the amount due under the Plan. A Participant is required to take whatever benefits are available to him or her from other sources besides the Plan, including enrolling under the Social Security Act to receive benefits for a disability that is covered under that Act.

When a Participant has been released to return to full or modified duty by the treating Physician, the Participant must return to work as directed by the Company. If the Participant fails or refuses to return to work when so directed, the Participant is subject to: (1) immediate cessation of Disability Benefits, and/or (2) termination of employment due to job abandonment or For Cause as determined by the Company. Disability Benefits shall cease if the Participant becomes employed by another employer or receives compensation for services as determined by the Committee.

To the extent applicable, the provisions of this Section shall be construed in accordance with the requirements of the Family Medical Leave Act of 1993 and the Americans with Disabilities Act of 1990, provided the Company is subject to the jurisdiction of these laws.

(3) Filing a Disability Benefit Claim

To be eligible to file a Disability Benefit claim under the Plan, a Participant or Authorized Representative must first comply with the reporting, communication and treatment requirement of Section 4.

(i) Timing of Actions

The Committee's designated representative will contact the Claimant of acceptance or denial of the claim within a reasonable time, but not later than 45 days after the receipt of the claim (unless special circumstances require an extension of time for processing the claim). If additional information is required to process the claim, the Committee's designated representative will notify the Claimant (in writing) within this 45-day period, and may request a one-time extension not longer than 30 days and place the claim in pendency until all information is received. If matters beyond the control of the Plan Administrator, Committee or the Committee's designated representative arise prior to the end of the first 30-day extension period and a benefit eligibility decision cannot be made, an additional 30-day extension shall be communicated to the Claimant in writing by the Committee's designated representative. This notification shall include the special circumstances requiring the additional processing time, the date by which a decision shall be reached, an explanation of the criteria on which the Benefit determination is based, the unresolved criteria that have prevented the Benefit determination and any specific additional information necessary to resolve the determination. The Claimant will be given at least 45 days to provide any requested specific additional information. If a 30-

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day extension is caused by the Claimant's failure to submit the necessary information to resolve the determination, the period for making the benefit determination shall be tolled from the date of the 30-day extension notice was mailed or communicated electronically to the Claimant until the date that the Claimant responds to the request for the specific additional information. The Committee's designated representative will transmit a written notice of any denial or adverse determination of a Disability Benefit Claim. This notice will contain the items included in Section 6 {C}.

(ii) Disability Benefit Claim Appeal Process

A Claimant will have an opportunity for a full and impartial appeal of a claim denied or adversely impacted by the Committee's designated representative. The appeal will be to the Committee to review the negative determination using the rules in Section 6 (B) and other rules the Committee deems appropriate.

(iii) Committee's Decision on an Appeal

The Committee will review the negative determination on a Disability Benefit claim in a reasonable time, but not later than 45 days (unless special circumstances require an extension of time for reviewing the determination) after receipt of the Claimant's appeal to the Committee. The Committee will notify the Claimant of the Plan's final position on the negative determination by the end of the 45-day period. If the Committee determines that an extension of time for review and determination is required, the Committee will notify the Claimant, in writing, of the extension prior to the end of the first 45-day period. The extension shall not exceed an additional 45 days from the end of the first 45-day period. The extension notice will contain the special circumstances causing the need for the extension and the new date by which the Committee will declare the Plan's final position on the negative determination. If the extension is caused by the Claimant's failure to provide specific additional information to the Committee, the period for the Plan's final position on the negative determination will be suspended from the date the 45-day extension notice was mailed until the date that the Claimant provides the specific additional information. The Committee will send the Claimant written notification of the Plan's final position on the appealed negative determination. The notice will contain the items included in Section 6 in the event of an adverse decision.

(E) Death and Dismemberment Benefits

Subject to the terms and conditions of the Plan, if a Participant dies as the direct and sole result of, and within 365 days of, an Occurrence, then the Participant's Death Beneficiary shall be eligible to receive a Death Benefit equal to the Death Benefit Amount shown in the Schedule unless the Death Benefit must be reduced so that the Maximum Benefit will not be exceeded. Subject to the Maximum Plan Benefit shown in the Schedule, in all cases the Death Benefit shall not be greater than the lesser of:

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the Death Benefit amount shown in the Schedule or the Salary Multiple shown in the Schedule times the annualized pre disability pay. Any Death Benefit under this Section will be reduced by any amounts paid under Disability Income Benefits.

1. Dismemberment Benefit

Subject to the terms and conditions of the Plan, if a Participant sustains one or more of the following Dismembering Injuries as the direct and sole result of, and within 365 days of, an Occurrence, as determined by the Committee, then the Participant shall be eligible to receive one (the larger) Dismemberment Benefit in a dollar amount equal to the percentage of the Death Benefit (as would be determined under the immediately preceding paragraph above if the Participant had been killed by the Occurrence that caused the **"Dismembering Injury"**) as indicated for that one particular Dismembering Injury. **"Dismemberment Benefit"** means any Benefit payable under this Section.

Loss of Both Hands or Both Feet	100%
Loss of Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Hearing in Both Ears and Speech	100%
Loss of One Foot and Sight of One Eye	100%
Loss of One Hand and Sight of One Eye	100%
Loss of Use of Both Arms and Both Legs	100%
Loss of Use of Both Arms or Both Legs	75%
Loss of Use of One Arm and One Leg	75%
Loss of Hearing in Both Ears or Speech	50%
Loss of One Hand or One Foot	50%
Loss of Sight of One Eye	50%
Loss of Use of One Arm or One Leg	50%
Loss of Thumb and Index Finger	25%
Loss of Finger or Toe (two joints)	10%
Loss of Finger or Toe (one joint)	5%

2. "Loss" regarding a Dismembering Injury means: (a) regarding a hand or foot, severance at or above the respective wrist or ankle joint or total loss of the ability to perform each and every act and service that the hand or foot was able to perform before the Occurrence; (b) regarding sight of an eye, entire and irrevocable loss of sight; (c) regarding hearing, the total and irrevocable loss of hearing in both ears; (d) regarding speech, total and irrevocable loss of the entire facility; (e) regarding thumb and index finger, severance through or above metacarpophalangeal joints. Any "Loss" must continue without interruption for a period of not less than 52 consecutive weeks and must be total and irrevocable and beyond remedy by surgical or other means, all as determined by the treating Physician.

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3. Limitations, Payment Method and Conditions

The Plan will pay for only one Death Benefit or Dismembering Injury to a Participant due to the same Occurrence. If a Participant is both killed and dismembered, or if a Participant sustains more than one Dismembering Injury, then the Plan will pay the larger of either (a) the Death Benefit, or (b) the larger applicable Dismemberment Benefit. The Death Benefit or Dismemberment Benefit will be reduced by the amount of any Disability Benefits paid with respect to the Occurrence. A Participant is not eligible for Disability Benefits if the Participant is entitled to a Dismemberment Benefit, but a Death Benefit or Dismemberment Benefit is in addition to Medical Benefits payable by the Plan, subject to the Maximum Benefit (Section 7)

Death Benefit is paid to the Participant's Death Beneficiary (or Beneficiaries) as follows:

(i) 100% of the Death Benefit is paid in a lump-sum cash payment (or equal lump-sum cash payments if there is more than one Death Beneficiary) as soon as administratively possible following the death of the Participant and the Committee's determination of the proper Death Beneficiary (or to the deceased Participant's estate if there is no Death Beneficiary); and

A Dismemberment Benefit is paid to the Participant in a lump-sum cash payment as soon as administratively possible following the Occurrence.

4. Death and Dismemberment Benefit Claim Procedure

To be eligible to file a Death or Dismemberment Claim under the Plan, a Participant or Authorized Representative (or Participant's Death Beneficiary or estate) must comply (where appropriate) with the reporting, communication and treatment requirements of Section 4 and comply with the administrative requests of the Committee and its designated representatives.

(i) Timing of Actions

The Committee's designated representative will contact the Claimant of acceptance or denial of the Claim within a reasonable time, but not later than 90 days after the receipt of the claim (unless special circumstances require an extension of time for processing the claim). If additional information is required to process the claim, the Committee's designated representative will notify the Claimant (in writing) within this 90-day period, and may request a one-time extension not longer than 90 days and place the claim in pendency until all information is received. If matters beyond the control of the Plan Administrator, Committee or the Committee's designated representative arise prior to the end of the first 90-day extension period and a benefit eligibility decision cannot be made, an additional 90-day extension shall be communicated to the Claimant in writing by the Committee's designated representative. This notification shall include the special circumstances requiring the additional processing time, the date by which a decision shall be reached, an explanation of the criteria on which

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the Benefit determination is based, the unresolved criteria that have prevented the Benefit determination and any specific additional information necessary to resolve the determination. A decision on the acceptance or denial of the claim will be made within 180 days after the receipt of the claim. The Committee's designated representative will transmit a written notice of any denial or adverse determination of a Death and Dismemberment Benefit Claim. This notice will contain the items included in Section 6(C).

(ii) Death and Dismemberment Claim Appeal Process

A Claimant will have an opportunity for a full and impartial appeal of a claim denied or adversely impacted by the Committee's designated representative. The appeal will be to the Committee to review the negative determinations using the rules in this Section and other rules the Committee deems appropriate. The Claimant will have at least 60 days after receipt of the notification of the denied or adversely impacted decision to appeal to the Committee.

(iii) Committee's Decision on an Appeal

The Committee will review the negative determination on a Death or Dismemberment Benefit claim in a reasonable time, but not later than 60 days (unless special circumstances require an extension of time for reviewing the determination) after receipt of the Claimant's appeal to the Committee. The Committee will notify the Claimant of the Plan's final position on the negative determination by the end of the 60-day period. If the Committee determines that an extension of time for review and determination is required, the Committee will notify the Claimant, in writing, of the extension prior to the end of the first 60-day period. The extension shall not exceed an additional 60 days from the end of the first 60-day period. The extension notice will contain the special circumstances causing the need for the extension and the new date by which the Committee will declare the Plan's final position on the negative determination. A decision in an appeal will be made within 120 days of receipt of the appeal by the Committee. The Committee will send the Claimant written notification of the Plan's final position on the appealed negative

SECTION 7 MAXIMUM BENEFITS

A) The **"Maximum Benefit"** the Plan shall be liable to pay, which overrides any other provisions of the Plan, is limited to:

B) Participant Maximum Benefit – The maximum total of Medical Benefits, Disability Benefits and Death and Dismemberment Benefits payable to each Participant for any one Occurrence is the Participant Maximum Benefit as shown in the Schedule.

C) Aggregate Maximum Benefit – The maximum total Medical Benefits, Disability Benefits and Death and Dismemberment Benefits payable to all Participants arising from a single Accident and/or Occupational Disease is the Aggregate Maximum Benefit shown in the Schedule. If the aggregation of individual Participant benefit

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amounts due to two or more employees being injured in the same Occurrence amounts to more than the Aggregate Maximum Benefit, then the amount applicable to each Participant involved in such Occurrence may be proportionally reduced is such manner as the Claims Administrator or Committee may determine.

SECTION 8 DENIAL, SUSPENSION OR TERMINATION OF BENEFITS

The Committee shall deny, terminate, suspend or reduce Plan benefits (including Death Benefits) otherwise due a Participant (or a Death Beneficiary or a deceased Participant's estate) due to any of the following events or occurrences:

(A) Participant (or a Death Beneficiary or Deceased Participant's Estate) Fails To

(1) comply with the provisions of the Plan, or the rules and/or procedures adopted by the Committee for the administration of the Plan, or the Committee's requests;

(2) properly and/or timely report the Accident or Occurrence causing the injury as prescribed within Section 4;

(3) provide, upon request by the Committee or its designee, a complete statement, affidavit, or deposition concerning the incident that the Participant believes resulted in an Injury;

(4) provide truthful information during the hiring process at the Company;

(5) provide truthful information and cooperate fully with the Committee and act in good faith in connection with the administration of the Plan and/or in the coordination of benefits;

(6) provide accurate information to, and follow the directions or continue to be under the care of, a treating Physician;

(7) keep and be on time for all scheduled appointments with Designated Healthcare Providers or allow an authorized representative of the Company to go with the Participant to appointments with Designated Healthcare Providers;

(8) follow fully and completely the advice of, or the course of treatment prescribed by a Physician and fulfill the prescribed treatment plan;

(9) refrain from conduct which hinders recovery from the injury;

(10) appear upon reasonable notice for an examination by a Physician or other medical provider;

(11) take a drug and/or alcohol test at the time of the Emergency Treatment or when requested by the Committee or Company;

(12) report to Participant's Company supervisor weekly or more often if directed until able to return to work, including notice of expected recovery time after each appointment with a Physician;

(13) report to the Company immediately after being informed that Maximum Rehabilitative Capacity has been reached;

(14) report to his or her supervisor and return to work after the treating Physician releases the Participant to work for the Company; or

(15) comply with the mediation and arbitration provisions of the Plan, if any, and the Participant or his or her Death Beneficiary, estate, spouse, child, heir, parent, sibling, or legal representative brings a lawsuit against this Plan, and/or files a

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lawsuit for negligence against the Company seeking damages that would be provided by the Plan;

(B) Or, if the Injury is Related to any of the Following

(1) the Participant's fraudulent or other deliberate conduct intended to mislead the Designated Healthcare Provider, Committee or Company as to the nature or severity of the claimed injury;

(2) an intentionally self-inflicted or aggravated injury while the Participant was sane or insane, or caused by his willful action (for example, fighting, horseplay);

(3) voluntary participation by the Participant in an off-duty recreational, social, or athletic activity not a part of work-related duties, except where these activities are required for employment with the Company;

(4) an act of a third person or Employee that was intended to injure the Participant because of personal reasons and not directed at the Participant in the Scope of Employment;

(5) engagement in, or participation in, the commission or attempted commission of a crime, illegal occupation, felonious act or aggravated assault, or participation in a riot, rebellion, act of civil disturbance or insurrection or horseplay or any act incident to any of these events (as used in this, paragraph "participation" means to take an active part in common with others and "riot" means any use of or threat to use force or violence by three or more persons without the authority of the law);

(6) the Participant's employment with the Company being terminated For Cause; or the date the Participant voluntarily resigns his/her employment; or is incarcerated for any reason.

(7) the Participant or his or her Death Beneficiary, estate, spouse, child, heir, parent, sibling or legal representative present a claim or file a lawsuit in conflict with the provisions of the Plan or directives, rules or procedures of the Committee; or

(8) the injury resulted from the Participant's own reckless behavior, the failure to follow mandatory safety rules and/or repeated failure to follow one or more safety practices as specified in safety policies and/or manuals of the Company.

(C) Or, if the Injury Occurred From a Non-Occupational Exposure or Excluded Exposure

(1) determined to be non-occupational, i.e., to have occurred at a time when the Participant was not in Active Duty including, without limitation, a non-occupational injury that is merely aggravated at a time when the Participant is in Active Duty;

(2) while commuting (travel to and from work, as distinguished from travel while actually in Active Duty);

(3) with regard to aircraft, the Plan shall not pay Benefits for injuries resulting from:

(i) riding, boarding, alighting from, exiting or being struck by any aircraft owned, operated or leased by the Participant or a member of the Participant's household;

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(ii) riding as a pilot, operator or crew member having any duties aboard the aircraft;

(iii) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or

(iv) riding as a passenger in an aircraft owned, leased or operated by the Company.

(4) the use of, or contact with, any asbestos, asbestos fibers, or asbestos product or the hazardous properties of any nuclear material or nuclear by-product material;

(5) performing, learning to perform or instructing others to perform as a master or crew member of any vessel;

(6) the injury occurred outside the United States of America and its territories or possessions. This exclusion does not apply to a Participant who is temporarily outside the United States of America within his or her Scope of Employment;

(7) injury to any Participant who is covered by the Federal Employers Liability Act, United States Longshore and Harbor Workers' Compensation Act, the Non-appropriated Fund Instrumentality Act, the Outer Continental Shelf Lands Act, the Defense Base Act, the Federal Coal Mine Health and Safety Act of 1969, Seasonal Agricultural Worker Production Act and other United States or State Workers' Compensation law, unemployment compensation law, disabilities law, occupational disease law or any amendment to such laws;

(8) the Participant has reached Maximum Rehabilitative Capacity;

(9) charges (except for Emergency Treatment) are from a health care provider, which is not a Designated Healthcare Provider; or

(10) injury to any Participant directly or indirectly, contributed by, caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence of the injury:

(i) from an act of war whether declared on undeclared, acts of foreign enemies, hostilities (whether or not war is declared), civil war, act of terrorism, mutiny, revolution, rebellion, insurrection, uprising, military or usurped power; confiscation by order of any public authority, or government dejure or defacto, martial law.

(ii) while participating in the military forces of any country or any civilian non-combatant or humanitarian unit serving with such forces or while confined in a hospital owned or operated by the United States Government or an agency for treatment of military service-related injuries or disease.

(D) Exhaustion of Claim Appeal Procedure

No legal action or arbitration shall be commenced to recover Benefits under the Plan before the claim and appeal procedures as detailed in the Plan have been completed. Denial of a claim for Plan Benefits does not render an appeal of that denial futile or otherwise excuse it from being made. There shall be no de novo review by an arbitrator or court of any decision by the Plan Administrator and any review shall be limited to determining whether the decision was so arbitrary and capricious so as to be an abuse of discretion.

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SECTION 9 COORDINATION, ACCELERATION, RECOVERY OF BENEFITS AND REDUCTION FOR PRIOR INJURIES

(A) Coordination of Benefits

Payments of Plan Benefits will be reduced by amounts paid by Social Security, Medicare or Medicaid benefits and/or under any state or federal workers' compensation act or similar law and/or under any other benefit plan or insurance contract or policy covering the Participant. However, Plan Benefits will only be reduced to the extent necessary to prevent the total amount of Plan Benefits and these other benefits from exceeding 100% of the Medical Expenses incurred by the Participant and 100% of the Participant's Pre-Disability Pay. Benefits under the Plan are secondary to and excess of all other sources of benefits covering a Participant, such that all other sources of benefits pay in full before any Benefits are paid under the Plan. A Participant must, upon request, provide the Committee with copies of and information about any other sources of benefits potentially providing coverage for a Participant's injury, treatment or disability.

(B) Acceleration of Benefits and Final Compromise and Settlement

The Plan Administrator, the Company, and any other related party, at any time after the date of a Bodily Injury or Occupational Disease, and prior to the payment of all Benefits relating to such Bodily Injury or Occupational Disease, may enter into a final compromise and settlement giving any remaining Benefits payable to or with respect to such Participant and any other claims or demands of the Participant.

A Participant or Beneficiary can apply to the Committee for acceleration of the payment of Benefits, and a Participant, Beneficiary, the Plan and the Company may enter into a final compromise and settlement of any remaining Benefits payable as a result of a Participant's Injury or death. The Plan can condition payment of all or any part of such fixed sum upon the payee(s) providing an indemnification and release of liability.

(C) Recovery of Benefits

If a Participant (or his or her beneficiaries, spouse, children, heirs, parents or legal representatives) seeks, becomes entitled to, or receives Benefits under the Plan for any Injury caused by another person, entity or organization and becomes entitled to or collects any compensation for such Injury (whether by insurance, litigation, arbitration, settlement or other proceeding), the Participant (or his or beneficiaries, spouse, children, heirs, parents or legal representative) must (1) reimburse the Plan out of such other compensation to the extent of the Plan Benefits paid to and on behalf of the Participant (without regard to whether said damages or other compensation fully compensate the Participant for his or her injuries and claims against the person or organization or such sums are allocated to any particular type of loss, damage, or expense), and (2) execute any documents requested by the Committee to enable the Plan to recover such Benefits.

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If a Participant fails or refuses to reimburse the Plan, then the Participant must return all Plan Benefits paid to him or her and the Plan may withhold and offset further Benefits to or on behalf of such Participant.

Prior to filing a lawsuit, arbitration or other proceeding or to entering into a settlement discussion or mediation to obtain from any person, entity or organization (other than the Company or an Employer) damages or compensation (in any form) for or on account of an injury to or the death of a Participant for which Plan Benefits have been paid or may in the future be sought, a Participant (or the Participant's Death Beneficiaries, spouse, heirs, parents or legal representatives) shall provide the Committee prior written notice of the lawsuit or other type of proceeding. The Plan may intervene in the lawsuit or other proceeding.

If a Participant (or his or her beneficiaries, spouse, children, heirs, parents or legal representatives) fails or refuses to seek damages or compensation from someone for any injury or death caused by his, her or its negligent or wrongful act or omission (for which Plan Benefits have been paid or may in the future be sought) the Plan may file a lawsuit or other proceeding to pursue reimbursement of Plan Benefits paid and to be paid in the future, plus any costs and expenses incurred by the Plan in pursuing such reimbursement.

Upon the request of the Committee, a Participant (or the Participant's Death Beneficiaries, spouse, children, heirs, parents or legal representatives) must assign to the Plan the right to intervene in or institute any lawsuit or other proceeding, and to do so in the Participant's name. The Plan shall have complete control over the lawsuit or proceeding until finally resolved. The Participant (and the Participant's Death Beneficiaries, spouse, heirs, parents and legal representatives) must fully cooperate with the Plan and its counsel in any such lawsuit or proceeding and must release the Plan, the Company, the Employer, the Committee, and their respective owners, 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 or proceeding.

(D) No Alienation of Plan Benefits

Notwithstanding Section 9, none of the payments, benefits or rights of any Participant shall be subject to any claim of any creditor, and, in particular, to the fullest extent permitted by law, all such payments, Benefits and rights shall be free from attachment, garnishment, trustee's process, or any other legal or equitable process available to any creditor of such Participant, except to the extent such rights are provided to the Plan (and its assignees) under Section 9 ("Recovery of Benefits"), No Participant shall have the right to transfer, alienate, pledge, encumber or assign, in whole or in part, either directly or by operation of law, any of the Benefits or payments, contingent or otherwise, which he or she may expect to receive under the Plan.

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SECTION 10 PLAN ADMINISTRATION COMMITTEE

The Company shall be the **Plan Administrator**. The Plan Committee is responsible for administration of the Plan. This Committee shall consist of at least three individuals, as appointed from time to time by the Board or the President of the Company. A member of the Committee shall serve at the discretion of the Company without additional compensation for such duties, but may be reimbursed for proper expenditures incurred in the course of performance of duties hereunder in accordance with applicable law or regulation.

(A) Administrative Powers and Duties

The Committee shall have the power and discretionary authority to take all actions reasonably required to carry out the terms, conditions, and provisions of the Plan, including, but not limited to, the following:

(1) to construe, construct, and interpret the Plan, including, as necessary, correcting any error or defect, supplying any omission or reconciling any inconsistency which may arise hereunder;

(2) to make or approve rules and regulations which are not inconsistent with the Plan, to the extent deemed necessary or appropriate, including but not limited to, (a) incident review procedures, (b) initial claims evaluation procedures to determine whether Benefits should be awarded hereunder, (c) procedures for Designated Healthcare Providers, (d) modified duty procedures, and (e) safety training procedures;

(3) to decide all questions as to eligibility to become a participant in the Plan and as to the rights of Participants under the Plan;

(4) to review claims for Benefits and to render determinations;

(5) to file or cause to be filed such annual reports, returns, schedules, descriptions, financial statements and other information as may be required by any law or regulation, agency or authority;

(6) to obtain from the Employer, Participants, dependents, beneficiaries or other interested persons, such information as may be necessary or appropriate for the proper administration of the Plan;

(7) to determine the proper amount, manner, and time of payment of Benefits hereunder;

(8) to contract with insurance carriers, third-party administrators or health care providers on behalf of the Plan;

(9) to communicate to any insurer, safety consulting organization, third-party administrator, or health care provider all information and directions which may be reasonably required;

SECTION 11 GENERAL INFORMATION

A) Availability of Plan Information and Documents

Any person having a question concerning the operation of the Plan, or the person's eligibility for Benefits under the Plan should contact the Committee either in person or in writing. The Employer shall keep copies of the Plan, including appendices, exhibits

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and amendments thereto, and any related documents on file in its administrative offices. Such documents and any other records which pertain to Participants shall be available for review by Participants at any reasonable time during regular business hours.

B) Preservation of Rights

The Plan is maintained for the exclusive benefit of the Participants and their rights hereunder shall be legally enforceable in accordance with the terms and provisions of the Plan. Amendment or termination of the Plan shall not affect the right of any Participant with regard to a legitimate claim for Benefits available under the Plan, provided that the event giving rise to such claim was incurred prior to the effective date of the amendment or termination of the Plan as it may affect such claim.

C) Not an Employment Agreement

Neither the Plan, nor this Summary Plan Description, shall be construed to create any contract of employment, express or implied. Nor do the Plan or Summary Plan Description, and the payment of any Benefit hereunder in any way alter the at-will status of an Employee or Participant's at-will employment with the Company (or an Employer). The Company (or Employer) may terminate the employment of any at-will Employee or Participant at any time or modify an at-will Employee's or Participant's working relationship as desired for any or no reason, with or without cause, and as freely and with the same effect as if this Plan had never been established and this Summary Plan Description never existed.

D) Plan Document Controls

The Plan document constitutes the entire Plan, and its text (rather than its titles and headings) control. No oral or written representation or promise concerning the Plan or Plan Benefits that is not set forth in the Plan document shall be binding on the Plan, the Company or an Employer. The Plan prevails over any contrary provision in the Plan's Summary Plan Description.

E) Severability

If any provision of the Plan is determined to be void, invalid, unenforceable or contrary to law, in whole or in part, such illegality or invalidity shall be fully severable and shall not affect the validity or operation of the remainder of the Plan and furthermore, the Plan shall be construed and enforced as if the illegal or invalid term or provision had not been included herein.

F) Construction

Whenever the context of the Plan so requires, any gender shall include the other genders, and words used in the singular or plural shall include the other. The words "herein," "hereof," "hereunder" and other similar compounds of the word "here" shall refer to the entire Plan, not to any particular section, paragraph or provision of the Plan. Headings of sections or paragraphs as used herein are intended solely for convenience and reference and shall not create any presumption, interference, and implications of construction of the Plan.

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G) Applicable Law

The terms, conditions and provisions of the Plan shall be governed, construed, and enforced in accordance with the provisions of ERISA, the Federal Arbitration Act, federal law in general, and, except where superseded by federal law, the laws of the State of Texas.

H) Title to Assets

No Participant shall have as a result of the adoption of the Plan any right to, or interest in any assets of the Plan or the Company, upon cessation of Participation or otherwise.

I) Expenses

All expenses for the administration of the Plan shall be paid by the Company.

SECTION 12 CONFIDENTIALITY and PRIVACY

The Plan Administrator adopts the following procedures in compliance with the "HIPAA Privacy Rules" codified in 45 CFR Part 160, 164, Subparts A and E to the extent that these rules apply to Medical Benefits provided by the Plan.

(A) General Use and Disclosure of Private Health Information ("PHI")

The Employer shall use or disclose PHI only for the limited purposes of (1) providing treatment, processing Payment of claims or Health Care Operations pursuant to the HIPAA Privacy Rules, or (2) as allowed or mandated for group health plans under the HIPAA Privacy Rules.

(B) Employer Certification as to Privacy. The Employer has provided the Plan with certification that it agrees to limit the disclosure of PHI for the following limited purposes and procedures:

(1) disclosure of PHI as permitted by law or required by Plan documents;
(2) disclosure of PHI by Employer to its agents only where agent agrees to the same restrictions as applicable to the Employer regarding PHI;
(3) allow Participants access to their PHI pursuant to HIPAA Privacy Rules;
(4) agree not to use PHI for employment-related decisions affecting any Participant in the Plan;
(5) report to Plan Administrator any use or disclosure of PHI inconsistent with the purpose of the Plan;
(6) allow Participants to make additions or corrections to their PHI;
(7) provide accounting to Participants regarding disclosures of their PHI as required by the HIPAA Privacy Rules;
(8) allow access by the U.S. Department of Health and Human Services to documents relating to use and disclosure of PHI provided to the Employer under the Plan;

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(9) destroy or return all PHI provided to the Employer by the Plan when Employer has no further need of the PHI, or in the alternative when destruction or retention of the PHI is not feasible, limit any further use or disclosure of the PHI;

(10) ensure adequate separation between the Employer and the Plan by limiting staff members designated to perform Plan functions, including access and use of PHI, to the Claims Administrator and/or Committee members.

(C) Employer's HIPAA Notice of Privacy Practices for Personal Health Information

The Plan requires an Employer to provide a legal notice to all Participants in the Plan regarding the privacy practices for use and disclosure of a Participant's Protected Health Information obtained through the administration of the Plan. **YOUR PRIVACY NOTICE IS PRINTED AS EXHIBIT A**

SECTION 13 BENEFITS, TAXES, AND SERVICE OF PROCESS

(A) Undeliverable Benefits

When a Participant becomes eligible for a Benefit payment under the Plan and such payment is not delivered within two years of the date the payment was due because: (1) the address provided to the Company or Committee by the Participant is incorrect; or (2) the Participant fails to respond to notice sent to the last address on file with the Company or Committee; or (3) the Participant is incarcerated, then such Benefit shall be rescinded and the claim shall cease to be a liability of the Plan.

(B) No Guarantee of Tax Consequences

No representation, commitment or guarantee is made that any amounts paid under the Plan will be excludable from the recipient's gross income for any tax purpose, or that any other tax treatment will apply or be available to such person. Benefit payments under the Plan will be reduced by the amounts determined by the Committee to be payable for federal or state income, employment or other taxes.

(C) Service of Process

The designated agent for service of legal process and the address where a processor may serve legal process on the Plan is shown in the Schedule.

SECTION 14 ARBITRATION PROCEDURE

The following provisions are incorporated by reference into, and made part of, the Election And Arbitration Agreement, the same as if they were set forth at length in the Election And Arbitration Agreement itself:

1. Required Notice for All Claims**:** Participant and the Company (and the Employers) agree that a party asserting one or more claims or causes of action against the other party must make a written demand for arbitration on the other party within the applicable statute of limitations, and that failure to make such written demand for arbitration within the applicable statute of limitations bars the claims and causes of action. Written demand on the Company (or an Employer) or one or more of its officers,

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directors, shareholders, employees, agents, affiliates, residents or benefit plans shall be sent to **TAOS Staffing Corporation**, Attention: **Bob Greene, 2912 N. MacArthur Blvd , Irving TX 75062** (or such other person or address as the Company may specify). If the Company (or an Employer, officer, affiliate, resident, etc.) wishes to assert a claim, it will make written demand for arbitration on Participant at the last address recorded in Participant's personnel file. This demand for arbitration shall be sent to the other party (or parties) by certified or registered mail, return receipt requested. **Neither filing nor serving a lawsuit stops the applicable statute of limitations from continuing to run.**

2. Representation: Any party may be represented during pre-hearing procedures (as defined below), at the arbitration hearing and/or during the arbitration appeal (as defined below) by an attorney or other representative selected by the party.

3. Mediation**:** The Company (and the Employers) and Participant agree that any arbitration that has been timely and properly demanded under Paragraph 1 above shall be stayed and shall not proceed until the parties to the arbitration have mediated the dispute with a mediator either agreed upon by all parties or, if agreement by all parties cannot be reached, by an agreed mediator. This mediation requirement may be waived by written agreement signed by all parties or their counsel. The cost of any mediation shall be split evenly between the two sides to the dispute; however, the Participant's part of such mediation cost shall not exceed $50.00.

4. General Procedures**:**

a. The Company (and the Employers) and Participant agree that the arbitration hearing will be conducted before one arbitrator (hereinafter the "hearing arbitrator") from American Arbitration Association. The then-current rules of American Arbitration Association. governing employment disputes shall control and be applied by the hearing arbitrator and by the appellate arbitrators (as defined below). The Participant and Company shall be provided with a panel of at least three different arbitrators by the arbitration provider. The Participant and the Company shall have an equal number of strikes as to the presented panel. After all strikes are exhausted, the remaining arbitrator will hear the claim. Any arbitrator hearing the case must be neutral to all parties and any non-neutral arbitrator must recuse him or herself.

b. The hearing arbitrator shall apply the substantive law (and the laws of remedies, if applicable), in the state in which the claim arose, or federal law, or both, depending upon the claims asserted. The hearing arbitrator shall also strictly apply the Federal Rules of Evidence, except that deposition testimony of a witness may be used at the arbitration hearing without regard to whether the witness is unavailable. The hearing arbitrator shall provide brief findings of fact and conclusions of law. All arbitration decisions and awards rendered pursuant to the

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Election And Arbitration Agreement shall be kept strictly confidential and shall not, except for filings regarding their judicial enforcement, be disclosed to anyone not a witness, attorney, party representative, or party who actually attended the arbitration hearing.

c. **The hearing arbitrator shall have the authority to rule on his or her own jurisdiction, including any objections with respect to the existence, scope or validity of the agreement to arbitrate.** The hearing arbitrator shall have the authority to hear and rule on prehearing disputes and is authorized to hold prehearing conferences by telephone or in person as the arbitrator deems necessary. The hearing arbitrator will have the authority to hear a motion to dismiss and/or a motion for summary judgment by any party and in doing so shall apply the standards governing such motions under the Federal Rules of Civil Procedure. The hearing arbitrator shall stay any timely and properly demanded arbitration until the parties mediate the dispute, unless mediation has been waived by written agreement signed by all parties or their counsel.

5. Pre-Hearing Procedures: Each party will have the right to take the deposition of one individual and any expert witness designated by another party. Each party will have the right to subpoena witnesses in accordance with the Federal Arbitration Act, Title 9 of the United States Code. Additional discovery may be had only upon agreement or where the hearing arbitrator so orders, upon a showing of substantial need. At least 30 days before the arbitration, the parties must exchange lists of witnesses, including any experts, and copies of all exhibits intended to be used at the arbitration hearing.

6. Arbitration Fees and Costs**:** There will be both administrative fees and arbitrator compensation incurred for any arbitration hearing. When Participant files and serves a demand, the filing fee, included in the administrative fees, for the arbitration hearing will be paid $350.00 by the Participant and the remainder by the Company. Unless Participant chooses to pay all or a part of them, all other administrative fees and all of the hearing arbitrator's compensation will be paid by the Company. Arbitrator compensation and administrative fees are not subject to re-allocation in the award, but any fees for postponements will be paid by the party causing the postponement. Either side may arrange for and pay the cost of a court reporter to provide a stenographic record of the proceedings at the hearing.

7. Attorneys' Fees**:** The Company (and the Employers) and Participant further agree as follows:

a. Each party shall be responsible for their own attorney's fees, if any; however, if any party prevails on a statutory claim which allows the winning party to be awarded attorney's fees, or if there is a written agreement providing for fees, the hearing arbitrator shall award

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reasonable fees to the prevailing party. The hearing arbitrator shall determine the prevailing party in accordance with the meaning of "prevailing party" under the Civil Rights Attorney's Fees Awards Act of 1976.

b. The hearing arbitrator shall assess attorney's fees against a party upon a showing that such party's claim, defense or position is frivolous, or unreasonable, or factually groundless.

c. If either party pursues a claim covered by this Agreement by any means other than those set forth in this Agreement, the responding party shall be entitled to dismissal of such action, and the recovery of all costs and attorney's fees and losses related to such action.

8. Appeal Procedures**:** The Company (and the Employers) and Participant further agree as follows:

a. Any party **<u>may</u>** appeal any arbitration award that has been rendered and become final under the rules governing the arbitration. The written appeal must be served in writing on the other party or parties to the arbitration and on American Arbitration Association by certified mail within thirty (30) days after the hearing arbitrator caused the arbitration award to be mailed to the parties or to their representatives. The writing evidencing the appeal must specify those elements of the arbitration award that are being appealed and must contain a short statement of the appeal's basis. Once an appeal is timely served, the arbitration award by the hearing arbitrator shall no longer be considered final for purposes of seeking judicial enforcement, modification or vacation under the Federal Arbitration Act.

b. Within fifteen (15) days after receipt of the appeal, the other party or parties may serve a written cross-appeal by serving it by certified mail on the other party or parties to the arbitration and on American Arbitration Association. The writing evidencing the cross-appeal must specify those elements of the arbitration award that are being appealed and must contain a short statement of the cross-appeal's basis. Once a cross-appeal is timely served, the arbitration award by the hearing arbitrator shall no longer be considered final for purposes of seeking judicial enforcement, modification or vacation under the Federal Arbitration Act, even if the appeal is subsequently withdrawn.

c. Within forty-five (45) days after receipt of the appeal, the parties to the appeal shall select a panel of three arbitrators (hereinafter the "appellate arbitrators") utilizing the procedures to select arbitrators set forth in the then-current rules of American Arbitration Association. The hearing arbitrator shall not be eligible to serve as an appellate arbitrator.

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d. The fees and expenses of the appellate arbitrators shall be shared equally if both an appeal and a cross-appeal are served. If only an appeal is served, the fees and expenses of the appellate arbitrators shall be paid by the appellant party (or parties). Each party serving an appeal or cross-appeal shall deposit funds or post other appropriate security for the appellate arbitrators' fees, in an amount and manner determined by American Arbitration Association within thirty (30) days after that party's service of an appeal or cross-appeal.

e. The record on appeal to the appellate arbitrators shall consist of any stenographic record or other record of the hearing before the hearing arbitrator and shall include all exhibits and deposition transcripts admitted into the record by the hearing arbitrator. The parties to an appeal shall assist and cooperate with American Arbitration Association in providing the record, exhibits and deposition transcripts to the appellate arbitrators.

f. The appellate arbitrators shall establish a briefing schedule, page limitations for briefs and a date and duration for oral argument; provided, however, that prior to the appellate arbitrators' rulings on these subjects, the parties to the appeal may agree to waive briefing and/or oral argument and may agree to their own page limitations for briefs.

g. The appellate arbitrators shall apply the same standard of review as the first-level appellate court would apply to the cause of action or defense on appeal in similar circumstances. If both federal and state-law causes of action (and/or defenses) are before the appellate arbitrators (either in a single appeal or as the result of a cross-appeal), the appellate arbitrators shall apply only the standards of review utilized by the United States Court of Appeals for the Fifth Circuit in similar circumstances.

h. By majority vote, the appellate arbitrators may affirm, reverse, render or modify an arbitration award. The appellate arbitrators may remand, but they may not remand to the original hearing arbitrator. In the event of a remand, the parties shall select a new hearing arbitrator under the procedures set forth in the rules governing the arbitration, and the fees and expenses of the new hearing arbitrator shall be shared equally by the parties to the re-hearing, unless otherwise agreed or ordered. The appellate arbitrators' decision shall include a brief, written opinion addressing the issues before them, and such opinion shall be delivered to the parties and to American Arbitration Association within thirty (30) days after the conclusion of any briefing schedule or any oral argument or as the parties may agree. Fifteen (15) days after receipt of the appellate arbitrators' opinion setting forth their decision, any award by them shall be considered final for purposes of judicial enforcement, modification or vacation under the Federal Arbitration Act.

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9. Interstate Commerce and the Federal Arbitration Act**:** The Company and the Employers are involved in transactions involving interstate commerce (*e.g.*, purchasing goods and services from outside Texas which are shipped to Texas; utilizing the interstate mail, telephone and highway systems; and recruiting and advertising outside Texas) and that Participant's employment and participation in the Plan involve such commerce. The Federal Arbitration Act, Title 9 of the United States Code, will govern the interpretation, enforcement, and all judicial proceedings under and/or with respect to the Election And Arbitration Agreement and this Section 14. However, if the Federal Arbitration Act should be held to be inapplicable to the Election And Arbitration Agreement and this Section 14, or if the Election And Arbitration Agreement and this Section 14 should be held to be unenforceable, for any reason, under the Federal Arbitration Act, then the Texas common law shall govern the Election And Arbitration Agreement, this Section 14, and all judicial proceedings under and/or with respect to them to the extent necessary to make them enforceable to the maximum extent possible.

10. Amendment of Arbitration Agreement: This arbitration provision shall be subject only to the following terms regarding termination and amendment. This Arbitration Agreement can be amended or terminated by the Company on a prospective basis only so that disputes that have arisen prior to the amendment or termination shall not be affected by the amendment or termination. Any amendment or termination shall be in writing and communicated to Participants in a manner reasonably calculated to be received by the employee.

SECTION 15 YOUR RIGHTS UNDER THE LAW

The Company maintains the Plan even though it is not required to do so by law. Participants and Death Beneficiaries of the Plan are entitled to certain rights and protections under the law.

The following Plan is governed by ERISA, as amended:

Employee Injury Official Plan

This booklet is:

The Summary Plan Description for the Plan listed above. The Plan is the legal Plan document and has the final word regarding the rights and obligations of Participants and their Death Beneficiaries.

This booklet is designed to explain, in simple language, important features of the Plan. Every effort has been made to provide clear, complete, and understandable information. However, the legal Plan document and insurance contracts, where applicable, have the final word about the rights of a Participant and his/her Authorized Representative, Death Beneficiary or estate.

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As a Participant in the Plan detailed in this booklet, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

(A) Receive Information about Your Plan and Benefits

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

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

You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

(B) Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Death Beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

(C) Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. If the Arbitration Procedure (Section 14) is not applicable (see the Schedule to determine applicability), the Participant has the right to bring a civil action against the Plan under Section 502 (a) of ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may have the right to initiate a claim under the Election and Arbitration Agreement (if applicable) or file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may have the right to initiate a claim under the Arbitration Agreement (if applicable) or file suit in a

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state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are unsuccessful regarding your claim the court may order you to pay these costs and fees, for example, if it finds your claim to be frivolous or filed in bad faith.

(D) Time Limit for Legal Action

Every right of action by any Participant, former Participant, a Participant's Authorized Representative, Death Beneficiary, or the Participant's estate against the Plan, or Plan fiduciary, must be brought no later than three (3) years from the date your employment ended, or from receipt of notice of denial of benefits, if earlier, except as otherwise required by ERISA. **If ERISA's limitations on actions do not apply, the laws of the State of Texas do apply. Any claims subject to the Election and Arbitration Agreement are required to be submitted to binding arbitration within the applicable statute of limitations.**

(E) Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor at 525 S. Griffin, Dallas, Texas 75202, 214-767-6831 or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

(F) How to Contact the Plan Committee

Refer to the information contained in the "**Schedule of Benefits and Summary Plan Description Highlights"** found in the back of this booklet.

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SCHEDULE

of BENEFITS and SUMMARY PLAN DESCRIPTION HIGHLIGHTS

The following is a brief summary of terms and provisions unique to this **SUMMARY PLAN DESCRIPTION ("SPD")** booklet, which describes the **OCCUPATIONAL INJURY BENEFIT PLAN** (the "**PLAN**") **for TAOS Staffing Corporation**

A. YOUR PLAN INFORMATION

1) Plan Name: **TAOS Staffing Corporation Employee Injury Benefit Plan**

2) Effective Date: **May 1, 2019**

3) Employer, Name and Address: **TAOS Staffing Corporation**
2912 N. MacArthur Blvd, Suite 109
Irving, TX 75062

4) Plan Sponsor, Name and Address: **TAOS Staffing Corporation**
2912 N. MacArthur Blvd, Suite 109
Irving, TX 75062

5) Employer ID # **65-0848339** **Plan # 501**

6) Plan Administrator, Name and Address: **Bob Greene**
TAOS Staffing Corporation
2912 N. MacArthur Blvd, Suite 109
Irving, TX 75062

Note: The Administration Committee may be contacted through the Plan Administrator.

7) Claims Administrator, Name and Address: Aspen American Insurance Company
c/o AccuRisk Solutions LLC
P.O. Box 638
Marshfield, MA 02050
800-786-0500 ext. 455

8) Company Representative, Name and Address: **Bob Greene**
TAOS Staffing Corporation
2912 N. MacArthur Blvd, Suite 109
Irving, TX 75062

9) Agent for Service of Legal Process, Name and Address: **Bob Greene**
TAOS Staffing Corporation
2912 N. MacArthur Blvd, Suite 109
Irving, TX 75062

10) Section 14. “Arbitration Procedure” is: **APPLICABLE**

B. BRIEF SUMMARY and SCHEDULE of YOUR BENEFITS

Benefit Limits: See Section 6 of SPD booklet for scope and limits of PLAN benefits

Medical Benefits: PLAN pays for care from approved doctors and hospitals if **you are injured at work up to a maximum of $250,000.00.**

Disability Income Benefits: PLAN pays scheduled income benefit if you are disabled and need time to recover from your occupational injuries.

Disability Income Percent (%): 75%

Elimination Period in Days: 7

Disability Maximum Benefit per Week: $600.00

Disability Income Maximum Number of Weeks: 110

Death and Dismemberment Benefit: PLAN pays a scheduled amount in event of your death or dismemberment. The benefit is the lesser of:

(1) Death Benefit Amount: $100,000.00 or
(2) Salary Multiple Maximum Amount: 10 X Annualized Pre-Disability Pay

This benefit is also subject to other reductions according to the PLAN provisions.

Maximum Benefits:

Participant Maximum Benefit : $1,000,000.00
Aggregate Maximum Benefit : $10,000,000.00

Injury Reporting Period: Immediately but no later than end of work shift on day of injury.

IMPORTANT NOTICE: All injuries must be reported within this period in order to be considered for coverage under the PLAN.

REMINDER

You should refer to a copy of the actual PLAN document for details, definitions and exclusions under the PLAN. The PLAN document is available from your employer. The above information is merely a brief summary of benefits available and schedule of limits for those benefits described in the attached SPD. These matters are explained in greater detail in the actual PLAN document. In the event there is any misunderstanding or inconsistency between this SPD and PLAN document, the PLAN document controls in all cases of occupational injury.

SUMMARY OF IMPORTANT TIME LIMITS

The following tables are a summary of time limits that the Plan Administrator or Committee has to respond to your initial claim (depending on the type of claim involved) and appeal; and the time limit for you to respond to requests for additional information and appeal an adverse decision :

Time Limits for Responding to a Claim*

	Emergency Medical Claim	Pre-Service Care (non-urgent) Claim	Post-service Care Claim	Disability Claim	Death and Dismemberment Claim
For the Claims Administrator to make an initial determination	72 hours (depending on medical circumstances)	15 days (depending on medical circumstances)	30 days	45 days	90 days
Extension for the Claims Administrator to make a determination (if proper notice and delay is beyond Plan control)	None	15 days	15 days	30 days	90 days
For the Claims Administrator to request	24 hours	15 days	30 days	30 days	90 days

missing information from you					
For you to provide missing information	48 hours	45 days	45 days	45 days	90 days

* A concurrent care claim is subject to either the Urgent Care or Pre-Service Care claim time frames, as applicable.

You must submit your written appeal within 180 days after you receive notice of your denied claim for benefits. The Claims Administrator must notify you of the Plan's final decision in writing within the time limits shown in the following table.

Time Limits for Responding to an Appeal*

	Emergency Medical Claim	Pre-Service Care (non-urgent) Claim	Post-service Care Claim	Disability Claim	Death and Dismemberment Claim
To make a determination on appeal	72 hours (depending on medical circumstances)	30 days	60 days	45 days	90 days
Extension (if proper notice and delay is beyond Plan control)	No provision (unless you consent in writing)	No provision	No provision	45 days	90 days

* A concurrent care claim is subject to either the Emergency Medical Claim or Pre-Service Care claim time frames, as applicable.

Exhibit A

HIPAA Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS DOCUMENT CAREFULLY.

Dear Employee:

This is your official notice of the privacy policy, procedures and practices followed by TAOS Staffing Corporation, hereafter referred to as the "Company". Please read it carefully. You have received this notice because you are a Participant in our TAOS Staffing Corporation Employee Injury Benefit Plan, hereafter referred to as the "Plan". References such as "us", "our" and "we" found in this notice refer to the Company.

This notice describes how the privacy and confidentiality is maintained regarding the Protected Health Information (hereafter referred to as "PHI") we have obtained about you and which relates to your participation in the Plan or otherwise obtained by us in the due course of administering Company policies, procedures and benefits. The notice describes the uses we may make of this information and how we may disclose this information to others within or outside the Company. Under federal regulations, PHI generally refers to and includes individually identifiable information which relates to your past, present or future health condition, medical treatments or payment for health care services, such as those provided under the Plan. This notice also describes your rights regarding your PHI and information on exercising those rights.

The information in this notice is provided to you under the requirements of a federal law, namely the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For additional information regarding our HIPAA PHI privacy policy, please contact ("Company Representative").

HIPAA regulations require us to:

- Adopt policies and procedures to maintain the confidentiality and privacy of your PHI,
- Provide this notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the policies and procedures contained in this notice.

We take very serious our obligation to protect the PHI of our employees from improper disclosure or use. Company employees having the responsibility to administer our benefits, including those provided under the Plan, as well as the outside vendors, business associates, third-party administrators or other companies that assist us in administration of these benefits are required under the federal regulations to comply with procedures that protect the privacy and confidentiality of your PHI. They may look at your PHI only when there is a clear business justification and "need to know", such as in the administration of claims made under the Plan.

Our policy prohibits the disclosure of your PHI to any vendor, business associate, third party administrator or other company for their use in marketing products or service to you.

I. Use and Disclosure of PHI

The Company will disclose and use PHI for business purposes relating to your employee benefits (including the Plan). We may use or disclose your PHI for the following reasons: 1) provide assistance in determining your benefits eligibility status (including eligibility as a Participant in the Plan); 2) provide assistance with filing claims or resolving issues relating to claims under our benefits program; 3) for Plan enrollment purposes; and/or 4) for Plan administration. The following is a nonexclusive list describing these and other possible uses and/or disclosures, together with some examples.

- **Payment of Claims**: We may use and disclose PHI to assist you in researching a claim dispute. For example, we may review PHI, at your request, which is contained on claim forms submitted by medical providers in an effort to verify that the claim was paid correctly.

- **Health Care Operations**: We may use and disclose PHI for benefit operations, including those related to the Plan. These purposes include, for example, evaluating an employee's eligibility for participation and the administration of the Plan. We may also disclose PHI to a business associate or third part administrator for Plan enrollment and eligibility purposes. PHI may also be disclosed as part of the Plan renewal process so that we can make an informed decision regarding possible changes to our benefit program.

- **Public Health Activities or as Otherwise Legally Required**: The Company will disclose PHI when required by federal, state or local law. Mandatory disclosure of PHI pursuant to law includes, for example, notifying state or local health authorities regarding particular communicable diseases, or providing PHI to a governmental agency or regulator with health care oversight responsibilities. We may also release PHI to a coroner or medical examiner to assist in identification of a deceased individual or determination of the cause of death.

- **Serious Threat to Health or Safety**: PHI may be disclosed to avert a serious threat to an individual's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies in order to allow such entities to carry out their responsibilities in specific disaster situations.

- **Health-Related Benefits or Services**: We may use PHI to provide you with information about benefits available to you under a current benefits plan.

- **Law Enforcement or Specific Government Functions**: PHI may be disclosed in response to requests by law enforcement officials made pursuant to court order, subpoena, warrant, summons or similar legal process. Pursuant to national security and related legal requirements PHI may be disclosed to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Regulatory or Legal Proceeding**: If you, your beneficiary or estate are involved in a lawsuit, dispute, or other proceeding (including arbitration under the Plan), we may disclose PHI about you in response to a legal, court or administrative order. Your PHI may also be disclosed by the Company in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **Other Uses of PHI Require Your Written Authorization**: Other uses and disclosures of PHI not covered by this notice and/or permitted by HIPAA regulations will be made by the Company only with your written authorization or that of your legal representative. Once we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that the Company has taken action and already disclosed PHI in reliance upon the authorization.

II. Your Rights Regarding Personal Health Information

The following describes your rights as a consumer under HIPAA concerning your PHI.

- **Right to Inspect and Copy Your Personal Health Information**: In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. To inspect and copy PHI, you must submit your request in writing to

("Company Representative"). To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. Certain types of PHI will not be made available for inspection or copying. This includes PHI collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your PHI. If we do, you may appeal and request that the denial be reviewed. An individual chosen by the Company who was not involved in the original decision to deny your request will conduct the review. We will comply with the outcome of that review.

I understand that Aspen American Insurance Company performing functions on behalf of the TAOS Staffing Corporation Employee Injury Benefit Plan, is using and disclosing my personal health information. I authorize the TAOS Staffing Corporation and Aspen American Insurance Company to use and disclose my personal health information electronically for the administration of company policies, procedures and benefits.

- **Right to Amend Your Personal Health Information**: If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to ("Company Representative"). We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that:
  - Is accurate and complete;
  - Was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
  - Is not part of the PHI kept by us or for us; or
  - Is not part of the PHI that you would be permitted to inspect and copy.

- **Right to a List of Disclosures**: You have the right to request a list of the disclosures the Company has made of PHI about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to ("Company Representative"). Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. The Company may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**: You have the right to request a restriction or limitation of PHI we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. To request a restriction, you must make your request in writing to ("Company Representative"). In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both and to whom you want the limits to apply. We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our benefit program, including the Plan.

- **Right to Request Confidential Communications**: You have the right to request that we communicate with you

about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to ("Company Representative") and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to File a Complaint**: If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. If you have questions about how to file a complaint or wish to file a complaint, please forward all inquiries and/or correspondence to ("Company Representative"). All complaints must be submitted in writing. You will not be penalized for filing a complaint.

III. <u>Changes to this Notice</u>:

We reserve the right to change the policy, procedures and practices of this privacy notice at any time. We reserve the right to make the revised or changed notice effective on a retroactive basis for PHI we already have about you as well as prospectively for any PHI we receive in the future. You will receive a copy of any revised privacy notice by mail, E-mail, hand delivery or other appropriate means.

(End of HIPAA Notice)

Exhibit B

ELECTION AND ARBITRATION AGREEMENT

By signing this Election and Arbitration Agreement (hereinafter "Agreement"), I, the undersigned employee, voluntarily elect to participate in the **TAOS Staffing Corporation Employee Injury Benefit Plan** (hereinafter the "Plan") and agree with my Employer (hereinafter "the Company") to the following:

ENROLLMENT IN THE PLAN: I understand that the Company, as expressly permitted by Texas law, does not carry workers' compensation insurance for its Texas employees, that it is a "nonsubscriber" under the Texas Workers' Compensation Act (hereinafter the "Act"), that it is not required as a nonsubscriber to provide any benefits whatsoever for on-the-job injuries, that it has instead voluntarily established the Plan under federal law to provide certain benefits for on-the-job injuries, and that the Plan is not workers' compensation insurance.

I understand that if I am injured on the job, I am, by signing and agreeing to this Agreement, eligible under the Plan's terms for the medical, disability, death, burial and dismemberment benefits described in the Plan and summarized in the Summary Plan Description. I understand that if I reject this Agreement, I will not be eligible for Plan Benefits.

I understand and agree that the Plan's benefits are not workers' compensation benefits, but are provided without regard to my own fault or negligence, without the necessity of me initiating a lawsuit or arbitration, and without me proving that the Company (or one of its employees) was negligent in causing my injury (or death).

I have received a copy of the Summary Plan Description of the Plan. I understand and agree that, if I am injured on the job, I will follow the rules and procedures described in the Summary Plan Description.

MUTUAL PROMISES TO RESOLVE CLAIMS BY BINDING ARBITRATION: I recognize that disputes may arise between the Company and me during or after my employment. I agree with the Company to submit any and all such disputes to binding arbitration.

I acknowledge and understand that by signing this Agreement I am giving up the right to a jury trial on all of the claims covered by this Agreement in exchange for eligibility for the Plan's medical, disability, dismemberment, death and burial benefits and in anticipation of gaining the benefits of a speedy, impartial, mutually-binding procedure for resolving disputes.

This agreement to resolve claims by arbitration mutually binds and benefits both me (and my spouse, minor children, heirs, parents and legal representatives) and the Company (and its successors, subsidiaries, affiliates, and all of their officers,

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directors, shareholders, members, partners, owners, employees and agents and the Plan and its administrators and fiduciaries).

EXAMPLES OF CLAIMS SUBJECT TO ARBITRATION: Examples of claims and disputes covered by this Agreement include, but are not limited to:

(a) all claims and disputes that I (and my spouse, minor children, heirs, parents and legal representatives, if any) may now have or may in the future have against the Company or against its successors, subsidiaries, affiliates or residents or any of their officers, directors, shareholders, members, partners, owners, employees and agents, or against the Plan or its administrators and fiduciaries, and
(b) all claims and disputes that the Company or its successors, subsidiaries and affiliates or any of their officers, directors, shareholders, members, partners, owners or the Plan may now have or may in the future have against me (and my spouse, minor children, heirs, parents and legal representatives, if any).

Examples of the types of claims covered by this Agreement include, but are not limited to, any and all:

- claims for wages or other compensation;
- claims for breach of any contract, covenant or warranty (express or implied);
- tort claims, including negligence, negligence per se and gross negligence claims (including claims for personal or bodily injury or physical, mental or psychological injury, without regard to whether or not such injury was sustained on the job);
- claims for wrongful termination (including retaliatory discharge claims);
- claims of harassment or discrimination (including claims based on race, sex, religion, national origin, age, medical condition or disability);
- claims for benefits under the Plan (after exhausting administrative remedies under the terms of the Plan);
- claims for a violation of any other federal, state or other governmental law, statute, regulation or ordinance; and
- **claims challenging the existence, validity or enforceability of this Agreement (in whole or in part) or challenging the applicability of this Agreement to a particular dispute or claim.**

CLAIMS NOT SUBJECT TO ARBITRATION: The following matters only are not covered by this Agreement: (a) any criminal complaint or proceedings, and (b) claims before administrative agencies for unemployment benefits.

COMPLETE AGREEMENT: The Arbitration Procedures in Section 14 of the Summary Plan Description are incorporated by reference into, and made part of, this Agreement the same as if they were all written here. This Agreement, together with the incorporated Arbitration Procedures in Section 14 of the Summary Plan Description, is the complete agreement between the Company and me. It takes the place of any other oral understanding about arbitration, but other written agreements, policies or procedures may also require me to arbitrate any disputes that I may have with the Company.

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I am not relying on any statements, oral or written, on the subject, effect, enforceability or meaning of this Agreement, except as specifically stated in this Agreement. If any provision of this Agreement is determined to be void or otherwise unenforceable, in whole or in part, such determination shall not affect the validity of the remainder of this Agreement.

NOT AN EMPLOYMENT AGREEMENT: Neither this Agreement, the Plan nor the Summary Plan Description shall ever be construed to create any contract of employment, express or implied. Nor does this Agreement, the Plan or the Summary Plan Description in any way alter the at-will status of my employment.

RATIFICATION BY RECEIPT OF PLAN BENEFITS: I agree that each and every time that I receive Plan benefits, or have Plan benefits paid to a medical provider on my behalf, I ratify and reaffirm this Agreement the same as if I had signed this Agreement again on the date the benefits were paid.

REQUIREMENTS FOR MODIFICATION OR REVOCATION: This Agreement will survive the termination of my employment. This Agreement can only be revoked (except as provided in the paragraph below) or modified by a writing signed by both me and the Company's authorized representative that specifically states an intent to revoke or modify this Agreement, and this requirement of a signed writing cannot itself be waived except by such a signed writing.

REVOCATION OF ACCEPTANCE: If, after accepting this Agreement by signing below, I decide to revoke my acceptance of this Agreement, I may do so only by notifying the Company in writing by certified mail, return receipt requested, of my revocation. I understand and agree that I may not revoke my acceptance of this Agreement if the Plan has paid (or become obligated to pay) benefits to or for me. I understand and agree that I may only revoke my acceptance of this Agreement: (a) within five (5) calendar days after the date of my signature below, or (b) within five (5) calendar days after receiving written notice of a material reduction in benefits provided by the Plan.

VOLUNTARY AGREEMENT: I acknowledge and agree that I have carefully read this Agreement, that I understand its terms, and that I have entered into this Agreement voluntarily and without duress, pressure or coercion from any person and without relying on any promises or representations by the Company other than those contained in this Agreement itself. I am not under the influence of alcohol or any other impairing substance, nor am I under any mental incapacity that would affect me at the time of signing this Agreement. I am aware of the consequences of signing this Agreement and, to the extent that I deem necessary, I have consulted or will consult with an attorney. Finally, I agree and acknowledge that signing this Agreement is **not** a condition of my employment.

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TAOS Staffing Corporation
Employee Injury Benefit Plan

Election and Arbitration Agreement

CHECK ONLY ONE OF THE FOLLOWING BOXES:

☐ I agree to the terms of this Agreement. **OR** ☐ I reject the terms of this Agreement.

_____ _____

Signature Of Employee **Date**

_____

Name Of Employee Printed

_____ _____

Witness Signature **Witness Signature**

_____ _____

Printed Name of Witness **Printed Name of Witness**

Accepted and Agreed: **TAOS Staffing Corporation**

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