VISION EMPLOYMENT GROUP

OCCUPATIONAL INJURY EMPLOYEE BENEFIT PLAN

EFFECTIVE DATE: SEPTEMBER 8, 2018

PARA LOS EMPLEADOS QUE HABLAN ESPAÑOL

ESTE RESUMEN DESCRIPTIVO DEL PLAN DE BENEFICIOS SOBRE LESION PARA EL TRABAJADOR CONTIENE UN RESUMEN EN INGLES DE LOS DERECHOS Y BENIFICIOS DEL PLAN DE Vision Employment Group SI TIENE DIFICULTAD ENTENDIENDO ALGUNA PARTE DE ESTE RESUMEN, LE PUEDE ASSISTIR SU SUPERVISOR DURANTE LAS HORAS DE TRABAJO. TAMBIEN PUEDE CONTACTAR AL ADMINISTRADOR DEL PLAN Lisa Stiles or Kari Foster TELEPHONO: (806) 445-0426 O LLAMANDO AL NUMERO DE TELEFONO QUE SE ENCUENTRA EN LA PAGINA DE CONTENIDO DE EL PRESENTE RESUMEN. PUEDE SER ATENDIDO DURANTE LA SEMANA DESDE LAS 8:30AM HASTA LAS 5:00PM.

SUMMARY PLAN DESCRIPTION

VISION EMPLOYMENT GROUP

OCCUPATIONAL INJURY EMPLOYEE BENEFIT PLAN
Benefits Schedule

Company Information

1. Company Name, address and telephone number: Vision Employment Group
2026 82nd St., #101
Lubbock, Texas 79423
(806) 445-0426

2. Federal Tax Identification Number: 27-3107455

3. Name and telephone number of contact person for Participant questions: Lisa Stiles/Kari Foster
2026 82nd St., #101
Lubbock, Texas 79423
(806) 445-0426

4. Name and address of agent for service of legal process: Charles Amato
2026 82nd St., #101
Lubbock, Texas 79423

5 Plan Number: 501-P

Benefit Limits

6. Commencement Date of Plan: September 8, 2018

7. Benefit Period: 104 weeks from date of Covered Occurrence

8. Covered Classes: All of the following classes of employees of the Company who are in Company's Active Service:
Class 1: All active employees, including owners.

9. Weekly Disability Benefits:
(a) Benefit Waiting Period: 7 days
(b) Percentage of Average Weekly Earnings: 75% up to $600.00
(c) Benefit Period: 104 weeks
(d) Time Period for Initial Loss: 30 days from the date of a Covered Occurrence

10. Maximum Accidental Medical Expense Benefits: $250,000.00
Time Period for Initial Loss: 30 days from date of a Covered Occurrence

11. Accidental Death, Dismemberment and Paralysis Benefit: $200,000.00 or 10 times annual base salary (exclusive of bonuses, overtime, and commission), whichever is less.
Time period for Loss: 365 days from the date of a Covered Occurrence

12. Combined Limit for All Benefits:
(a) Combined Single Limit Per Participant: $250,000.00
(b) Combined Single Limit Per Occurrence: $750,000.00
(c) Annual Aggregate: $2,000,000.00

IMPORTANT NOTICE: All benefits are subject to the terms and conditions of the Official Plan Document. Please see the Official Plan Document for other benefit limitations and exclusions.

Signature and Date

The Company hereby adopts this Plan by the signature of its authorized Representative.

______________________________ ____________________
Signature and Title Date

SUMMARY PLAN DESCRIPTION OF THE OCCUPATIONAL INJURY EMPLOYEE BENEFIT PLAN

The Company, identified in item No. 1 of the benefits schedule (and any Participating Employers identified in the benefits schedule) is pleased to announce the adoption of the Occupational Injury Employee Benefit Plan ("Plan") for the exclusive benefit of Employees of the Company whose principal place of employment is in the State of Texas. This Plan provides medical care for accidental, work related on-the-job injuries and salary continuance benefits for periods of disability resulting from accidental, work related on-the-job injuries. 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.

The Company has rejected coverage for its Texas Employees under the Texas Workers' Compensation Act and hereby adopts this Plan as of the Effective Date, to provide the benefits as set forth herein for Occurrences taking place on or after the effective date stated in item No. 6 of the benefits schedule. The agent of the Plan for service of legal process is identified in item No. 4 of the benefits schedule. Legal process may also be served on a plan trustee or the plan administrator.

The Company shall serve as the Plan Administrator for all purposes under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. A Plan Administrator may be appointed by the Board of Directors of the Company to carry out the day-to-day responsibility for administration of the Plan.

The following Summary Plan Description is intended to generally explain and give an overview of the various benefits offered by the Plan and the terms and conditions under which benefits will be payable. A more detailed description of benefits, exclusions, and requirements is contained in the Occupational Injury Employee Benefit Plan. If there is a discrepancy between the Plan and the Summary, the Plan controls.

1. CONTACT INFORMATION

The Company's name, address, telephone number, and Employer Identification Number are stated in items Nos. 1 and 2 of the benefits schedule.

The contact person for any questions you may have about this Plan or its benefits is listed in item No. 3 of the benefits schedule.

The Plan Number assigned to the Plan is stated in item No. 5 of the benefits schedule.

The agent for service of legal process is stated in item No. 4 of the benefits schedule.

2. GENERAL INFORMATION

This Plan shall apply to Occurrences to Participants sustained in the furtherance of the business of the Company by a Participant. This Plan specifies the only benefits for which a Participant is eligible in the event of such Occurrence. The Plan document shall govern in all cases as to eligibility and benefits, including limitations and exclusions. Provision of benefits to a Participant pursuant to this Plan shall not constitute an admission of liability on the part of the Company for the Occurrence. If there is a discrepancy between the Plan and the Summary, the Plan controls.

3. WHAT THE PLAN COVERS

Plan benefits shall consist of the provision of Accidental Medical Benefits for eligible medical treatment rendered by a Provider, Weekly Disability Benefits for periods of disability resulting from accidental work related on-the-job injuries, and applicable Death and Accidental Death, Dismemberment and Paralysis Benefits.

The combined aggregate of all possible benefits under this Plan (including, but not limited to, Accidental Medical Expense Benefits, Weekly Disability Benefits, Accidental Death, Dismemberment and Paralysis Benefits) payable to a Participant or on his behalf shall not exceed the amount stated in item No. 12(a) of the benefits schedule. The combined aggregate of all possible benefits under this Plan (including, but not limited to, Accidental Medical Expense Benefits, Weekly Disability Benefits, Accidental Death, Dismemberment and Paralysis Benefits) payable because of an Occurrence, regardless of the number of Participants, shall not exceed the amount stated in item No. 12(b) of the benefits schedule. The combined aggregate of all possible benefits under this Plan (including, but not limited to, Accidental Medical Expense Benefits, Weekly Disability Benefits, Accidental Death Dismemberment and Paralysis Benefits) payable regardless of the number of Occurrences or the number of Participants shall not exceed the Annual Aggregate amount stated in item No. 12(c) of the benefits schedule.

All benefits must be for Occurrences after the Commencement Date as stated in item No. 6 of the benefits schedule. The maximum duration of any benefit for any occurrence is stated in item No. 7 of the benefits schedule.

4. YOUR RESPONSIBILITIES

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

Each Participant has the obligation to observe all safety rules and follow safe working practices at all times and to use appropriate safety equipment as provided. The Participant must report to his immediate Supervisor any faulty equipment, hazardous conditions, damaged property, blocked passageways or exits, or any other conditions that may be a safety hazard to Participants, customers, and others. Failure to observe all safety rules may subject a Participant to disciplinary action, and the

Participant's entitlement to continuing benefits under this Plan may be forfeited, suspended, or discontinued.

5. HEALTH CARE PROVIDERS

The Company may designate one or more medical providers to administer medical treatment to Participants (hereinafter referred to as "Provider" or "Providers"), and the Company may change Providers at any time. At a Participant's request, any health care provider that has not been designated as a Provider may be approved by the Company, the Plan Administrator, or by a Third Party Administrator who is retained by the Company to administer claims arising under this Plan ("Third Party Administrator") prior to the time a Participant incurs an expense that is payable or reimbursable under the Plan. A Provider may provide treatment to a Participant only when the Participant submits to the Provider at the time of treatment the physician's authorization and report form provided by and available from the Plan Administrator. Notwithstanding the foregoing, a medical provider that has not been designated as a Provider may be utilized to provide emergency medical treatment if an injury occurs when the Participant is not at his regular place of employment or if an emergency vehicle takes the injured Participant to a health care provider that has not been designated as a Provider. Any continued medical treatment after emergency medical treatment, however, shall be administered by a designated Provider. Except as provided above, benefits shall not be paid under this Plan for treatment received from a health care provider that has not been designated as a Provider in accordance with this Plan.

6. EXCLUSIONS

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

1. Suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury, or any Injury that is intentionally caused or aggravated by a Participant;
2. The Participant's participation in: a) a riot or act of civil disturbance; b) an assault or a felony, except an assault committed in the defense of the Company's business or property; c) war or act of war, whether declared or undeclared; or d) service in the military of any country or any civilian non-combatant unit serving with such forces or any Loss or Damage directly or indirectly occasioned by confiscation, nationalization, requisition, or destruction of, or damage to property by or under the order of any government of public or local authority;
3. Terrorism, meaning an act, or acts of any person or group of persons committed for political, religious, ideological or similar purposes with the intention to influence any government or put the public, or any section of the public, in fear. Terrorism can include, but is not limited to, the actual use of force or violence or the threat of such use. Perpetrators of terrorism can be acting alone, or on behalf of, or in connection with, any organization or government.
4. Use of: a) nuclear weapons of mass destruction, meaning use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level

of radioactivity capable of causing incapacitating disablement or death to people or animals; b) use of chemical weapons of mass destruction meaning the emission,
discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound that, when suitably distributed, is capable of causing incapacitating disablement or death to people or animals; and c) use of biological weapons of mass destruction meaning the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism or biological produced toxin including genetically modified organisms and chemically synthesized toxins that are capable of causing incapacitating disablement or death to people or animals.

5. Liability assumed by the Company under any contract or agreement, including representations, warranties, or indemnities of any kind, except this Plan;
6. Travel to or from work, except when a) the transportation is furnished as a part of the contract of employment, or is paid for by the Company, or the means of transportation are under the Company's control; or b) the Participant is directed in his or her Scope of Employment to proceed from one place to another place;
7. An act of a third person intended to injure the Participant because of personal reasons and not directed at the Participant as an Employee or because of his or her employment with the Company;
8. Voluntary participation in an off-duty recreational, social, or athletic activity not constituting part of the Participant's Scope of Employment;
9. Participation in any activity or hazard not specifically within the Participant's Scope of Employment;
10. An act of God, unless employment with the Company exposed the Participant to a greater risk of Injury from an act of God than ordinarily applies to the general public;
11. Any claim that does not result from an Accident;
12. Claims arising from employment relationships including, without limitation, claims for any type of employment discrimination, wrongful discharge, retaliatory discharge, coercion, sexual harassment, American with Disabilities Act claims, and claims arising under the Labor Code of any state, and all other claims affecting or arising from the employment relationship whether arising under state or federal statutes or regulations or the common law;
13. Liability under the Federal Employer's Liability Act, United States Longshore and Harbor Workers' Compensation Act, the Jones Act or the Migrant Seasonal Agricultural Worker Protection Act;
14. Fines, assessments or penalties, pursuant to federal, state, local or other statute;
15. Charges incurred by a Participant for which he or she is entitled to receive benefits under any state worker's compensation law, occupational disease law, unemployment compensation disability benefits law, or other similar law;
16. Any diagnostic procedure, treatment, service or supply that is not Medically Necessary;
17. The part of any charge that is in excess of the Usual or Customary Charge;
18. Any Injury occurring while the Participant was legally intoxicated or under the influence of drugs;
19. The Participant being under the influence of drugs unless taken under the advice of and as directed by a Doctor;
20. Treatment by persons employed or retained by the Company, or by any Immediate Family or member of the Participant's household;
21. The use of, or exposure to: 1) asbestos, asbestos fibers or asbestos products; or 2) the hazardous properties of nuclear material; or 3) silicon, silicate dust; 4) radon; 5) lead; 6) mercury;

22. All statutory causes of action including, but not limited to, Title VII Civil Rights Act of 1964, Civil Rights Act of 1991, Civil Rights Act of 1866, Age Discrimination In Employment Act, Employee Retirement Income Security Act (except for plan benefits awarded under actions brought pursuant to §502(a)(1)(9B) of ERISA, 29 U.S.C. §1132(a)(1)(B), Fair Labor Standards Act, Bankruptcy Code, Texas Commission on Human Rights, Texas Worker's Compensation Act, Railway Labor Act and National Labor Relations Act;
23. The following common law causes of action alleged against the Company by a Participant: a) claims under any contract of employment whether written, oral, or implied; b) a breach of duty of good faith and fair dealing; c) breach of non-competition agreements; d) claims for tortuous interference with contractual relations; e) intentional or negligent infliction of emotional distress; and f) claims based on assault and battery, defamation, invasion of privacy, false light publicity, negligent invasion of privacy, misrepresentation and fraud, false imprisonment, false arrest, malicious prosecution, unreasonable search, and retaliatory discharge;
24. Any obligation imposed by a Workers' Compensation, occupational disease, unemployment compensation, disability benefits or similar law;
25. Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound during the Participant's Scope of Employment independent and in the absence of any underlying sickness, disease or condition including, but not limited to, diabetes;
26. Travel or flight in or on (including getting in or out of, or on or off of) an airplane, helicopter or any other device used for aerial navigation, if the Participant is: a) flying in an aircraft that is rocket propelled; b) flying in any aircraft used for aerobatics, racing or endurance test, crop dusting or seeding or 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 or experimental usage; c) flying when a special permit or waiver from the proper authority has to be issued; d) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; e) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; f) riding as a passenger in an aircraft owned, leased or operated by the Company;
27. Any Pre-Existing Condition;
28. Occupational Disease, except as stated in Section 10, below;
29. Cumulative Trauma, except as stated in Section 10, below;
30. Osteoarthritis, arthritis, or any other degenerative process of the joints, bones, tendons or ligaments;
31. Mental trauma and mental, nervous, emotional or psychological conditions or disorders;
32. The medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment;
33. Stroke or cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm, regardless of cause;
34. The Participant's horseplay was a producing cause of the injury.
35. An Occurrence for which the Participant could receive benefits under any state workers' compensation law, or occupational disease law, or unemployment compensation, or disability benefits law, or other similar law.
36. Charges for medical services performed by:
    a. a person who normally lives with the Participant; or

b. the spouse of the Participant; or
c. a parent of the Participant or of the Participant's spouse; or
d. a child of the Participant or of the Participant's spouse or
e. a brother or sister of the Participant or of the Participant's spouse.

7. ACCIDENTAL MEDICAL EXPENSE BENEFIT

A participant is eligible for Accidental Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from bodily Injury that results from an Occurrence. The cumulative amount of Accidental Medical Expense Benefits is subject to the Maximum Accidental Medical Expense Benefit shown in the Schedule of Benefits in Item No.10 and the Benefit Period stated in Item No. 7 of the Benefits Schedule. This amount will accumulate to the Combined Single Limit and will be less any payments made to or on behalf of the Participant under the Plan for the same Occurrence.

Accident Medical Expense Benefits are only payable:

1. for Usual, Customary and Reasonable Charges incurred for the Appropriate Care of a Covered Person; and

2. for Covered Expenses that are Medically Necessary; and

3. for Covered Expenses incurred within the Benefit Period shown in the Schedule of Benefits, provided the first charges were incurred within the Time Period for Initial Loss shown in the Schedule of Benefits.

No benefits will be reimbursed for any expenses incurred that are in excess of Usual, Customary and Reasonable Charges, are not Medically Necessary or any expenses that are eligible for payment or reimbursement under any other medical expense plan or policy.

Covered Expenses are:

1. Hospital or Skilled Nursing Facility charges. Hospital room and board charges are limited to the cost of a semi-private room unless the Covered Person's condition requires confinement in a private room or intensive care unit;

2. Medical, surgical, podiatric, optometric, dental (limited to Injury to sound natural teeth), Nurse, and physical therapy services provided by or at the direction of a Doctor;

3. Chiropractic Care provided it is recommended by a Doctor for the treatment of the Employee's Occupational Injury and services are not rendered by the Doctor recommending the treatment;

4. Physical rehabilitation services performed by a licensed occupational therapist provided by or at the direction of a Doctor;

5. Charges for medical or surgical treatment, services, supplies, prescription drugs and any other service that is Medically Necessary;

6. Charges for Medical Emergency ground ambulance services.

Payment of Accidental Medical Expense Benefits is further subject to:

a. The Combined Single Limit Per Participant and Per Occurrence stated in Items Nos. 12(a) and 12(b) of the Benefit Schedule;
b. the Annual Aggregate stated in Item No. 12(c) of the Benefit Schedule; and
c. The Benefit Period stated in Item No. 7 of the Benefit Schedule.

8. ACCIDENTAL DEATH, DISMEMBERMENT AND PARALYSIS BENEFIT

If Injury to the Participant results, within the Time Period for Loss shown in Item No. 11 of the Benefits Schedule, in any one of the losses shown below, the Participant (or his designated beneficiary in the case of death) is eligible for the Accidental Death, Dismemberment and Paralysis Benefit stated in Item No. 11 of the Benefit Schedule in the percentage shown below for that loss. If multiple losses occur, only one Benefit amount, the largest, will be paid for all losses due to the same Accident. The amount paid as Accidental Death, Dismemberment and Paralysis Benefits will accumulate to the Combined Single Limit shown in the Schedule of Benefits and will be less any payments made to or on behalf of the Participant under the Plan for the same Covered Occurrence.

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

"Quadriplegia" means total Paralysis of both upper and lower limbs. "Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body. "Paraplegia" means total Paralysis of both lower limbs or both upper limbs. "Paralysis" means total loss of use. A Doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted.

"Member" means Loss of Hand or Foot, Loss of Sight, Loss of Speech, and Loss of Hearing. "Loss of Hand or Foot" means complete Severance through or above the wrist or ankle joint. "Loss of Sight" means the total, permanent Loss of Sight of one eye. "Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of Hearing" means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means. "Loss of a Thumb and Index Finger of the Same Hand" or "Loss of Four Fingers of the Same Hand" means complete Severance through or above the metacarpophalangeal

joints of the same hand (the joints between the fingers and the hand). "Severance" means the complete and permanent separation and dismemberment of the part from the body.

Payment of Accidental Death, Dismemberment and Paralysis Benefits is further subject to:

a. The Combined Single Limit Per Participant and Per Occurrence stated in Items Nos. 12(a) and 12(b) of the Benefit Schedule; and
b. the Annual Aggregate stated in Item No. 12(c) of the Benefit Schedule.

9. WEEKLY DISABILITY BENEFITS

A Participant is eligible for the Weekly Disability Benefit shown in the Benefits Schedule if a Participant is Temporarily Disabled by an Occupational Injury that is a direct result of, and from no other cause but, a Covered Occurrence. The eligible amount under this benefit is subject to the Maximum Benefit shown in the Schedule of Benefits. This amount will accumulate to the Combined Single Limit and will be less any reimbursements made for the Covered Participant under the Plan for the same Covered Occurrence.

The Temporary Disability must begin within the Time Period for Initial Loss shown in the Schedule of Benefits. A Participant is eligible for Weekly Disability Benefits from the first day of Temporary Disability when:

1. the applicable Benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and

2. the Participant provides the Plan Administrator with satisfactory proof of Temporary Disability and of being under the Appropriate Care of a Doctor.

Disability Benefits will be reimbursed on a weekly basis at the lesser of the Percentage of Average Weekly Earnings minus Other Income Benefits or the Maximum Weekly Benefit shown in the Schedule of Benefits subject to the Combined Single Limit. Once a Participant is eligible to receive Temporary Disability Benefits and is Temporarily Disabled for any period of time less than a full week, the Participant is eligible for 1/7th of the Weekly Benefit for each day the Participant is Temporarily Disabled.

If the Participant remains Temporarily Disabled but is able to return to work on a part-time basis or earning less than his or her Average Weekly Earnings, he or she will be deemed Partially Disabled. The Participant's Weekly Disability Benefit will be reduced by the amount of the Participant's earnings during the period of Partial Disability.

No reimbursement will be made if the Participant refuses to participate in any medically recommended rehabilitation program or if the Temporary Disability is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo and the Participant has not availed himself or herself of the treatment.

A participant shall no longer be entitled to Weekly Disability Benefits after the first of the following dates:

1. the date the Participant dies; or
2. the date the Participant is no longer Temporarily Disabled; or
3. the date the Benefit Period shown in the Schedule of Benefits ends; or
4. the date the Participant fails to submit satisfactory proof of continuing Disability.

Once a Participant's Weekly Disability Benefits are eligible for reimbursement under the Plan, separate periods of Disability resulting from the same or related causes are a continuous period of Disability unless the Participant can return to Active Service for 14 or more consecutive days. A period of Disability is not continuous if separate periods of Disability result from unrelated causes or the later Disability occurs after eligibility under the Plan ends. A Participant is not eligible for Weekly Disability Benefits for successive periods of Disability that result from entirely different and unrelated causes unless such periods of Disability are separated by at least one full day during which the Participant is not Disabled and returns to Active Service.

Payment of Weekly Disability Benefits is further subject to:

a. The Combined Single Limit Per Participant and Per Occurrence stated in Items Nos. 12(a) and 12(b) of the Benefit Schedule;
b. the Annual Aggregate stated in Item No. 12(c) of the Benefit Schedule; and
c. The Benefit Period stated in Item No. 7 of the Benefit Schedule.

10. OCCUPATIONAL DISEASE / CUMULATIVE TRAUMA BENEFITS

A Participant is eligible for Accidental Medical Expense Benefits for Covered Expenses shown in the Benefits Schedule that result directly, and from no other cause, from an Occupational Disease or Cumulative Trauma to a Participant while he or she is performing within his or her Scope of Employment. A Participant is also eligible for a Weekly Disability Benefit shown in the Benefits Schedule if a Participant is Temporarily Disabled as a direct result of and from no other cause by an Occupational Disease or Cumulative Trauma while he or she is performing within his or her Scope of Employment. The Weekly Disability Benefits and the Accidental Medical Expense Benefits under this section are subject to the Benefit Period stated in Item No. 7 of the Benefits Schedule. Any amount paid for a benefit relating to Occupational Disease or Cumulative Trauma will accumulate to the Combined Single Limit and will be less any payments made to or on behalf of the Participant under the Plan for any Occurrence or Occupational Disease or Cumulative Trauma.

Benefits available for Occupational Disease and Cumulative Trauma are subject to the terms, conditions and exclusions relating to Accidental Medical Expense Benefits and Weekly Disability Benefits set forth in this Plan. Further, benefits for Occupational Disease and Cumulative Trauma are subject to the following additional conditions:

1. The Occupational Disease must first manifest itself during the Plan Term and while the Participant is eligible for benefits under the Plan. It must be caused solely by a Disease producing agent or agents found present in the Participant's occupational environment.

2. All Occupational Diseases suffered by any one Participant due to exposure to the same or related Disease producing agent within the Scope of Employment will be considered a single Occurrence of the Occupational Disease.

3. The last day of the Participant's last exposure to the conditions causing or aggravating the Cumulative Trauma must take place during the Plan Term and while the employee is a Participant in the Plan.

4. All Cumulative Trauma suffered by any one Participant due to the combined effect of the same or related physical activities within the Scope of Employment will be considered a single Occurrence of the Cumulative Trauma.

5. The Participant must be diagnosed by, and under the Appropriate Care of, a Doctor for the Occupational Disease or Cumulative Trauma during the Plan Term.

Any reference in the Plan to the date of an Occupational Injury, Accident or Occurrence means, for the purposes of Occupational Disease, the date that the Covered Person was last exposed to the Disease producing agent or agents in his or her occupational environment, or for the purposes of Cumulative Trauma, the date that the Covered Person last performed the activities causing the condition.

The following definitions also apply to the Occupational Disease/Cumulative Trauma Benefits

"Disease" means a condition marked by a pronounced deviation from the normal healthy state of an Employee that is first diagnosed or treated by a Doctor while this Plan is in force with regard to the person whose sickness is the basis of a claim.

"Cumulative Trauma" means Injury to a Participant, occurring within his or her Scope of Employment, and which is caused by the combined effect of repetitious, physically traumatic activities extending over a period of time. Cumulative Trauma excludes Occupational Injury.

"Occupational Disease" means a disease arising out of the Covered Person's duties in his or her Scope of Employment, that causes damage or harm to the physical structure of the body. Occupational Disease includes other diseases or infections that naturally result from work-related diseases.

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

Immediate Medical Assistance. The provision of immediate medical assistance is not an admission of negligence or liability of the Company and shall not constitute a determination that the Participant is entitled to further benefits under this Plan.

Acceptance of Medical Treatment. The acceptance of medical treatment by a Participant shall not obligate the Company to pay any or all related medical expenses if it is determined that the injury or illness is not an Occurrence as provided herein.

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

11. SUBROGATION

If the Participant's injury is caused by a third party's wrongful act or negligence, the following provisions shall apply.

In order to receive any Plan benefits for that injury, the Participant or the Participant's legal representative (or in the case of the Participant's death, the Participant's estate) must agree in writing: (i) that the Employer (as the source for payment of benefits under the Plan) will be subrogated to any recovery (irrespective of whether there is recovery from the third party of the full amount of all claims against the third party) or right of recovery against that third party; (ii) not to take any action that would prejudice the Employer's subrogation rights; (iii) to cooperate in doing what is reasonably necessary to assist the Employer in any recovery including, but not limited to, signing and delivering documents to evidence or secure the right of recovery; and (iv) to include in any liability claim against any third party any benefits payable to or on behalf of the injured party under this Plan.

The Employer will be subrogated only to the extent of the Plan benefits paid because of that injury.

Subrogation rights of the Employer under this Article II will not be jeopardized merely because the Employer fails to recognize its right of subrogation until after paying Plan benefits, or if the Employer recognizes its right of subrogation, but fails to obtain the necessary consent before paying Plan benefits. Any Plan benefits paid to Participant, his legal representative, or his estate must be returned to the Employer immediately in the event the Employer requests the agreement provided for herein and the recipient of such Plan benefits fails or refuses to execute or comply fully with such an agreement.

The Participant, by participation in this Plan, agrees that his estate and the legal representative of such estate shall be obligated to agree that the Employer will be subrogated to any recovery or right of recovery the estate has against any third party with respect to the Occurrence or with respect to any wrongful death claim or action.

12. SUSPENSION OF BENEFITS

A Participant's entitlement to continuing benefits under this Plan may be forfeited, suspended, or discontinued if the Participant fails to comply with or satisfy any of the requirements or provisions of this Plan. Without limiting the foregoing, and by way of example only, a Participant shall not be entitled to benefits under this Plan if:

(a) the Occurrence or alleged Occurrence is (i) not an Occurrence covered by this Plan, (ii) determined by the Plan Administrator to be intentional or feigned, or (iii) determined by the Plan Administrator to be an attempt to defraud the Company;
(b) the Occurrence is not reported immediately to the Supervisor or designee;
(c) the Participant utilizes a health care provider other than an authorized Provider;
(d) the Participant fails to follow the treatment and advice prescribed by the Provider;
(e) the Participant does not obtain treatment within 30 days of an on-the-job-injury;
(f) the Participant refuses or fails to obtain a second opinion prior to surgery, if requested to do so by the Plan Administrator;
(g) the Participant fails to give the Company a weekly progress report by contacting the Company once each week while receiving benefits;
(h) the Participant fails to report to his Supervisor for work immediately upon being released in whole or in part by the Provider to return to work;
(i) the Plan Administrator determines that the Participant was under the influence of drugs or alcohol at the time of the Occurrence;
(j) the Plan Administrator determines that the Occurrence was caused by horseplay, scuffling, fighting, altercation, or other inappropriate behavior;
(k) the Participant fails to execute immediately upon request a medical authorization for release of medical records to the Third Party Administrator;
(l) the Plan Administrator determines the injury resulted from an intentional or willful act of the Participant or of another;
(m) the Plan Administrator determines that at the time of the injury, the Participant was in violation of state, federal, or local law;
(n) the Participant tests positive for drugs or alcohol;
(o) the Occurrence arises from or is aggravated by a pre-existing condition;
(p) the Participant becomes employed by another employer while receiving benefits under this Plan;
(q) the Participant fails to provide a complete statement, affidavit, or deposition upon request by the Plan Administrator concerning the incident that the Participant believes resulted in an injury;
(r) the Participant was untruthful in regard to any aspect of the required information supplied as part of the employment process including, without limitation, information as to physical or mental abilities to perform the job; and
(s) the Participant refuses to submit to drug and/or alcohol testing.

13. COORDINATION OF BENEFITS

If a Participant is covered under one or more other plans including, but not limited to, automobile or health insurance, the benefits payable for expenses under this Plan incurred in a calendar year will be reduced by the amount of any benefits payable by such other plan so that the total benefits paid with respect to any one Accident or Occurrence will not exceed 100% of the expenses incurred. The Plan Administrator will determine which plan is the primary plan that will pay its benefits first according to the following rules. When only one of the plans has a coordination of benefits provision, then the plan without such a provision will be the primary plan. If both plans have such a provision, the plan under which the Participant is covered as an Employee will be the primary plan. If both of the foregoing rules do not establish which plan is the primary plan, then the plan that has covered the person for the longer period of time will be the primary plan.

14. FRAUDULENT CLAIMS

Participants submitting fraudulent claims for injuries allegedly suffered on-the-job are subject to criminal penalties. If the Company believes that an injury or illness claim is fraudulent in any manner, such claim will be denied and the Participant may be subject to disciplinary action up to and including termination and any legal remedies available to the Company.

15. CLAIM PROCEDURE

Reporting. A Participant must immediately report any Occurrence to his Supervisor or designee. The Participant must report every Occurrence, regardless of the nature or severity. Failure to immediately report an Occurrence may subject the Participant to disciplinary action up to and including termination and preclusion of benefits.

Drug and Alcohol Screen. Upon reporting an Injury, a drug and alcohol screen of Participant may be requested where there is a reasonable possibility that drug or alcohol was a contributing factor to the reported Accidental Injury.

Medical Treatment. The Participant's treatment and care will be conducted as follows:

A. The Participant will be sent to a Provider. Participant will be required to accept referral within an approved referral network so that the cost of treatment for the Occurrence will be maintained by the Company. If a Participant chooses to go to a physician of his choice, the Company will not be responsible for such expenses incurred by the Participant. In addition, the Company reserves the right to require that a Participant undergo an initial and subsequent evaluation by a Provider prior to allowing the Participant to return to work after an Occurrence.

B. The Company will pay for all prescription drugs prescribed by an authorized Provider in treatment of an injury.

Second Opinion. The Plan Administrator may require a second or additional medical opinions relating to any Occurrence. Failure of a Participant to submit to a second opinion upon request may result in denial of benefits under this Plan.

Incapacity. After initial treatment, the Provider may instruct the Participant not to return to work pending further treatment and until released at a later date. The Participant must report for work immediately after being released in whole or in part to return to work by the Provider.

Weekly Contact. A Participant must contact the Human Resource Department or Safety Department at the facility's office weekly while receiving benefits to report on his progress and expected recovery time. Failure to do so will cause the Participant's entitlement to continuing benefits under this Plan to be discontinued.

Social Security. If the Participant receives or is entitled to receive Social Security disability benefits for the same period of time for which salary continuance benefits are payable hereunder, the weekly benefit provided hereunder will be reduced by the total amount of such Social Security disability benefits.

Failure to Return to Work. If, after treatment, whether emergency or long term, the authorized Provider releases the Participant to return to work, whether at full capacity, part-time, or light duty, and the Participant fails to return to work, all medical payments and salary continuance benefits will immediately cease.

Termination. Upon Participant's separation of employment with the Company, all Weekly Disability Benefits shall cease.

Claim Procedure. When a Benefit is due, the Participant should submit his claim requirement within the Reporting of the Plan to the person or office designated by the Plan Administrator to receive claims.

Independence and Impartiality. All claims and appeals for disability benefits shall be adjudicated in a manner that ensures the independence and impartiality of the persons involved in making the decision. Decisions regarding hiring, compensation, termination, promotion or similar matters with respect to any individual, including any claims adjudicator, member of the Appeals Committee, or any expert retained by the Plan, shall not be based upon the likelihood that the individual will support the denial of disability benefits. The Plan shall not contract with a medical or vocational expert based on the expert’s reputation for outcomes in contested cases, rather than based on the expert’s professional qualifications.

Notice of Benefit Determination. The Claims Administrator or Appeals Committee, as applicable, shall provide a Participant with written or electronic notification of the Plan’s benefit Determination on review. In the event that a claim for benefits is to be denied in whole or in part, then the Plan Administrator shall provide the Participant or the Participant's representative with written or electronic notification of the Plan’s adverse determination. The term "Adverse Benefit Determination" means any of the following : A denial, reduction, or termination of, or a failure to

provide or make payment (in whole or in part) for, a benefit , including any such denial, reduction , termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in a plan, and including , a denial, reduction , or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review , as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and any rescission of disability coverage with respect to a Participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect.

The Adverse Benefit Determination shall contain the following:

(A) A discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (a) the views presented by the Participant to the Plan of health care professionals treating the Participant and vocational professionals who evaluated the Participant; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination regarding the Participant presented by the Participant to the Plan made by the Social Security Administration; and

(B) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Participant 's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(C) reference the specific Plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based and for claims for Disability Benefits only, instead of the statement set forth above, the notice may alternatively state that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(D) A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;

(E) a description of any additional material or information necessary for the Participant to perfect the claim for appeal and an explanation of why that material or information is necessary;

(F) a description of the Plan's review procedures and the time limits applicable to those procedures;

(G) a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination upon review; and

(H) in the case of an Adverse Benefit Determination involving a claim for urgent care, a description of the expedited review process applicable to urgent claims; and

(I) any applicable contractual limitations period that applies to the Participant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(J) if ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary of Labor, the Company shall: (i) provide assistance with filing claims and appeals in that non-English language that includes oral language services (such as a telephone customer assistance hotline) that include answering questions in any non-English language and providing assistance with filing claims and appeals in any applicable non-English language, (ii) upon request, provide a notice in that non-English language to the Participant; and (iii) include a non-English statement prominently displayed in the English version of the notice on how to access the non-English language services provided by the Plan.

Timing of the Notice of Adverse Benefit Decision. The deadline for providing the notice of a claims Adverse Benefit Decision depends on the type of claim being denied and the reason the claim is being denied, as set forth below.

For claims other than Disability Benefits:

(a) If the claim is being denied because the Participant or the Participant's representative did not follow the Plan's procedure for submitting the claim, the Plan Administrator must notify the Participant or the Participant's representative of the correct procedure within five days after the claim is received. *Exception for Urgent Care*: If the claim is for urgent care, the notification must be given within 24 hours after the claim is received.

(b) If the claim is being denied because the Participant or the Participant's representative followed Plan procedures but did not submit sufficient information for the Plan Administrator to determine whether the claim is covered or payable by the Plan, the Plan Administrator shall notify the Participant or the Participant's representative of the additional information needed within five days after receipt of the claim, and the Participant or the Participant's representative shall be given 45 days after the date the notice is received to provide the missing information. The Plan Administrator shall then review the additional information and notify the Participant or the Participant's representative within 15 days after the additional information is received of the Plan's determination with regard to the claim. If no additional information is received during the 45-day response period, the Plan Administrator shall send a notice of claim denial within 15 days after the end of the 45-day period. *Exception for Urgent Care*: If the claim is for urgent care, the Plan Administrator shall notify the Participant or the Participant's representative of the additional information needed within 24 hours after the claim is received, and the Participant or the Participant's representative shall be given 48 hours to provide the missing information. The Plan Administrator shall then review the additional information and notify the Participant or the Participant's representative within 48 hours after the additional information is received of the Plan's determination with regard to the claim. If no

additional information is received during the 48-hour response period, the Plan Administrator shall provide a notice of denial of the claim within 48 hours after the end of the response period.

(c) If the Participant or the Participant's representative has followed Plan procedures and has submitted sufficient information for a determination to be made, but the Third Party Administrator has determined that the claim is to be denied, then the deadline for the Third Party Administrator to provide the notice of denial is 15 calendar days after the receipt of the claim. *Exception for Urgent Care*: If the claim being denied is for urgent care, then the deadline for providing the notice of denial is 72 hours after receipt of the claim.

(d) Concurrent Medical Care Decisions - If the Third Party Administrator has approved an ongoing course of medical treatment to be provided over a period of time or number of treatments:

(i) The Third Party Administrator shall notify the Participant of any reduction or termination by the Plan of such course of treatment. Such reduction or termination shall be considered an Adverse Benefit Determination and the Third Party Administrator shall notify the Participant sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a benefit determination on review before the course of treatment is actually reduced or terminated.

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

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

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

(e) Disability Benefits Claims - The Plan Administrator shall provide the Participant with written or electronic notification of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan, or such period as is required by applicable law or Department of Labor regulation, and disability is not based on the Social Security acts.

When a Claim is Received. The Plan will be deemed to have received a claim for benefits if a claim or a Participant's representative makes a written communication, except in the case of urgent care, in which case the claim may be communicated orally, reasonably calculated to bring a request for a claim to the attention of the Third Party Administrator.

Identification of Experts. Upon request of a Participant, the Claims Administrator or Appeals Committee, as applicable, shall identify the individual names of any medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination, without regard to whether the advice of such experts was relied upon in making the benefit determination.

Manner of Giving Notice. Notice shall be given to Participants, Beneficiaries, and other specified individuals in a manner reasonably calculated to ensure actual receipt. Notice shall be given in writing and shall either be sent by first class mail or by hand delivery. Materials furnished upon written request shall be mailed to the address provided by the requesting Participant or Beneficiary, or personally delivered to the Participant or Beneficiary. Notice may only be given electronically (e.g., by email or by employer portal if the employer commonly posts such information in the employer portal, and the employee is aware of such postings and has access to such postings) if the Plan Administrator ensures that the message:

(a) Results in actual receipt of the transmitted information (e.g., using return-receipt notice);
(b) Protects the confidentiality of personal information relating to the individual's accounts and benefits;
(c) The electronically delivered documents are prepared and furnished in a manner that is consistent with the style, format, and content requirements applicable to that particular document;
(d) Notice is provided to each Participant, beneficiary, or individual that apprises the individual of the significance of the document when it is not otherwise reasonably evident as transmitted; and
(e) Upon request, the Participant, beneficiary, or other individual is furnished with a paper version of the electronically furnished document free of charge.

Electronic notice may be provided to the Participant only if the Participant has the ability to effectively access the documents in electronic form at any location where the Participant is expected to perform his or her duties as an employee and whose access to the employer's electronic information system is an integral part of those duties; or a Participant, beneficiary, or any other person who is entitled to documents under Title I of the Act or the regulations issued thereunder who has affirmatively consented, in electronic or non-electronic form, to receiving documents through electronic media and has not withdrawn such consent,, has affirmatively consented in a manner that reasonably demonstrates the individual's ability to access information in the electronic form that will be used to provide the information that is the subject of the consent, and has provided an address for the receipt of electronically furnished documents, and prior to consenting, is provided a clear and conspicuous statement including:

(a) The types of documents to which the consent would apply;

(b) That consent can be withdrawn at any time without charge;

(c) The procedures for withdrawing consent and for updating the Participant's beneficiary's or other individual's address for receipt of electronically furnished documents or other information;

(d) The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and

(e) Any hardware or software requirements for accessing and retaining the documents.

In the event that the hardware or software used for access to and retention of the electronically furnished software is changed, the Participant, beneficiary, or other individual must be provided with a statement of the revised hardware or software requirements for access to and retention of those documents; the Participant, beneficiary, or other person must be given the right to withdraw consent without charge and without the imposition of any condition or consequence that was not disclosed at the time of the initial consent; and the Participant, beneficiary, or other person must again consent to the receipt of documents through electronic media.

Definition of Claim Involving Urgent Care. "Urgent care" means medical care or treatment with respect to which the application of the periods for making non-urgent care determinations: (i) could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function; or, (ii) would, in the opinion of a physician familiar with the Participant's medical condition, subject the Participant to severe pain that cannot be adequately managed without the care or treatment being applied for. Whether a claim should be treated as an "urgent care" claim can either be determined by a physician with knowledge of the Participant's medical condition or by an individual acting on behalf of the Plan, provided that individual applies the judgment of a reasonable individual who is not a trained health professional.

Time Deadlines After Adverse Benefit Determination Is Issued. The Participant will have 60 days after receiving the initial adverse benefit determination to contest the denial of the claim. The appeal of an Adverse Benefit Determination must be decided within 45 days of receipt of a request for review. This 45-day period may be extended for an additional 45 days if the Plan Administrator determines that it needs additional time due to special circumstances; that the Participant or Beneficiary is notified in writing or electronically of the extension within the initial 45-day period, and the disability is not based in the Social Security Acts. The extension notice will indicate the special circumstances which require extension and the date by which the Plan expects to render the benefit determination.

Appeal Procedure. A Participant's claim will be subject to a full and fair review. The Plan Administrator will provide the Participant or Beneficiary with a reasonable opportunity to submit any issues and comments in writing for a review of the decision denying the claim and to submit and review any pertinent documents. Before the Plan will issue any Adverse Benefit Determination on review, the Participant shall be provided, free of charge and as soon as possible and sufficiently in advance of the date on which notice of the determination on review must be provided to the Participant to give the Participant reasonable opportunity to respond prior to the deadline, any new or additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim; and for disability benefits claims only, free of charge to the Participant, any new or additional

rationale that the disability benefit claim is based on. The rationale shall be provided as soon as possible and sufficiently in advance of the date upon which the notice of Adverse Benefit Determination on review is required to be provided to give the Participant a reasonable opportunity to respond prior to that date. Any determination on review shall be written in a manner calculated to be understood by the Participant and Beneficiary, and shall include the specific reasons for the decision and shall include specific references to the pertinent Plan provisions on which the decision is based.

If the Appeals Committee makes a final written determination denying the Participant's or Beneficiary's claim, the Participant and Beneficiary will be forever barred from filing legal action to contest the denied claim unless such action is filed not later than 180 days following the date of the Plan Administrator's final determination.

If Participant submits his or her denial of benefits claim for review, the Participant may submit written comments, documents, records, and other information relating to the Participant's claim for benefits. The Appeals Committee will take all information, including all information submitted by the Participant (without regard to whether such information was submitted or considered in the initial benefit determination), into account in performing its review.

In determining a claim on review:

(a) The claim will be reviewed without deference to the initial Adverse Benefit Determination, and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

(b) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

(c) The Appeals Committee shall not utilize or rely upon any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

16. AMENDMENT AND TERMINATION

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

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

automatically terminate if there is a general assignment to or for the benefit of the creditors of the Sponsor. This Plan shall also terminate upon any action by the Company or an insurance carrier to cancel, non-renew, or otherwise fail to renew an occupational injury insurance policy that was purchased in conjunction with the adoption of this Plan document.

17. ADMINISTRATION OF THIS PLAN

A Plan Administrator shall be appointed to administer this Plan. The Administrator has the exclusive responsibility for the general administration of the Plan.

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

18. FUNDING OF PLAN

The Plan is funded by the Company. The Company shall obtain insurance to provide funds to the Company to pay for all of the benefits provided under this Plan. Any such insurance contract or proceeds shall be owned by Company, and shall not be considered an asset of the Plan. If such insurance coverage terminates or for any reason is not available to Company, benefits under this Plan shall terminate or not be payable. Company has no obligation to establish a fund or trust for the payment of benefits under this Plan. Any payments paid to a Participant, whether funded by insurance or not, shall not be considered a collateral source. Company is entitled to a credit or offset for any such payments, whether the source of the funds is general Company assets or insurance procured by Company.

19. STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, 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 Pension and Welfare Benefit Administration.

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 updated summary plan description. The administrator may make a reasonable charge for the copies.

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 beneficiaries. No one, including your employer, your union, 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.

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. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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 office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

APPENDIX A
NOTICE OF PRIVACY POLICIES REGARDING YOUR 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 READ IT CAREFULLY.

Federal legislation requires that the Plan comply with the "Standards for Privacy of Individually Identifiable Health Information," which are set out in Subparts A and E of 45 CFR Parts 160 and 164 (also known as the Health Information Portability and Accountability Act ("HIPAA") Privacy Rules). Under these regulations, which take effect on April 14, 2004, the Plan must ensure the privacy of your Protected Health Information to the extent HIPAA applies to health benefits provided under the Plan. The term "protected health information" encompasses any information created or maintained by the Plan that relates to your past, present, or future physical or mental health as well as any documents relating to health care provided to you and payment thereof. The Plan may not use or disclose your protected health information without first obtaining your written consent or express authorization. Your consent is not required, however, for any purpose described below.

Permitted uses and disclosures:

1. For Treatment: The Plan may disclose protected health information to a doctor, nurse, hospital, or other health care provider for any treatment you might receive. Treatment entails the provision, coordination, or management of health care and related services by one or more health care provider, including consultations and patient referrals from one health care provider to another.

2. For Payment: The Plan may disclose protected health information to another health plan or a health care provider for the payment activities undertaken by the Plan Administrator in determining or fulfilling its responsibility for coverage under the Plan. These activities may include, but are not limited to, reimbursement for any health care provided to you as well as coverage determinations, billing, claims management, collection, and related health care data processing. In other words, the Plan may disclose your protected health information to, for example, an insurance company that may make payments to your hospital and doctors.

3. For Health Care Operations: The Plan may disclose protected health information about you to another health plan or health care provider for any health care operation activities of the Plan. Such activities include: (1) quality assessment and improvement ; (2) reviewing the competence of and providing training to health care professionals; (3) underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits; (4) Conducting legal services, auditing functions, or a medical review; (5) business planning and development; and (6) business management and general administrative activities of your employer. For example, the Plan may use your private health information to examine and make improvements upon its policies and procedures for handling claims. The Plan may also disclose protected health information to another covered entity for health care operation activities of the entity that receives the information, provided that entity has a relationship with you pertaining to the health information disclosed, and the disclosure is: (1) for health care operations or (2) for the purpose of health care fraud and abuse detection or compliance.

4. Upon Written Authorization: Any uses and disclosures of your protected health information other than those mentioned in paragraphs (1), (2), and (3) above will be made only with your written

authorization, and such disclosure shall be limited in scope to the permitted uses described in the authorization. You may revoke your authorization at any time, provided the revocation is in writing and the Plan has not already disclosed your protected health information in reliance on the authorization. Notwithstanding anything else in this Notice, the Plan must obtain your authorization to use or disclose psychotherapy notes about you. Psychotherapy notes include any notes recorded by a mental health professional during a private counseling session with you that are separated from the rest of your medical record. They do not include any summary of your diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

5. Disclosures to the Plan Administrator: The Plan may disclose your private health information to your employer in order for it to conduct plan administrative functions as long as your employer:

a. Does not use or further disclose the information other than for performing plan administrative functions;

b. Ensures that any agents to whom it provides protected health information agree to the same restrictions and conditions that apply to the Employer with respect to your information;

c. Does not use or disclose the information for employment-related actions and decisions;

d. Reports to the Plan any use or disclosure of your information that is inconsistent with the permitted or required uses or disclosures;

e. Allows you access to your own protected health information so that you may inspect or copy the information in your file. Excluded from this provision is any information compiled in reasonable anticipation of, or for use in, a civil lawsuit or criminal proceeding;

f. Complies with your right to amend protected health information and incorporate any amendments into your record;

g. Provides upon request an accounting of any disclosures it has made of your protected health information;

h. Makes its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with the HIPAA Privacy Rules;

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

j. Ensures adequate separation between itself and the Plan. From this, it must be established that the only employees or other persons under the control of your employer who shall be given access to your protected health information for use and disclosure are (i) the Plan’s designated Claim’s Administrator, (ii) the Plan’s Committee Members; and (iii) those staff members designated to perform Plan functions. The Employer must restrict the access to and use by such persons to the plan administration functions that the Employer performs for the Plan.

6. Exception: Notwithstanding anything else stated in this Notice, the Plan may disclose summary health information to the Plan Administrator if the Plan Administrator requests such information for the purpose of: (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan, (b) modifying, amending, or terminating the Plan, or (c) determining whether the individual is participating in the Plan. "Summary health information" means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan has provided health benefits and is not individually identifiable health information.

Individual Rights:

1. You have the right to request restrictions on certain uses and disclosures of your protected health information. The Plan is not required to agree to a request for restriction.

2. You have a right to receive confidential communications of protected health information from your health care provider, including the right to request disclosure through alternative means.

3. You have the right to inspect and copy your protected health information as described in paragraph 5(e) above.

4. You have the right to amend your information as described in paragraph 5(f) above, subject to certain exceptions.

5. You have the right to receive an accounting of any disclosure of your protected health information as described in paragraph 5(g) above, subject to certain exceptions for permitted or required disclosures described in the Notice.

6. You have the right to obtain a paper copy of this Notice from the Plan upon request.

Duties of the Plan:

The Plan is required by law to protect the privacy of protected health information and provide you with notice of its legal duties and privacy practices with respect to your protected health information. The Plan must abide by the terms of this Notice or subsequent notices. The Plan reserves the right to change the terms of this Notice and to make the new notice provisions effective for all protected health information that it maintains. Revised notices will be distributed in the same manner as this Notice was distributed.

Complaints:

If you suspect the Plan, Plan Administrator, and/or your employer to have violated the terms of this Notice, you have the right to file a complaint to the Plan or the Secretary of Health and Human Services. You may exercise your right to file a complaint for any noncompliance by submitting a written request to the Plan's Contact Person listed at the end of this Notice. The Plan shall respond to your claim within 30 days, subject to a 30 day extension. If the Plan disagrees with your complaint or the claim is otherwise denied, the Plan will provide you with a written denial explaining the basis for the denial. You may then submit your own written statement of disagreement. You may also pursue further action by taking the matter before the Secretary of Health and Human Services. Your employer will not retaliate against you for filing a complaint.

Contact Person:

For information, questions, or concerns regarding the contents of this Notice, please contact the person named in the Benefit Schedule.