RELIABLE STAFFING CORPORATION OCCUPATIONAL INJURY BENEFIT PLAN

(Effective November 1, 2012)

OFFICIAL PLAN DOCUMENT

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(1) shall, in the case of a non-electronically transmitted written communication, be plainly marked "ADVERTISEMENT" on its first page, and on the face of the envelope or other packaging used to transmit the communication. If the written communication is in the form of a self-mailing brochure or pamphlet, the word "ADVERTISEMENT" shall be:

(i) in a color that contrasts sharply with the background color; and

(ii) in a size of at least 3/8" vertically or three times the vertical height of the letters used in the body of such communication, whichever is larger;

(2) shall, in the case of an electronic mail message, be plainly marked "ADVERTISEMENT" in the subject portion of the electronic mail and at the beginning of the message's text;

(3) shall not be made to resemble legal pleadings or other legal documents;

(4) shall not reveal on the envelope or other packaging or electronic mail subject line used to transmit the communication, or on the outside of a self-mailing brochure or pamphlet, the nature of the legal problem of the prospective client or non-client; and

(5) shall disclose how the lawyer obtained the information prompting the communication to solicit professional employment if such contact was prompted by a specific occurrence involving the recipient of the communication or a family member of such person(s).

(c) Except as provided in paragraph (f) of this Rule, an audio, audio-visual, digital media, recorded telephone message, or other electronic communication sent to prospective clients for the purpose of obtaining professional employment:

(1) shall, in the case of any such communication delivered to the recipient by non-electronic means, plainly and conspicuously state in writing on the outside of any envelope or other packaging used to transmit the communication, that it is an "ADVERTISEMENT";

(2) shall not reveal on any such envelope or other packaging the nature of the legal problem of the prospective client or non-client;

(3) shall disclose, either in the communication itself or in accompanying transmittal message, how the lawyer obtained the information prompting such audio, audiovisual, digital media, recorded telephone message, or other electronic communication to solicit professional employment, if such contact was

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RELIABLE STAFFING CORPORATION
OCCUPATIONAL INJURY BENEFIT PLAN

This Reliable Staffing Corporation Occupational Injury Benefit Plan (the "Plan")by Reliable Staffing Corporation.

WITNESSETH THAT:

WHEREAS, the Company has rejected coverage for its Texas Employees and the Texas Employees of Reliable Staffing Corporation, under the Texas Workers' Compensation Act, effective as of November 1, 2008; and

WHEREAS, the Company desires to establish an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), effective as of November 1, 2008, to provide a means by which the Company and other adopting Employers (including, but not limited to, Reliable Staffing Corporation.) can protect themselves from certain liabilities as nonsubscribers to the Texas workers' compensation insurance system by providing non-fringe disability, death, dismemberment and medical benefits with respect to any covered injury sustained by Texas employees in the course and scope of employment;

NOW, THEREFORE, in consideration of the premises, the Company hereby establishes this Plan to provide benefits and be administered in accordance with the following:

ARTICLE I

DEFINITIONS

1.1 "Accident" means an event which:

(a) was unforeseen, unplanned, and unexpected;

(b) occurred at a specifically identifiable time and place;

(c) occurred by chance or from unknown causes; and

(d) results in physical injury to the Participant.

1.2 "Adverse Benefit Determination" encompasses the definition prescribed by the United States Department of Labor in 29 C.F.R. § 2560.503-1(m)(4) and means generally a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. For example, this includes denial, reduction or termination of benefits based upon (a) a claimant's ineligibility to participate in the Plan, (b) application of any utilization review, (c) a medical service being experimental or investigational or not Medically Necessary or appropriate, or (d) the Participant's no longer being Disabled.

1.3 "Appeals Committee" means the individual or individuals appointed by the Company to make Determinations on appeal of benefit claims and otherwise administer the Plan on behalf of the Company and all other Employers. The Claims Administrator cannot serve as the Appeals Committee or as a member of the Appeals Committee, and no individual who is a subordinate of the Claims Administrator can serve as the Appeals Committee or as a member of the Appeals Committee.

The Appeals Committee shall have maximum discretionary legal authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to an employee's rights, to decide questions of Plan interpretation and those of fact relating to the Plan, make factual findings, review referred appeals and uphold or reverse any denials and keep and maintain records pertaining to the referred appeals.

1.4 "Approved Facility" means a hospital, other medical care facility or medical service or supply provider either expressly approved by the Claims Administrator, included on an approved list of facilities adopted by the Claims Administrator, or otherwise approved in writing by the Claims Administrator upon the request of a Participant. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any list of Approved Facilities at any time.

1.5 "Approved Physician" means a person duly licensed under applicable state law as a Medical Doctor or Doctor of Osteopathy and either expressly approved by the Claims Administrator, included on an approved list of physicians adopted by the Claims Administrator, or otherwise approved in writing by the Claims Administrator upon the request of a Participant. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any list of Approved Physicians at any time.

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

(a) If there is an Eligible Spouse or Eligible Domestic Partner, all Death Benefits shall be paid to the Eligible Spouse or Eligible Domestic Partner.

(b) If there is no Eligible Spouse or Eligible Domestic Partner, Death Benefits shall be paid in equal shares to the Eligible Child or Eligible Children. If an Eligible Child has predeceased the Participant, Death Benefits that would have been paid to that child if he or she had survived the Participant shall be paid in equal shares per stirpes to the children of such deceased child.

(c) If the Participant is not survived by an Eligible Spouse, Eligible Domestic Partner or Eligible Child, any Death Benefits shall be paid to a surviving dependent (as determined in accordance with the support criteria set forth in section 152 of the Internal Revenue Code and such other rules as the

Claims Administrator may adopt or prescribe) of the Participant who is a parent, sibling, or grandparent of the deceased Participant. If more than one of those dependents survives the Participant, any Death Benefits shall be divided among them in equal shares.

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

(e) For purposes of this Section:

(1) "Eligible Spouse" means the surv1v1ng spouse of the deceased Participant, recognized by a marriage certificate issued under the laws of the State of Texas or similar government authority, or by a Texas court decree of common law marriage (obtained at such person's sole initiative and expense).

(2) "Eligible Domestic Partner" means the domestic partner identified and certified by the deceased Participant on Reliable Staffing Corporation Important Tax Information Domestic Partner Form.

(3) "Eligible Child" means a deceased Participant's, or deceased Participant's Eligible Domestic Partner's, surviving unmarried natural child, legally adopted child (including a child placed with the deceased Participant for the purpose of adoption), or stepchild, whether by blood, marriage, or legal adoption (including children placed with the deceased Participant for the purpose of adoption), if the child is:

(A) under 19 years of age;

(B) enrolled as a full-time student in an accredited educational institution and is less than 25 years of age; or

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

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

1.8 "Company" means Reliable Staffing Corporation.

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1.9 "Course and Scope of Employment" means an activity of any kind or character for which the Participant was hired and that has to do with, and originates in, the work, business, trade or profession of an Employer, and that is performed by a Participant in the furtherance of the affairs or business of an Employer. The term includes activities conducted on the premises of an Employer or at other locations designated by an Employer. This term does not include:

(a) a Participant's transportation to and from his or her place of employment, unless:

(1) the transportation is furnished as part of the Participant's employment arrangement or is paid for by an Employer; provided, however, that this exception does not include commuting to or from the Participant's usual place of employment;

(2) the means of the transportation are under the control of an Employer; or

(3) the Participant is directed in his or her employment to proceed from one place to another place. Commuting to the place where the Participant begins Employer business and commuting away from the place where the Participant ceased Employer business shall not be covered if such travel does not otherwise satisfy subsections (1) or (2) herein.

(b) travel by the Participant in furtherance of the affairs or business of an Employer if such travel is also in furtherance of personal or private affairs of the Participant, unless:

(1) the travel to the place where the Injury occurred would have been made even had there been no personal or private affairs of the Participant to be furthered by the travel; and

(2) the travel would not have been made had there been no affairs or business of the Employer to be furthered by the travel.

(c) any injury occurring before the Participant clocks in or otherwise begins work for an Employer or after the Participant clocks out or otherwise ceases work for an Employer, unless the injury occurs in a parking lot, common area or other area owned by the Employer (or *tor* which an Employer is responsible for maintenance).

(d) any injury occurring while the Participant is on a work break, unless:

(1) the injury occurs while the Participant is on a work break inside an Employer's facility (for purposes other than eating or smoking);

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(2) such work break was authorized by his or her supervisor (or was otherwise permitted consistent with the Participant's job description);

(3) the Participant is scheduled to return to work that same day following such work break; and

(4) the Participant has not clocked out or otherwise ceased work for an Employer.

1.10 "Covered Charge" means the cost to a Participant of a service or supply described in subsections (a) through (e) below, which service or supply is Medically Necessary, based on the nature of the Injury, as and when provided, and (1) cures or relieves the effects naturally resulting from the Injury; (2) promotes recovery; or (3) otherwise enhances the ability of the Participant to return to or retain employment. Such services and supplies are also subject to the medical management provisions of Section 4.2. For purposes of this Plan, the terms "service" or "supply" include, but are not limited to, any related treatment, medication, technique or method.

(a) **First and Continuing Treatment.**

(1) The first Covered Charge must be incurred within 14 days following the date of the Injury; and

(2) No further amount shall be considered a Covered Charge if the Participant does not receive medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days. This subsection (a)(2), however, shall not apply to any Covered Charge for testing and any follow up vaccination with respect to an Injury that involves a potential occupational exposure to a bloodborne pathogen.

(b) **Approved Provider and Pre-Authorization Requirements.** The cost of a service or supply shall be a Covered Charge only if:

(1) treatment is furnished by or under the direction of an Approved Physician or Approved Facility, acting within the scope of the Approved Physician's or Approved Facility's license, and pre-approved by the Claims Administrator (except when the Claims Administrator determines that prior approval was impossible under the circumstances). Such pre-approval may include authorization for multiple visits to an Approved Physician or Approved Facility, and must be in writing, or by electronic notics (except as otherwise specified in subsection (c) below or in Article VI herein); or

(2) treatment is provided as Emergency Care; and

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

(ii) after receiving primary Emergency Care, subsequent treatments are provided by, or at the direction of, an Approved Physician or Approved Facility in accordance with subsection (b)(1) above.

(c) **Covered Medical That Can Be Verbally Authorized.** Subject to the restrictions and limitations set out elsewhere in this Plan, Covered Charges that can be verbally authorized shall include the cost of the following:

(1) Approved Physician visits- at an Approved Facility (including charges for an emergency room), Approved Physician's office, or in the case of Home Health Care, at the Participant's home, including second opinion services requested by the Claims Administrator (in accordance with Section 4.2), and charges for a registered nurse;

(2) Medical supplies approved by the treating Approved Physician, including the following:

(A) Prescription drugs (generic, unless trade name drugs are requested by an Approved Physician) and over-the-counter drugs such as analgesics prescribed by an Approved Physician;

(B) Blood and other fluids (other than allergy, insulin, and similar drugs) injected into the circulatory system (but only to the extent not available through any refund or allowance by a blood bank or similar organization);

(C) Oxygen and its administration;

(D) Upon the written advice or prescription of an Approved Physician and only if obtained from an Approved Facility, rental or purchase of a wheelchair, assisted breathing apparatus, or other mechanical equipment necessary for the treatment of respiratory paralysis, and similar internal or external durable medical equipment designed primarily for therapeutic purposes;

(E) Surgical dressings, bandages, splints, casts, crutches, syringes, needles, trusses, and braces dispensed by an Approved Physician or Approved Facility; and

(F) Other items approved by the Claims Administrator;

(3) Ambulance services - professional ground ambulance service, or if no other means of transportation can reasonably suffice to

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deliver the individual to the closest appropriate Approved Facility, air ambulance, regularly scheduled railroad, or airlines;

(4) Eyeglasses or contact lenses - one pair per Injury up to $200, inclusive of professional office visit charges, but excluding routine eye examinations; and

(5) External hearing aid - up to $600, inclusive of professional office visit charges.

(d) Medical Requiring Specific Approval in Writing or by Electronic Notice. Subject to the restrictions and limitations set out elsewhere in this Plan, Covered Charges shall also include the cost of the following so long as the Claims Administrator specifically approves such charges in advance and in writing or by electronic notice:

(1) Admission to an Approved Facility on an inpatient or outpatient basis, including semi-private room and board, ambulatory day surgery, anesthesia and its administration, and similar services;

(2) Diagnostic testing, including x-ray examinations, laboratory tests, MRI, CAT Scan, nuclear medicine, radiology and pathology (including interpretive services) and similar testing;

(3) Speech, occupational and physical therapy provided by an Approved Physician or a licensed speech therapist, licensed occupational therapist or licensed physical therapist; provided, however, that such services shall be subject to case management approval regarding the number of visits, the types, and amount of services provided during such visits;

(4) Inpatient rehabilitation services provided in a Medical Rehabilitation Hospital; provided, however, that such services shall be subject to continued stay review by the Claims Administrator and case management approval regarding the types and amount of services provided;

(5) Limited or temporary pain management services (for example, epidural steroid injections), but not including pain management programs;

(6) Surgery that restores a reasonable, normal pre-Injury functioning;

(7) Se.rvices of a dentist or licensed oral surgeon - services for treatment and repair of broken teeth, fractures and dislocations of the jaw, or the replacement of teeth (excluding temporomandibular junction

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dysfunction services) when the injured Participant seeks treatment as soon as possible after the Injury;

(8) Home Health Care (with respect to physical needs only) up to 75 visits per Plan Year and up to eight (8) hours per visit for the first two (2) weeks of Home Health Care and up to four (4) hours per visit thereafter;

(9) Skilled Nursing Care, provided that an Approved Physician monitors the progress of the Participant at least once during each 30-day period of confinement;

(10) Orthotics, arch supports, corrective shoes, special bras or girdles, corrective appliances, prostheses, or any similar item;

(11) Organ and tissue transplant services not otherwise covered by some form of expense payment program, excluding the donor's transportation costs, organ procurement costs and the donor's surgical expenses;

(12) Charges for telephone consultations with the Participant, Participant's family, Approved Physicians or other health care providers;

(13) Mental health services (to the extent not otherwise covered by an Employer's Employee Assistance Program), but only when such services are provided for mental or emotional damage or harm resulting from a Participant being the victim of, or witness to, a Traumatic Event occurring during such Participant's Course and Scope of Employment; and provided, that such services shall not exceed five (5) visits with an Approved Physician or Approved Facility. This coverage shall apply solely to Medical Benefits coverage and shall not result in any payment of Wage Replacement Benefits or other benefits under this Plan;

(14) Services rendered primarily for training, testing, evaluation, counseling, or educational purposes;and

(15) Reasonable travel, meal and lodging expenses related to medical treatment that requires travel greater than 20 miles from the Participant's residence (one way), as interpreted by the Claims Administrator for application under this Plan and approved by the attending Approved Physician.

(e) **Non-Covered Medical.** Any provision of this Plan to the contrary notwithstanding, Covered Charges shall not include the cost of the following:

(1) Charges incurred prior to the Participant's date of participation in the Plan, or prior to the Participant's date of Injury;

(2) Charges rendered after the Participant's Medical Benefits under the Plan terminate;

(3) Expenses which are not Medically Necessary, as determined by the Claims Administrator;

(4) Charges incurred more than 60 days after the date of the Participant's last Covered Charge (except as otherwise specified herein);

(5) Expenses that exceed any fee schedule adopted by the Claims Administrator or the Usual and Customary charge for the same or similar treatment, services or supplies in the Employer's geographic area;

(6) Services or supplies payable by any government or subdivision or agency thereof, or any other applicable third-party payor;

(7) Services or supplies which are experimental, investigative, or for the purposes of research, including, but not limited to, services and supplies that have not been approved by the American Medical Association, the Food and Drug Administration, the appropriate medical specialty society, or the appropriate governmental agency, all phases of clinical trials, all treatment protocols based upon or similar to those used in clinical trials, or any treatment not generally accepted by the physician's profession in the United States as safe and effective for diagnosis and treatment;

(8) Services or supplies performed or provided while the Participant is not covered by the Plan;

(9) Services or supplies for which the Participant is not legally obligated to pay, or for which no charge would be made in the absence of the Plan;

(1O) Services for the evaluation or treatment of mental or psychological damage or harm, except to the extent provided above under subsection (d);

(11) Services or supplies for personal comfort or convenience, such as a private room, television, telephone, radio, guest trays, and similar items;

(12) Fraudulent claims or claims not filed in good faith as determined by the Claims Administrator;

(13) Canceled appointment charges;

(14) Self-administered services;

(15) Services or supplies to which the Participant's condition is persistently nonresponsive;

(16) Services or supplies relating to Preexisting Conditions, except to the limited extent (if any) that an Approved Physician clearly confirms an identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a Preexisting Condition; provided, however, that:

(A) coverage for such aggravation will be provided only if and to the extent that the Approved Physician -

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

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

(B) no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury. See Appendix B for more information regarding limitations of the Preexisting Condition exclusion;

(17) Acupuncture, behavior modification, pain management programs, hypnosis, biofeedback, other forms of self-care or self-help training or any related diagnostic testing, or any service or supply ancillary to any of these treatments;

(18) Chiropractic or spinal manipulation services;

(19) Substance abuse services;

(20) Custodial Care;

(21) Charges for the purchase, rental or repair of bedding, or environmental control devices, including, but not limited to, an air conditioner, humidifier, dehumidifier, or air purifier; and charges for jacuzzis, saunas, vans, or structural changes to the Participant's residence or moving expenses;

(22) Charges for services performed by:

(A) a person who normally lives with the Participant;

(B) the spouse or domestic partner of the Participant;

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(C) a parent of the Participant or of the Participant's spouse or domestic partner;

(D) a child of the Participant or of the Participant's spouse or domestic partner; or

(E) a brother or sister of the Participant or of the Participant's spouse or domestic partner; or

(23) The cost of any other service or supply not specified in subsection (c) or (d) above.

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

1.12 "Cumulative Trauma" means damage to the physical structure of the Participant's body occurring as a result of rapid, repetitious, physically traumatic activities that occur in the Course and Scope of Employment. The term "Cumulative Trauma" does not mean fatigue, soreness, strains or general aches and pain that may have been caused, aggravated, exacerbated or accelerated by the Participant's Course and Scope of Employment.

(a) Any provision of this Plan to the contrary notwithstanding, if an Employer has obtained an insurance contract or policy described in Section 5.2, the purpose of which (in whole or in part) is to pay Plan benefits to Participants or indemnify the Employer for Plan benefits, then the Participant's last day of last exposure to the condition causing or aggravating such Cumulative Trauma must have taken place during the policy period.

(b) Any provision of this Plan to the contrary notwithstanding, no benefits will be payable with respect to Cumulative Trauma unless the Participant has completed at least 180 days of continuous, active employment with an Employer and has been regularly engaged in a Course and Scope of Employment with the Employer involving rapid, repetitious, physically traumatic activities.

1.13 "Custodial Care" means care consisting of services and supplies provided to an individual in or out of an institution primarily to assist him in daily living activities, whether or not he is disabled, and no matter by whom recommended or furnished. Room and board and Skilled Nursing Care are not, however, considered Custodial Care if provided during confinement in an Approved Facility, and if combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the individual's medical condition which resulted from an Injury.

1.14 "Death Benefits" means any benefit payable under Section 3.2.

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

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

1.17 "Dismemberment Benefits" means any benefit payable under Section 3.3.

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

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

1.20 "Employer" means the Company, Reliable Staffing Corporation, and any other related trade or business that adopts the Plan pursuant to Section 9.6.

1.21 "First Aid" means on-site primary medical care rendered in accordance with Employer policy.

1.22 "Gross Misconduct" means the Employee's gross misconduct within the meaning of Section 49808 of the Internal Revenue Code, or any successor provision of law.

1.23 "Home Health Care" means the following care provided to the Participant on the recommendation of an Approved Physician at the Participant's home or a Home Health Care Agency:

(a) intermittent nursing care by a(n):

(1) Registered Nurse ("R.N.");
(2) Licensed Practical Nurse ("L.P.N.");
(3) Home Health Aide;

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(4) Occupational Therapist;
(5) Physical Therapist or Licensed Physical Therapy Assistant;
(6) Licensed Vocational Nurse ("L.V.N."); or
(7) Licensed Speech Therapist; and

(b) private duty nursing services of a R.N., L.V.N., L.P.N., or Certified Home Health Aid,

provided, however, that Home Health Care services shall not include services provided by persons who ordinarily live in the same household as the Participant or who are related by blood, marriage, or legal adoption to the Participant or the Participant's spouse or domestic partner.

1.24 "Home Health Care Agency" means any of the following: (i) a home health care agency licensed by the State in which it is located, (ii) a home health agency as defined by the Social Security Administration, or (iii) an organization which is certified by the Participant's Approved Physician as an appropriate provider of Home Health Care and which: has a full-time administrator, keeps written medical records, and has at least one R.N. on staff (or the services of an R.N. available).

1.25 "Injury" means damage or harm to the physical structure of the body caused solely as the result of either (i) an Accident, (ii) Cumulative Trauma, or (iii) an Occupational Disease. Such damage or harm must be incurred in, and directly and solely result from, the Course and Scope of Employment.

(a) Date of Injury. Any provision of this Plan to the contrary notwithstanding, in order to be subject to this plan document, the date of such Injury must be on or after November 1, 2008. For all purposes of this Plan, the date of Injury shall be either (i) the date of the Accident resulting in the Injury, (ii) the date that the damage or harm, or symptoms thereof, were first known to (or should have been known to) the Participant or diagnosed by an Approved Physician as Cumulative Trauma, or (iii) the date that the damage or harm, or symptoms thereof, were first known to (or should have been known to) the Participant or diagnosed by an Approved Physician as an Occupational Disease. All Injuries sustained by a Participant that relate to (i) an Accident, or related series of Accidents, (ii) exposure to an environmental or physical hazard that causes an Occupational Disease, or (iii) rapid, repetitious, physically traumatic activities that result in Cumulative Trauma shall be considered a single Injury for purposes of the Plan.

(b) Types of. Non-Covered Injuries. Any provision of this Plan to the contrary notwithstanding, the term Injury shall not include:

(1) any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure or other body part resulting from use of a video display terminal or keyboard, poor or inappropriate posture, the natural results of aging, osteoarthritis, arthritis,

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or degenerative process (including, but not limited to, degenerative joint disease, degenerative disc disease, degenerative spondylosis/ spondylolisthesis and spinal stenosis), factors to which the general public is exposed, or other circumstances prescribed by the Claims Administrator which do not directly and solely result from the Participant's Course and Scope of Employment;

(2) diagnostic labels which imply generalized musculoskeletal aches and pains in the absence of any demonstrable primary pathophysiology, such as Fibrositis, Fibromyalgia, Myofascial Pain Syndrome, Myositis, or Chronic Fatigue Syndrome;

(3) except to the limited extent provided under the definition of "Covered Charges," any mental injury, emotional distress, mental trauma or similar injury to the mental or emotional state of a Participant, including without limitation, any physical manifestations resulting from such mental or emotional state, and any mental or emotional damage or harm that arises primarily from a personnel action, including, but not limited to, a transfer, promotion, demotion or termination of employment or other disciplinary action;

(4) damage or harm resulting from airborne contaminants not commonly found in the Company's normal working environment, including, but not limited to, pollen, fungi, and mold;

(5) damage or harm resulting from job stress;

(6) any heart attack, stroke, or aneurysm (an "attack"), unless--

(A) the attack can be identified as --

(i) occurring at a definite time and place; and

(ii) caused by a specific event related to and occurring in the Course and Scope of Employment;

(B) the preponderance of the medical evidence regarding the attack indicates that the Participant's work rather than the natural progression of a preexisting heart condition or disease was a substantial contributing factor of the attack; and

(C) the attack was not triggered solely by emotional or mental stress factors, unless it was precipitated by a sudden work-related stimulus;

(7) hernia, unless such hernia is an inguinal hernia that --

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(A) appeared suddenly and immediately following the Injury;

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

(C) was accompanied by pain; or

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

(A) coverage for such aggravation will be provided only if and to the extent that the Approved Physician -

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

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

(B) no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury. See Appendix B for more information regarding limitations of the Preexisting Condition exclusion;

(c) Non-Covered Injury Circumstances. Furthermore, no benefits shall be payable under the Plan if:

(1) the Participant is not an employee of an Employer or the person's employment is not principally located in the State of Texas;

(2) the Injury occurred while the Participant was in a state of intoxication, or had otherwise lost the normal use of his or her mental or physical faculties as a result of the use of a drug or alcohol. Such intoxication or loss of faculties may be established on the basis of the facts and circumstances of the Injury, the testimony of witnesses, admissions or statements of the Participant, or on such other basis as the Claims Administrator may determine. For this purpose, the Participant shall be deemed to have been in a state of intoxication at the time of the Injury if the drug or alcohol test required by the Employer following the Injury finds a violation of the Employer's Drug and Alcohol Use policy;

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

(4) the Injury was caused by the Participant's willful intention and attempt to injure himself or herself or to injure another person, whether the Participant was sane or insane;

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

(6) the Participant's horseplay, scuffling, fighting, or similar inappropriate behavior was a proximate cause of the Injury;

(7) the Participant's long-term cell phone use, or second-hand smoke was a proximate cause of the Injury;

(8) the Injury was incurred while the Participant was "on suspension," "laid off" by his or her Employer, on a leave of absence for any reason, or otherwise outside of the Course and Scope of Employment;

(9) the Injury arose out of an act of a third person intended to injure the Participant because of personal reasons and not directed at the Participant as an Employee of, or because of his or her employment by, an Employer;

(10} the Injury arose out of a Participant's participation in an off-duty recreational, social or athletic activity not constituting part of the Participant's work-related duties, except where these activities are expressly required in writing by an Employer (more than an invitation or request to participate or attend);

(11) the Injury arose out of an act of God, unless the Participant's employment by an Employer exposes such Participant to a greater risk of Injury from an act of God than ordinarily applies to the general public;

(12) the alleged Injury is feigned or an attempt to defraud the Employer;

(13) the Injury arose out of the Participant's participation in:

(A) a riot or act of civil disturbance;

(B) a war, declared or undeclared;

(C) any act of war or terrorism;

(D) any illegal act;

(E) a felony or an assault, except an assault committed in defense of an Employer's business or property; or

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

(14) any damage or harm arising out of the use of or caused by-

(A) asbestos, asbestos fibers or asbestos products; or

(B) the hazardous properties of nuclear material or biological contaminants;

(15) the Injury arose out of the injured Participant's participation in the commission, or attempted commission, of any crime;

(16) the Injury occurred while the Participant was traveling or flying in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation if the Participant is:

(A) flying in any aircraft that is rocket propelled;

(B) flying in any aircraft that is 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 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; or

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

(17) the Injury did not occur during the Participant's Course and Scope of Employment; or

(18) the Injury was not timely reported (or requested information was not timely provided) in accordance with the timeframes specified under Article IV herein.

1.26 "Maximum Benefit Limit" means the total amount of all benefits payable to, or with respect to, any Participant under the Plan with respect to an Injury. Payments made for each form of benefit shall be counted towards the Maximum Benefit Limit amount. The Maximum Benefit Limit for this Plan is $300,000; provided, however,

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that the aggregate amount of the Maximum Benefit Limits with respect to claims of all Participants arising out of a single Accident, or related series of Accidents, or Occupational Disease or Cumulative Trauma exposure, shall not exceed $1,000,000. Such aggregate amount may proportionally reduce the Maximum Benefit Limit applicable to each Participant involved in such Accident, related series of Accidents, or exposure, in such manner as the Claims Administrator or Appeals Committee may determine.

1.27 "Medical Benefits" means any benefit payable under Section 3.4.

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

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

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

(c) not primarily for the convenience of a Participant, the Participant's family, a physician, or a facility.

Even though a physician may have prescribed a particular treatment, such treatment may not be considered Medically Necessary within this definition or may otherwise be excluded from coverage under the terms of this Plan.

1.29 "Medical Rehabilitation Hospital" means an Approved Facility that:

(a) is licensed;

(b) provides facilities for the diagnosis and inpatient rehabilitative treatment of disease or injury with the objective of restoring physical function to the fullest extent possible. Examples of conditions treated in a rehabilitation hospital are: amputations, spinal cord injuries, head injuries, paraplegia and quadriplegia, cerebrovascular accident, paralysis;

(c) has facilities or a contractual agreement with another hospital in the area for emergency treatment, surgery, and any other diagnostic or therapeutic services that might be required during a confinement;

(d) provides all normal infirmary level medical services required for the treatment of any disease or injury occurring during confinement;

(e) has a staff of physicians specializing in physical medicine and rehabilitation directly involved in the treatment program, one of whom is present at all times during the treatment day;

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(f) is accredited as a medical inpatient rehabilitation hospital by the Joint Commission on Accreditation of Rehabilitation Facilities;

(g) is not a place for rest, the aged, drug addicts or alcoholics, a chronic disease facility, a nursing home or sheltered workshop; and

(h) does not provide as its primary purpose custodial care, treatment of mental disorders, special education, vocational counseling, job training, or social adjustment services. Any identifiable charges for educational, vocational or social adjustment services are not covered under the Plan, unless otherwise provided as a Covered Charge.

1.30 "Medicare" means Title XVIII of the Social Security Act, as amended, and the regulations promulgated thereunder.

1.31 "Modified Duty" means work which is either --

(a) a temporary accommodation that allows an Employee to perform his or her regular job; or

(b) an alternate, temporary job that complies with the Employee's work restrictions and Employer needs.

1.32 "Occupational Disease" means a condition marked by a pronounced deviation from the normal healthy state of a Participant arising out of such Participant's assigned duties in his or her Course and Scope of Employment. Occupational Disease includes other diseases or infections that naturally result from the work-related disease. Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of a Participant's assigned duties in his or her Course and Scope of Employment. Any provision of this Plan to the contrary notwithstanding, if an Employer has obtained an insurance contract or policy described in Section 5.2, the purpose of which (in whole or in part) is to pay Plan benefits to Participants or indemnify the Employer for Plan benefits, then the Participant's last day of last exposure to the condition causing or aggravating such Occupational Disease must have taken place during the contract or policy period.

1.33 "Partial Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury that results in the Participant being -

(a) unable to fully perform the normal duties for which he or she was employed;

(b) under the regular care of an Approved Physician;

(c) released to Modified Duty by such Approved Physician; and

(d) working for the Employer in such a Modified Duty position approved by the Employer.

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In the event it is determined by the Approved Provider that the Participant is subject to permanent work restrictions as a result of the Injury sustained, a review compliant with the Americans with Disabilities Act ("ADA") shall be conducted for the purpose of evaluating the availability of a position within the Participant's permanent restrictions. The existence of a Modified Duty position under this Plan does not imply or create a permanent modified duty position for purposes of the ADA.

1.34 "Participant" means a Covered Employee who satisfies the eligibility requirements of Article II.

1.35 "Plan" means the Reliable Staffing Corporation Occupational Injury Benefit Plan as herein set forth and as it may from time to time be amended.

1.36 "Plan Administrator" means the Company.

1.37 "Plan Year" means a 12 calendar month period beginning each January 1 and ending the following December 31, except that a period of less than 12 months may be a Plan Year for the initial and final Plan Year, and transition to a different 12 month period for the Plan Year.

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

1.39 "Preexisting Condition" means any Participant illness, injury, disease, impairment, or other physical or mental condition, whether or not work-related, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the date that the Employee became a Participant in the Plan.

1.40 "Pre-Injury Pay" means –

(a) for salaried Participants, regular bi-weekly salary from an Employer at the time of the Injury;

(b) for hourly Participants, the average earnings from an Employer for the 13 consecutive weeks immediately preceding the date of Injury; provided, however, that if such a Participant has worked for an Employer for less than 13 consecutive weeks, or if his or her earnings as of such date cannot be reasonably determined (in the judgment of the Claims Administrator), such 13-week average will be based upon the earnings received over such period by a similar employee of the Employer.

"Pre-Injury Pay" shall include pay for overtime and Participant contributions (through salary reduction or otherwise) to a 401(k) arrangement, cafeteria plan, or other pre-tax salary deferral employee benefit plan. "Pre-Injury Pay" shall not include any bonuses, benefits (including, but not limited to, Employer contributions to any employee benefit plans or matching contributions to a retirement plan) or other extraordinary remuneration.

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1.41 "Pre-Service Claim" means any claim for Medical Benefits with respect to which this Plan requires Claims Administrator approval in advance of obtaining medical care.

1.42 "Receipt, Safety Pledge, and Arbitration Acknowledgement" means the form attached hereto as Appendix D.

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

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

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the actual benefit determination;

(c) demonstrates compliance with the Plan's administrative processes and safeguards required for making the benefit determination; or

(d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

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

1.44 "Skilled Nursing Care" means service provided in a Skilled Nursing Facility by a R.N., L.P.N., or L.V.N., provided that the care is Medically Necessary and that the treating Approved Physician has prescribed such care. However, no benefit will be payable under the Plan for the following expenses:

(a) charges for food, housing, or homemaker's services;

(b) charges for the services of a person licensed or unlicensed who ordinarily resides in the Participant's home or is a member of the family of either the Participant or the Participant's spouse or domestic partner;

(c) charges for an illness or injury unrelated to the original hospital confinement; or

(d) charges that do not follow a hospital stay or are incurred when the Participant could otherwise receive services from private duty nursing at home.

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

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(a) provides room and board;

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

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

(d) provides medical social services;

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

(f) provides medical services by staff Approved Physicians;

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

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

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

1.46 "Totally Disabled" or "Total Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury, and commencing within six months from the date of Injury, that:

(a) causes the Participant to be unable to perform the normal duties for which he or she was employed;

(b) causes the Participant to be under the regular care of an Approved Physician; and

(c) causes the Participant to be unable to engage in Modified Duty or any other occupation for wage or profit.

In the event it is determined by the Approved Provider that the Participant is subject to permanent work restrictions as a result of the Injury sustained, a review compliant with the Americans with Disabilities Act ("ADA") shall be conducted for the purpose of evaluating the availability of a position within the Participant's permanent restrictions. The existence of a Modified Duty position under this Plan does not imply or create a permanent modified duty position for purposes of the ADA.

1.47 "Traumatic Event" means any act involving, or of the nature of, a violent crime or any other incident that would result in severe shock to a reasonable person.

1.48 "Urgent Care Claim" shall mean any claim for medical care or treatment with respect to which application of the time periods for making non-urgent Pre-Service

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Claim Determinations (i.e., generally, 15 days after the Claims Administrator's receipt of the claim):

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

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

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

1.49 "Usual and Customary" means a charge that is not more than the amount charged when there is no insurance, and is not more than the prevailing charge in the locality for a like service or supply. A like service is one of the same in nature and duration, requiring the same skill and performed by one of similar training and experience. A like supply is one which is the same or substantially equivalent. Locality is the city or town where the service or supply is obtained, if it is large enough so that a representative cross-section of like services or supplies can be obtained. In large cities, it may be a section or sections of the city, if the above criteria can be met. In smaller urban or rural areas, locality may have to be expanded to include surrounding areas to arrive at a representative cross-section.

1.50 "Wage Replacement Benefits" means any benefit payable under Section 3.1.

ARTICLE II ELIGIBILITY, NATURE OF PAYMENTS AND ARBITRATION OF INJURY-RELATED DISPUTES

2.1 Eligibility. Each Covered Employee shall become a Participant in this Plan as of the later of (a) 12:01 a.m. Central Time, November 1, 2008, or (b) the time and date of his or her employment as a Covered Employee. Except to the limited extent provided under Article III regarding the continuation of certain benefit payments, if a Participant ceases to be a Covered Employee, he or she shall thereupon cease to participate in this Plan; provided, however, that if such Participant is thereafter reemployed as a Covered Employee, he or she shall resume participating in the Plan as of the time and date of such reemployment.

2.2 Nature of Payments.

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

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

2.3 Resolution of Certain Injury-Related Disputes. Each Employer hereby adopts a mandatory company policy requiring that the following claims or disputes must be submitted to mediation, and if necessary, final and binding arbitration under this Section 2.3: (a) any legal or equitable claim or dispute relating to enforcement or interpretation of the arbitration provisions in a Receipt, Safety Pledge, and Arbitration Acknowledgement form or this Section 2.3; and (b) any legal or equitable claim by or with respect to an Employee for any form of physical or psychological damage, harm or death which relates to an Accident, Occupational Disease, or Cumulative Trauma (including, but not limited to, claims of negligence or gross negligence or discrimination; claims for intentional acts, assault, battery, negligent hiring/training/supervision/retention, emotional distress, retaliatory discharge, or violation of any other noncriminal federal, state or other governmental common law, statute, regulation or ordinance in connection with a job-related Injury, regardless of

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whether the common law doctrine was recognized or whether the statute, regulation or ordinance was enacted before or after the effective date of this Plan). This includes all claims listed above that an Employee has now or in the future against an Employer, or an Employer's officers, directors, owners, employees, representatives, agents, subsidiaries, affiliates, successors, or assigns.

This mandatory dispute resolution policy does not, however, include any legal or equitable claim under the Employee Retirement Income Security Act of 1974 (as amended) ("ERISA") for benefits, to remedy a fiduciary breach, or seeking other relief solely relating to benefits payable under this Plan. If an Employee wishes to appeal a denial of benefits under the Plan, such Employee must follow the process described in ARTICLE VI of the Plan. Only after exhausting the appeal process outlined in ARTICLE VI of the Plan may an Employee bring any action challenging a Plan decision or pursuing any other ERISA right of action.

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

(a) Mediation Prior to Arbitration: A party must first seek resolution of a claim or dispute through mediation prior to a request for arbitration.

(b) Required Notice of All Claims:

(1) Mediation. When a party seeks to resolve a claim or dispute through mediation, such party must give written notice of any claim to the American Arbitration Association and the other party. The party requesting mediation must send written notice in triplicate to the American Arbitration Association, Attention: Regional Claims Administrator, 13455 Noel Road, Two Galleria Tower, Suite 1750, Dallas, Texas 75240-6620. If an Employee wishes to seek mediation, the Employee must also send written notice to the Employer, in care of the Manager – Workers' Compensation, Reliable Staffing Corporation 14603 Heubner Rd. Building 8, San Antonio, TX 78230(or such other person or address as the Employer may specify). If the Employer wishes to seek mediation, the
Employer must also give written notice to the Participant at the last address recorded in his or her personnel file.

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(2) Arbitration.

(A) When a party seeks to resolve a claim or dispute through arbitration, such party must give written notice of any claim to the American Arbitration Association and the other party within the applicable statute of limitations. The day the act complained of occurred will be counted for purposes of determining the applicable period. If such notice is not given, the claim shall be void and deemed waived. The party requesting arbitration must send written notice in triplicate to the American Arbitration Association, Attention: Regional Claims Administrator, 13455 Noel Road, Two Galleria Tower, Suite 1750, Dallas, Texas 75240-6620. If an Employee wishes to invoke arbitration, the Employee must also send written notice to the Employer, in care of the Manager – Workers' Compensation, Reliable Staffing Corporation 14603 Huebner Rd. Building 8, San Antonio, TX 78230(or such other person or address as the Employer may specify). If the Employer wishes to invoke arbitration, the Employer must also give written notice to the Employee at the last address recorded in the Employee's personnel file. The party requesting arbitration must specifically identify and describe in the written notice all claims asserted and the facts on which the claims are based. This written notice shall be sent certified or registered mail, return receipt requested. The responding party shall have the ability to file special exceptions with the arbitrator on the basis that the written notice does not satisfy the requirements of this arbitration requirement.

(B) Judicial Review. Any party may file an action in a court of competent jurisdiction to compel arbitration, to enforce an award rendered by the arbitrator, or to vacate an arbitration award. In an action to vacate an award, the standard of review applied to the arbitrator's findings of fact and conclusions of law will be the same as that applied by an appellate court reviewing a decision of a trial court sitting without a jury.

(c) Procedures:

(1) Mediation Procedures: Mediation under this Section shall be handled by a mediator appointed by the American Arbitration Association ("AAA") who is skilled in handling conflicts. The goal of mediation is to develop a solution that satisfies both parties in a way that strengthens the working relationship. The mediator will listen to both sides and will offer creative solutions to the problem. If the parties cannot agree to a solution through a mediator, either party may request arbitration.

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

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

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

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

(d) Payment of Fees and Expenses:

(1) Mediation: The AAA filing fee for mediation shall be equal to the standard employee filing fee specified under the then-current AAA Employment Arbitration Rules and Mediation Procedures. The Employee's share of this fee is $50. The Employer will then pay the remainder of the AAA filing fee. The Employer will also pay the entire mediator's fee and any other AAA administrative expenses. Each party shall be responsible for his, her or its own attorney fees, if any.

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

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

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

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

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

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

(3) If either party pursues a claim covered by this Section by any means other than the dispute resolution provisions of this Plan, the

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responding party shall be entitled to dismissal of such action and to recover all costs and attorney fees and expenses related to such action.

(e) Interstate Commerce and Venue: The Employer is engaged in transactions involving interstate commerce (for example, purchasing goods and services from outside Texas which are shipped to Texas, and providing goods to customers from other states) and the Employee's employment involves such commerce. The Federal Arbitration Act shall govern the interpretation, enforcement, and proceedings under the arbitration provisions of this Plan. Unless contrary to applicable law, any lawsuit seeking to enforce or vacate an arbitration award shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

(f) Binding Effect of Arbitration: This provision for resolving claims by arbitration is equally binding upon, and applies to any such claims that may be brought by, an Employer and each Employee and the Employee's spouse, domestic partner, children, stepchildren, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns. This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.

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

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

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ARTICLE III

BENEFITS

Participants shall be entitled to receive under this Plan the benefits described in this Article III with respect to any Injury incurred (i) in the Course and Scope of Employment by an Employer, and (ii) during his or her participation in this Plan.

3.1 Wage Replacement Benefits.

(a) Total Disability: From the first full day of an injured Participant's Total Disability, the Plan shall pay Wage Replacement Benefits equal to 90% of the injured Participant's Pre-Injury Pay.

(b) Partial Disability: From the first full day of an injured Participant's Partial Disability, the Plan shall pay Wage Replacement Benefits equal to 90% of the portion of the injured Participant's Pre-Injury Pay that the Participant is unable to earn (due to the Approved Physician's restrictions) while working Modified Duty.

(1) If a Participant with a Partial Disability is released to Modified Duty, but (i) the Company has no Modified Duty position available, and (ii) an Approved Physician has not assigned permanent restrictions and released the Participant to any other gainful employment, then the Participant shall be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified in subsection (a) above.

(2) If a Participant with a Partial Disability has made a good faith effort to comply with the treating Approved Physician's instructions and carry out the Participant's responsibilities in the Modified Duty position, but is either:

(A) again determined by an Approved Physician to be Totally Disabled, or

(B) the Modified Duty position ceases to be available (for example, the position reaches its maximum duration) and an Approved Physician has not assigned permanent restrictions and released the Participant to any other gainful employment;

then the Participant will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified in subsection (a) above.

(c) **Payment Terms and Other Limitations:** An Approved Physician must make the determination regarding whether a Participant is Totally Disabled or Partially Disabled, except to the extent that such determination is made in conjunction with Emergency Care as determined by the Claims Administrator.

Wage Replacement Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week shall be prorated. Only the Participant's normal, scheduled workdays shall be considered in calculating benefits (based upon his or her employment status as of the date of Injury). Wage Replacement Benefits shall be reduced as described in Article VII.

(d) When Wage Replacement Benefits Cease: Wage Replacement Benefits shall continue until the earliest of:

(1) the expiration of 120 weeks from the date of the Injury. This 120-week maximum period for Wage Replacement Benefits is calculated continuously from the date of the Injury, regardless of whether or not the Participant qualifies as Disabled at all times during such period or receives Wage Replacement Benefits continuously throughout such period;

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

(3) the date that the Maximum Benefit Limit is met;

(4) termination of both the Participant's status as a Covered Employee <u>and</u> all other employment of the Participant with an Employer; provided, however, that this paragraph (4) shall not apply if termination of employment is solely due to -

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

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

(5) the date the Participant is placed in jail, is deported or detained by or at the request of any government agency or foreign government, has left the local area for an extended period of time, or is similarly unavailable for work; provided, however, that this paragraph (5) shall operate to cease Wage Replacement Benefits only for such period of time that such Participant is unavailable tor work; or

(6) as otherwise provided under Section 4.3.

3.2 Death Benefits. In the event that a Participant dies as the direct and sole result of, and within 365 days of, an Injury, then the Plan shall pay such Participant's Beneficiary a Death Benefit equal to $200,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Maximum Benefit Limit. The Death Benefit shall be paid to the Participant's Beneficiary as follows: (i) 20% of the Death Benefit shall be paid in a lump sum cash payment as soon as administratively possible following the death of the Participant and the determination of the proper Beneficiary; and (ii) the remainder of the Death Benefit shall be paid in 35

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equal monthly installments (without interest), commencing on the first day of the month following the initial lump sum payment. Death Benefits payable under this Plan shall be in addition to Medical Benefits, Wage Replacement Benefits, and Dismemberment Benefits payable to, or with respect to, the Participant; provided, however, that no interest in future Dismemberment Benefits survives after a Participant's death which results in the payment of benefits under this Section 3.2. In addition to the Death Benefits set forth above, the Plan shall reimburse reasonable burial expenses to any person who incurs liability therefor, up to $6,000.

3.3 Dismemberment Benefits. In the event a Participant suffers a loss described in the Schedule of Losses below as the direct and sole result of, and within 365 days of, an Injury, then the Plan shall pay the Participant an amount equal to the applicable percentage from the schedule below times $200,000; provided, however, that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Maximum Benefit Limit. The Dismemberment Benefit shall be paid as follows: (i) 20% of the Dismemberment Benefit shall be paid in a lump sum cash payment as soon as administratively possible following the date of loss; and (ii) the remainder of the Dismemberment Benefit shall be paid in 35 equal monthly installments (without interest), commencing on the first day of the month following the initial lump sum payment.

SCHEDULE OF LOSSES

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

(a) If the Participant suffers more than one Injury described above from any one Accident, related series of Accidents, or Occupational Disease or Cumulative Trauma exposure only one of the applicable Dismemberment Benefits listed above, the largest single amount, will be payable with respect to such Accident or exposure.

{b) Total and permanent loss of use of a member of the body is the same as loss of such member. Prior to payment of the benefit, loss of use must be certified following the care of an Approved Physician for 12 straight months from the date the loss of use began. At the end of this time it must be medically determined by an Approved Physician that the loss of use is total and not reversible.

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

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

{e) Dismemberment Benefits shall be in addition to Wage Replacement Benefits and Medical Benefits; provided, however, that payment of Dismemberment Benefits will cease in the event of the death of the Participant which results in the payment of Death Benefits.

3.4 **Medical Benefits.** Subject to the medical management and other provisions of this Plan, the Plan shall pay Medical Benefits to, or with respect to, a Participant for an Injury in an amount equal to all Covered Charges; provided, however, that Medical Benefits shall cease upon the earliest of:

{a) the expiration of 120 weeks from the date of an Injury;

{b) reaching the Maximum Benefit Limit;

{c) involuntary termination of employment of the Participant with an Employer for Gross Misconduct;

{d) the Participant's not receiving medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days; or

(e) as otherwise provided under Section 4.3.

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ARTICLE IV

ADDITIONAL REQUIREMENTS AND LIMITATIONS ON BENEFITS

4.1 Reporting. The Participant must report every incident or fact that the Participant believes results, or might reasonably be expected to result, in an Injury in accordance with the following requirements:

(a) Notice of Injury: The Participant (or a person acting on his or her behalf) must provide verbal notice immediately after being injured at work to his or her supervisor, no matter how minor the Injury appears to be. For Injury due to an Accident, or for a known exposure to an Occupational Disease, verbal notice must be provided within 24 hours of the time of the Injury. For an actual Injury due to Occupational Disease or Cumulative Trauma, verbal notice must be provided within 24 hours after being medically diagnosed or within 30 days after the Participant should have known of the Injury, whichever is earlier.

(1) With respect to reporting an Injury due to Occupational Disease or Cumulative Trauma, if an Employer has obtained an insurance contract or policy described in Section 5.2, the purpose of which (in whole or in part) is to indemnify Participants or the Employer for Plan benefits, then the notice of Injury due to Occupational Disease or Cumulative Trauma must in all events be provided not later than 35 months after the end of the policy period.

(2) No benefits will be payable under the Plan if notice is not provided as required above, unless the Claims Administrator determines that good cause exists for failure to give notice in a timely manner. In addition to the foregoing, the Participant must also notify his or her supervisor (verbally or in writing) of expected recovery time immediately after receiving primary medical treatment, and after each succeeding appointment with the treating Approved Physician.

(b) Providing Required Information: An injured Participant (or a person acting on his or her behalf) and such Participant's supervisor then on duty (or such other person as the Claims Administrator may specify) must complete such Injury report, investigation, and authorization forms, file such written statements, provide such recorded statements (whether sworn or unsworn), and provide such proof and demonstrations (relating to the Injury or any prior or subsequent damage or harm suffered by the Participant, in or out of the Course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may from time to time direct. The written incident report must be provided within 24 hours after the Injury is reported. No benefits will be payable under the Plan if all information is not provided as required above, unless the Claims Administrator determines that good cause exists for failure to provide such information in a complete and timely manner.

4.2 Medical Management.

(a) Use of Approved Providers: Requirements for the use of Approved Physicians and Approved Facilities are found in the "Covered Charge" definition of this Plan. If necessary, the Claims Administrator will assist a Participant in arranging for appropriate medical treatment from an Approved Physician or Approved Facility. A Participant does not have the right to select and have the Plan pay for his or her choice of a primary care provider or provider of specialty medical care, even if such a provider is an Approved Physician or Approved Facility.

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

(c) Initial Treatment and Denial: Any provision of this Plan to the contrary notwithstanding, an Employer may render First Aid, or the Plan may pay for Emergency Care, pay Wage Replacement Benefits or pay for a medical evaluation or treatment of a Participant, and the Plan can still make a subsequent determination that the Participant has not suffered a covered Injury or otherwise deny any or all further benefits under the provisions of this Plan.

(d) Medical Provider Referrals: If the treating Approved Physician finds it necessary to refer a Participant to another healthcare provider, the treating Approved Physician must notify such Participant and the Claims Administrator of his or her desire to make the referral and the objectives of such referral. The Claims Administrator will provide advance approval or disapproval of all referrals (and may rescind any such approval at any time) based upon such criteria as the Claims Administrator may determine for the effective administration of the Plan. It is the Participant's responsibility to determine the status of any such approval or disapproval, and the expense of services or supplies relating to any disapproved referral shall be solely the responsibility of the Participant.

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(e) No Interference with Patient-Provider Relationship: Although benefits under this Plan are conditioned on a Participant's use of only Approved Physicians and Approved Facilities, a Participant remains entitled to seek any medical care he or she deems appropriate from any provider of his or her choice at his or her expense. However, expenses for such medical care shall not be payable under the Plan and the Participant's use of a non-approved physician or facility may result in a complete denial or termination of Plan benefits. The Employer, Claims Administrator, and Appeals Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other healthcare services provided by any Approved Physician, Approved Facility or other designated healthcare service provider. Healthcare providers are not agents of the Plan, Employer, Claims Administrator, or Appeals Committee. The Plan, Employer, Claims Administrator, or Appeals Committee is not liable or responsible for the acts or omissions of any healthcare provider. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of the attending Approved Physician and other healthcare providers based on their independent judgment for the provision of health care.

(f) Professional Medical Review and Quality/Efficiency Features: The Claims Administrator shall have the discretion to assign Approved Physicians and other healthcare providers or firms to a Participant's case in order to (i) coordinate and expedite medical treatment of the Participant, in consultation with the treating Approved Physician, (ii) facilitate such case management, quality, and efficiency measures and procedures as the Claims Administrator deems appropriate, based upon particular facts and circumstances, and (iii) review the propriety of any and all treatment, services, and supplies, including charges for such treatment, services, and supplies. Without limiting the generality of the foregoing, the following case management, efficiency, quality control and cost containment features may be utilized under the Plan, at the direction of the Claims Administrator, to help ensure that healthcare services are being provided effectively and efficiently:

(1) Fee Schedules: No cost shall be a Covered Charge to the extent that it exceeds the charge specified in any fee schedule approved or adopted by the Claims Administrator. In the event such charge is not listed in such a fee schedule, the charge shall not be considered a Covered Charge to the extent it exceeds the Usual and Customary charge.

(2) Alternative Health Care Facilities: Use of Approved Facilities other than hospitals, including surgicenters, Skilled Nursing Facilities, and Home Health Care Agencies;

(3) Concurrent Review: A review by designated healthcare personnel that utilizes Approved Physician-developed criteria and standards for determining the appropriateness of reimbursement for initial or continued treatment or hospital confinement;

(4) Cost-Saving Techniques: Such techniques include not admitting to hospitals on weekends whenever possible and obtaining second opinions before surgery if deemed advisable by the Approved Physician or the Claims Administrator;

(5) Pre-Admission Evaluation: A review made by healthcare personnel to (i) determine whether each Approved Facility admission is Medically Necessary, and (ii) evaluate the number of days for an inpatient Approved Facility confinement that would be considered reasonably necessary for the care and treatment of the diagnosed Injury;

(6) Pre-Admission Testing: Routine diagnostic, x-ray and laboratory examinations performed within three days of a scheduled Approved Facility confinement (these tests must be performed at the same Approved Facility where such confinement is to occur);

(7) Utilization Review: A review made by designated healthcare personnel to consider, in accordance with established medical criteria, requests from Approved Physicians for medical procedures, tests or other services prior to the provision of such requested services to determine whether they are Medically Necessary, the specific benefit of the services for the Participant, and any alternative means to provide such services;

(8) Nurse Case Managers: The Claims Administrator may assign a nurse case manager or other healthcare professional to monitor services provided or requested on behalf of a Participant, and to otherwise assist the Claims Administrator or the Participant with his or her return to work; and

(9) Referral to Specialty Providers: The Claims Administrator may direct any Participant to an Approved Physician or other healthcare provider who is recognized to be a specialist with the type of condition for which the Participant may need assistance.

(g) Second Medical Opinions. The Plan reserves the right to require a second medical opinion from an Approved Physician selected by the Claims Administrator for purposes of obtaining an Independent Medical Evaluation (IME) or for any other reason relating to the payment of Medical Benefits, Wage Replacement Benefits, or any other benefits under this Plan. If a Participant refuses to be examined by an Approved Physician selected by the Claims Administrator for the second opinion, all benefits under the Plan shall be suspended.

(1) The Claims Administrator will weigh the findings of the treating Approved Physician and the Approved Physician providing the second opinion and make a benefit determination under the Plan.

However, if the Participant is in disagreement with the diagnosis or treatment recommended by the Approved Physician whose opinion is accepted by the Claims Administrator ("Physician A"), then the Participant may request a second medical opinion. The Participant must notify the Claims Administrator in advance of receiving any second medical opinion in order for this opinion to be considered by the Plan. If the Participant provides advance notice to the Claims Administrator, then the Participant shall have the right to a one-time examination at his or her own expense by another physician ("Physician B"). This examination by Physician B shall be solely for the purpose of evaluating the Participant's condition and making a treatment recommendation.

(2) If the diagnosis and treatment recommended by Physician B is contrary to that of Physician A, then the Claims Administrator shall designate a peer review physician who will evaluate the medical records and advise the Claims Administrator, and who may designate another Approved Physician for a further medical examination. If the Participant refuses to be so examined, all benefits under the Plan may be suspended. The diagnosis and/or recommended treatment of the peer review physician or this last Approved Physician will be controlling. The fees and related expenses of the peer review physician and this last Approved Physician will be paid by the Plan (although the Participant shall have the option of paying up to one-half of such fees and expenses).

(h) Use and Disclosure of Protected Health Information. See Appendix A attached hereto.

4.3 Suspension or Termination of Benefits. The Claims Administrator may deny a claim for, or suspend or terminate the payment of, Plan benefits otherwise due a Participant if:

(a) the Participant refuses to submit to drug and/or alcohol testing in accordance with the Employer's Drug and Alcohol Use policy, or refuses to provide the Company and its designated representatives with (or access to) drug and/or alcohol testing information related to an Injury;

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

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

(d) the Participant refuses to submit to examination by an Approved Physician selected by the Claims Administrator (other than the treating Approved Physician) as required by the Claims Administrator with respect to any surgical procedure or other diagnosis or treatment opinion rendered by the treating

Approved Physician for which the Claims Administrator considers a second medical opinion advisable;

(e) the Participant is persistently nonresponsive to treatment, including, but not limited to, nonresponsiveness due to the need for Participant behavioral modification recommended by the treating Approved Physician;

(f) the Participant fails to provide accurate information to, or fails to follow the directions of, a treating Approved Physician. Following the directions of a treating Approved Physician includes, but is not limited to, any recommended treatment, therapy, course of action, abstinence, or rehabilitation program;

(g) the Participant fails to keep, or is late for, a scheduled appointment with a healthcare provider. Except in extraordinary circumstances as determined by the Claims Administrator, a first missed appointment shall result in a warning and/or suspension of benefits and a second missed appointment shall result in a termination of benefits;

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

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

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

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

(I) the Participant has been untruthful in regard to any aspect of the required information supplied as part of the injury reporting or employment process;

(m) the Participant is untruthful or otherwise fails to cooperate fully with the Claims Administrator (including, but not limited to, failure to comply with the provisions of Section 4.1(b)) or demonstrates bad faith in connection with the administration of the Plan, including, but not limited to, subrogation or coordination of benefits procedures; or

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

4.4 Final Compromise and Settlement. At the Claims Administrator's option within 120 weeks after the date of Injury, and at any time thereafter if the Claims Administrator elects to extend such 120-week period after the date of Injury, the Claims Administrator may notify the Participant of the Plan's intention to be released from any further known and unknown benefit and all other injury-related claims by such Participant and pay a final claim settlement to, or with respect to, such Participant in exchange for the Participant's agreement to a release of liability in favor of the Plan, Employer, Claims Administrator, Appeals Committee, and other interested parties with respect to such claims. In that event, the Claims Administrator may appoint an actuary, appraiser, and/or Approved Physician to investigate, determine, and capitalize such claims, or use such other valuation method as the Claims Administrator may specify. The payment by the Plan and/or Employer of the value of such claims (as finally determined by the Claims Administrator) shall be made in such manner as the Claims Administrator may determine. No additional claims will be subsequently accepted with respect to such Injury. Any actuary or appraiser shall apply such rules, standards, and assumptions (present value discount, inflation, and mortality rates, etc.) as the Claims Administrator may determine. The Participant must cooperate and provide all information, sign such forms and agreements, and submit to all medical examinations as may be requested by the Claims Administrator to arrive at a valuation and settlement of the Participant's claims. No further benefits will be payable to, or with respect to, a Participant who fails or refuses to accept the Claims Administrator's claim valuation, sign the release agreement presented by the Claims Administrator, or otherwise comply with the requirements of this Section or other provisions of the Plan. Prior or subsequent to the Claims Administrator's evaluation and determination of the value of a Participant's claims, the Claims Administrator may determine not to capitalize and satisfy any such claim as described above and instead to continue eligibility for benefit payments and defer the above valuation and settlement.

ARTICLE V

ADMINISTRATION

5.1 Plan Administrator.

(a) Administrator: The Company shall be the Plan Administrator and named fiduciary of the Plan. The Plan shall be administered on behalf of the Company and all other Employers by the Claims Administrator and Appeals Committee. The Claims Administrator or an individual member of the Appeals Committee so appointed shall serve in such office until his or her death, resignation, or removal by the Company. The Company may change the Claims Administrator or Appeals Committee with or without cause at any time, and may modify the membership of the Claims Administrator or Appeals Committee positions at any time and from time to time. The Claims Administrator and

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Appeals Committee shall keep such records of their proceedings and acts as they deem to be necessary or appropriate for the purposes of the Plan. The Claims Administrator and Appeals Committee shall cause such information, documents or reports to be prepared, provided and/or filed as may be necessary to comply with the provisions of ERISA, or any other applicable law. The members of the Appeals Committee shall receive no remuneration from the Plan for their services as the Appeals Committee. The Plan shall operate and keep its records on the basis of the Plan Year.

(b) Administrative Authority: Subject to the Plan claims procedures, the Claims Administrator and Appeals Committee shall have discretionary and final authority to interpret and implement the provisions of the Plan, including, but not limited to, making all factual and legal determinations, correcting any defect, reconciling any inconsistency and supplying any omission, and making any and all determinations that may impact a claim for benefits hereunder. The Claims Administrator and Appeals Committee shall perform all of the duties and may exercise all of the powers and discretion that the Claims Administrator and Appeals Committee deem necessary or appropriate for the proper administration of the Plan, and shall do so in a uniform, nondiscriminatory manner. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter. Every interpretation, choice, determination or other exercise by the Claims Administrator or Appeals Committee of any power or discretion given either expressly or by implication to it shall be conclusive and binding upon all parties having or claiming to have an interest under the Plan or otherwise directly or indirectly affected by such action, without restriction, however, on the right of the Claims Administrator or Appeals Committee to reconsider and redetermine such action. There shall be no de novo review by any arbitrator or court of any decision rendered by the Appeals Committee and any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion. The Claims Administrator and/or Appeals Committee may adopt such rules and procedures for the administration of the Plan as are consistent with the terms hereof.

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

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responsibilities pursuant to this Plan shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of the Plan.

5.2 Funding Policy and Method. All benefits payable to or with respect to a Participant under this Plan shall be paid or provided for by the Employer who was the employer of such Participant at the time of his or her Injury. Unless provided by a trust established pursuant to the Plan, said benefits shall be paid by such Employer at the direction of the Claims Administrator or Appeals Committee or its designated representative solely out of the general assets of such Employer. The Employers shall have no obligation to establish any fund or trust for the payment of benefits under this Plan. An Employer shall have no obligation, but shall have the right, to obtain insurance contracts or policies with one or more insurers to provide funds to the Employer that can be used, if the Employer so desires in its sole discretion, to pay all or any portion of a benefit payable under this Plan but no benefits under the Plan are guaranteed under any contract or policy of insurance and the Employer of the Participant shall be solely responsible for the payment of claims hereunder. Any such funds shall not be considered "plan assets" for purposes of ERISA and shall constitute a part of the general assets of the Employer. Any such insurance contract or policy shall be owned by, and (unless contrary to legal requirements adhered to by the insurer) all amounts shall be payable thereunder to, the Employer that applied for the contract or policy, and no Participant shall have any interest in, or right to, any amounts payable under the contract or policy. As a condition to the receipt of benefits under this Plan, and unless otherwise prohibited by law, the Claims Administrator may require a Participant to sign a form prescribed by the Claims Administrator which will serve to assign all or a portion of any benefits payable under such an insurance contract or policy to the Employer that applied for the contract or policy. If, notwithstanding the provisions of this Section 5.2, any insurance benefits are paid directly by an insurance company to a Participant or Beneficiary with respect to an Injury covered under this Plan, such payments shall be deemed to be made under this Plan by an Employer or shall otherwise be subject to the coordination of benefits provisions of Section 7.2, as determined by the Claims Administrator.

ARTICLE VI CLAIMS

PROCEDURES

6.1 Filing a Claim for Benefits. A claim for Medical Benefits, Wage Replacement Benefits, or Dismemberment Benefits under the Plan shall be initiated by a Participant by (i) complying with the notice requirements of Section 4.1, and (ii) submitting to medical treatment in accordance with Section 4.2. A claim for Medical Benefits can also be directly submitted by a healthcare professional to the Claims Administrator on behalf of a Participant. A claim for Death Benefits under the Plan shall be initiated by a Beneficiary providing notice of entitlement thereto to the Claims Administrator within 90 days after the date of the Participant's death.

(a) What is a Claim-Each (i) medical service or supply for which payment is requested, (ii) Wage Replacement Benefit for a particular payroll

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

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

(c) Information to Submit-Claims must include the information required by Section 4.1(b) and such other reasonable information requested by the Claims Administrator, such as medical records or a written statement from an independent service provider evidencing the date, type of services rendered, and the total cost of such services. In addition, the Claims Administrator may require the claimant to provide a written and signed statement which provides that the Covered Charge has not been reimbursed, or is not reimbursable under any other plan or program. Further, the Claims Administrator may also request that the claimant file all appropriate claims and requests for payment from any other plan or program maintained by the claimant prior to making any payments under this Plan. See ARTICLE VII on "Coordination of Benefits and Subrogation." The Claims Administrator may rely upon all such information furnished by the claimant, including the claimant's current mailing address, and shall have no obligation or duty to locate a claimant.

(d) Submission of Medical Bills for Payment-Approved Physicians and Approved Facilities will be requested to invoice all healthcare-related charges directly to the Claims Administrator (or an Employer, which shall immediately transmit such invoice to the Claims Administrator). However, in the event that a Participant receives such an invoice or pays such a charge, all requests for payment or reimbursement of Covered Charges must be filed with the Claims Administrator within 30 days from the date such expenses are incurred or, if later, the date such Participant receives an invoice from an

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Approved Physician, Approved Facility, or other healthcare provider (in the case of Emergency Care) for such expenses.

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

6.2 Claims Review.

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

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

(A) The Claims Administrator shall notify the claimant as soon as possible, but not later than 24 hours after its receipt of the claim, of the procedure to follow or the specific information necessary to complete the claim. Notification may be oral, unless the claimant requests a written notice. This notice requirement shall only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

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

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

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

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

(B) For an Urgent Care Claim, any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan shall be decided as soon as possible, taking into account the medical exigencies of the claim. The Claims Administrator shall make an initial benefit Determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made 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).

(C) For a non-Urgent Care Claim, any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan 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).

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

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

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

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

(4) Post-Service Medical Benefit, Wage Replacement Benefit, Death Benefit, and Dismemberment Benefit Claims - In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, Death Benefits or Dismemberment Benefits, the Claims Administrator shall notify the claimant of an Adverse Benefit Determination within 30 days after its receipt of the claim. The Claims

Administrator may extend this period up to an additional 15 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan. Notice of such extension must be provided to the claimant prior to the expiration of the initial 30-day period and state (i) the special circumstances requiring the extension, and (ii) the date by which the Plan expects to render a decision. If the extension relates to a claim for Wage Replacement Benefits, such notice shall also state (i) the standards on which entitlement to benefits is based, and (ii) unresolved issues that prevent a benefit determination on the claim and what additional information is needed to resolve those issues. If additional information is requested with the extension notice, the claimant shall have 45 days from the date of the notice of extension to provide the specified information. However, the Claims Administrator's timeframe for making a benefit Determination shall be suspended until the date the claimant responds to the request for additional information.

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

(1) Any electronic notice shall satisfy ERISA regulations specifying the standards for electronic disclosure of benefit plan information (including, but not limited to, 29 C.F.R. § 2520.104b-1(c)(i), (iii), and (iv));

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

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

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

(5) If the Adverse Benefit Determination of a Medical or Wage Replacement Benefits claim is based upon medical necessity, an experimental treatment or similar exclusion or limit, the notice shall provide either an explanation of the scientific or clinical judgment for the Adverse Benefit Determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

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(6) The notice shall include a statement that in the case of an Adverse Benefit Determination on review by the Appeals Committee, the Plan offers no further voluntary levels of appeal and the claimant can pursue his or her right to bring an action pursuant to ERISA Section 502(a), 29 U.S.C. § 1132(a);

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

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

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

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

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

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

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

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

(1) The claimant may submit written comments, documents, records, and other information relating to the claim for benefits, and the Appeals Committee shall take all of such information into account when

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reviewing such claim, without regard to whether such information was submitted or considered in the initial benefit Determination;

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

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

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

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

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

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

(2) Non-Urgent Care, Pre-Service Medical Claims - In the case of a Pre-Service Claim for Medical Benefits that is not an Urgent Care Claim, the Appeals Committee shall notify the claimant of the Plan's

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benefit Determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after its receipt of the appeal request. No extension of time is available for Appeals Committee Determinations on the review of Pre-Service Claims for Medical Benefits.

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

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

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

(h) **Exhaustion of Administrative Remedies:** No legal action can be brought by or with respect to a Participant to recover benefits under the Plan before the foregoing claims procedure has been exhausted. Every ERISA right of action by any Participant, former Participant, a Participant's representative, Beneficiary, or the Participant's estate against the Plan or any Plan fiduciary must be brought no later than three (3) years from the date the Employee's employment ended, or from receipt of the Appeals Committee's benefit Determination on review, if earlier, except as otherwise required by ERISA.

ARTICLE VII

COORDINATION OF BENEFITS AND SUBROGATION

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

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

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

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

7.2 Coordination of Benefits. If a Participant is covered under this Plan and one or more other benefit plans, then (unless otherwise subject to Section 7.3) any Medical Benefits and Wage Replacement Benefits payable under this Plan will be either regular benefits or reduced benefits that, when added to the benefits of the other plan(s), will not exceed 100% of the amount described herein. The purpose of this provision is to prevent duplicate payments under plans that would exceed 100% of the benefits described in this Plan. In the coordination of benefits, one of the plans will be designated as the primary plan and the other plans will be designated as secondary. The primary plan will pay its full benefits first, then the secondary plan(s) will pay, but payments will be coordinated so that the total from all plans will not be more than the benefits described in this Plan.

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

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and can be obtained and maintained only because of membership in or connection with a particular organization or group.

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

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

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

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

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

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

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

7.3 **Subrogation and Reimbursement Rights.** For purposes of Sections 7.3, 7.4, and 7.5 of this Plan, the term "Payee" means a Participant or Beneficiary or his, her or its family members, heirs, estate, or other representative (in

their individual or representative capacities), singularly or collectively as the context may require to give the Plan the broadest possible rights of recovery.

(a) Right of Subrogation: If a Payee becomes entitled to or directly or indirectly receives Plan benefits for any Injury caused by the negligence or other act or omission of any person or organization (including, but not limited to, an Employer), and is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury (including, but not limited to, damages for negligence, survival, wrongful death or other legal or equitable action), whether by insurance, litigation, settlement or other proceeding, the Payee shall automatically be required to (i) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation to the extent of the Plan benefits paid to, or with respect to, the Payee and (ii) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation for all medical management, investigation, attorney fees, costs of recovery, and other expenses related to the claim for benefits (including any subrogation proceeding). Acceptance of benefits from this Plan also gives rise to an equitable lien and constructive trust against the net proceeds of any recovery. The subrogation rights of this Plan even apply with respect to a Payee who is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury but has not and will not receive any Plan benefits if such person's claim for damages or other compensation is dependent on whether the Participant had or has a valid claim against a third party.

(b) Written Confirmation: Upon request of the Plan, the Payee shall provide the Plan written confirmation of this subrogation right, including execution of any assignment, lien form or other document requested by the Claims Administrator to enable the Plan to recover such Plan benefits and related expenses. Any failure of a Payee to give written confirmation of the Plan's subrogation rights does not adversely affect its rights of subrogation because the Plan's right of subrogation arises automatically once payment under this Plan is made to or on behalf of the Payee.

(c) Right to Reimbursement: If (i) a Payee fails, refuses or neglects to reimburse the Plan or otherwise comply with the provisions of this Section, or (ii) payments are made under the Plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the Plan, then the Plan shall still have all remedies and rights of recovery specified herein. The Plan shall also have the right to terminate, reduce, or suspend benefit payments and/or recover the reimbursement of all amounts above due to the Plan by withholding, offsetting and recovering such amounts out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such Payee.

(d) Right of Recovery: The Plan shall have the first lien recovery against any benefits paid or to be paid by the Plan. The Plan shall also have the

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right to bring a lawsuit and assert a constructive trust or other interest against any and all persons that have assets to which the Plan can claim rights. The Plan has the right of first recovery from any judgment, settlement or other payment, regardless of whether the Payee has been "made whole."

(e) Attorney Fees and Expenses: The Plan's subrogation rights and first lien will not be reduced by attorney fees or expenses incurred by any party in pursuing recovery against a third party and the "common fund" doctrine shall not apply. Any attorney fees and/or expenses incurred by or at the request of the Payee or his, her or its attorneys in a third party or other action shall be the sole responsibility of such party.

7.4 Notice of Legal Proceedings. A Payee (whether or not such person has received or may in the future directly or indirectly receive Plan benefits) shall provide the Claims Administrator with prior written notice of the involvement of such party in any lawsuit, settlement discussion or other proceeding (for negligence, wrongful death, survival or other cause of action), one of the principal purposes of which is recovering, from any person or organization, damages or other compensation in any way related to any Injury for which Plan benefits have been or may in the future be paid. The Plan shall have the right to intervene for itself and on behalf of a Payee in any such lawsuit, settlement discussion or other proceeding. If a Payee neglects, fails or refuses to seek a recovery from any person or organization for any Injury caused by the negligence or other act or omission of such person or organization, the Plan shall have the right to institute a lawsuit or other proceeding or do any other act that in the opinion of the Claims Administrator may be necessary or desirable to recover the Plan benefits paid (and to be paid in the future), plus all medical management, investigation, attorney fees, costs of recovery, and other expenses incurred by the Plan.

7.5 Assignment of Rights. By participating in this Plan, a Participant obligates himself or herself, as well as all other Payees (in both their individual and representative capacities), to the provisions of this Plan, including, without limitation, Sections 7.3, 7.4, and 7.5 hereof. Upon the request of the Claims Administrator, a Payee shall assign to the Plan the right to intervene in or institute any lawsuit, settlement discussion, or other proceeding described in Sections 7.3 and/or 7.4, and to use the name of such party for such purpose. The Plan shall have the right to select legal counsel of its own choice and such counsel shall have complete control over the conduct of any such lawsuit, settlement discussion, or other proceeding without the consent or participation of any such Payee. Whenever the Plan shall intervene in or institute any lawsuit or other proceeding as permitted by the provisions of this Section, the Plan may pursue the lawsuit or other proceeding to a final determination and the Plan expressly reserves the right to appeal from any adverse judgment or decision. The Payee shall give the Plan all reasonable aid in any such lawsuit, settlement discussion, or other proceeding in effecting settlement, in securing evidence, in obtaining witnesses, or as may otherwise be requested by the Claims Administrator. The Payee shall release the Plan, the Employer, the Plan Administrator, the Claims Administrator, the Appeals Committee, and their respective directors, officers, agents, consultants, attorneys, and employees from all claims, causes of action, damages and liabilities of

whatever kind or character that may directly or indirectly arise out of the pursuit or handling by the Plan of any such lawsuit, settlement discussion or other proceeding.

ARTICLE VIII TERMINATION AND AMENDMENT

The Company shall have the right and power at any time and from time to time to amend this Plan, in whole or in part, on behalf of all Employers, and at any time to terminate this Plan or any Employer's participation hereunder; provided, however, that no such amendment or termination shall alter the arbitration provisions incorporated into the Plan with respect to, or reduce the amount of any benefit payable to or with respect to a Participant under the Plan in connection with, an Injury occurring prior to the date of such amendment or termination. In addition, any such amendment or termination of the arbitration provisions incorporated into the Plan shall not be effective until at least 14 days after written notice has been provided to Plan Participants. Any such amendment or termination shall be pursuant to formal written action of a representative authorized to act on behalf of the Company.

ARTICLE IX GENERAL PROVISIONS

9.1 Inability to Make Payment. In the event an individual becomes entitled to a payment under this Plan and such payment cannot be made (i) because the address provided by the individual is incorrect, (ii) because the individual fails to respond to a notice sent to the address provided by the individual, (iii) because of conflicting claims to such payment, or (iv) because of any other reason, the amount of such payment, if and when made, shall be the amount determined under the provisions of ARTICLE III without interest thereon. If, within two (2) years after any amount becomes payable hereunder to a claimant, the amount shall not have been claimed, provided the Claims Administrator has exercised reasonable diligence in attempting to make such payment, the amount thereof shall be forfeited and shall cease to be a liability of this Plan.

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

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

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

9.5 Discharge for Benefit Payments. If the Claims Administrator determines that a Participant is unable to apply a benefit payment under this Plan in furtherance of his or her own interest and advantage, the Claims Administrator may direct all or any portion of such payment to be made (i) to the guardian of the person, managing conservator or guardian of the estate of the Participant, (ii) to a relative or friend of the Participant, to be expended for the Participant's benefit, (iii) to a custodian for the Participant under any Uniform Gifts to Minors Act, or (iv) to a trust established for the Participant. The Claims Administrator shall not be obligated to see to the proper application or expenditure of any payment so made. Any payment made pursuant to the power herein conferred upon the Claims Administrator or Appeals Committee shall operate as a complete discharge of all obligations of the Plan and the Claims Administrator and Appeals Committee, to the extent of the payments so made.

9.6 Participation by Affiliates. With the consent of the Company, any incorporated or unincorporated trade or business which is a member of a control group (within the meaning of Section 3(40) of ERISA, 29 U.S.C. § 1002(40)) with respect to which the Company is also a member may adopt and become a participating Employer under this Plan.

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

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

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

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

BY ACCEPTING EMPLOYMENT FROM RELIABLE STAFFING CORP. YOU AGREE TO ALL OF THE ABOVE CONDITIONS.

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APPENDIX A

HIPAA PRIVACY

Effective as of April 14, 2003, the Plan is subject to the administrative simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, as set forth in the Plan's Privacy Notice, implemented policies and procedures to protect to the protected health information (PHI) of Plan Participants.

1.1 Use and Disclosure of Protected Health Information CPHI).

(a) The Plan may disclose to the Plan sponsor, Reliable Staffing Corporation. ("Reliable Staffing Corporation"), "summary health information," as that term is defined in the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and Part 164, subparts A and E (the "Privacy Rule"), for the purpose of allowing Reliable Staffing Corporation to: (1) obtain bids from insurers for providing insurance coverage related to the Plan; or (ii) amend or terminate the Plan.

(b) The Plan may disclose a Participant's protected health information ("PHI"), as that term is defined in the Privacy Rule, to Reliable Staffing Corporation if authorized by the individual to make such disclosure in accordance with the Privacy Rule.

(c) Except as provided in provisions (a) and (b) above and subject to the other provisions of the Plan, the Plan may disclose the PHI of a Participant to Reliable Staffing Corporation only as necessary to enable Reliable Staffing Corporation to perform "Plan Administration Functions" on behalf of the Plan.

(d) The term "Plan Administration Functions" shall have the same meaning ascribed to it by the Privacy Rule and shall include those activities that meet the Privacy Rule's definition of "Treatment", "Payment", or "Health Care Operations," or as Required By Law, including, without limitation, activities related to claims processing, auditing, eligibility or coverage decisions, utilization review, billing and collections, coordination of benefits, claims management, quality assurance, case management, and benefit design. Notwithstanding the foregoing, the term "Plan Administration Functions" shall not include any activities related to (i) obtaining premium bids for insurance coverage related to the Plan, and (ii) amending or terminating the Plan. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the Plan.

(e) The Plan will disclose PHI to Reliable Staffing Corporation only upon receipt of written certification from Reliable Staffing Corporation that:

(i) the Plan document has been amended to incorporate the provisions in this Appendix A; and

(ii) Reliable Staffing Corporation agrees to implement the provisions in

Section 1.2.

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1.2 Conditions Imposed on Reliable Staffing Corporation. Reliable Staffing Corporation agrees:

(a) Not to use or disclose PHI other than as permitted or required by this Appendix A or as Required By Law;

(b) To ensure that any agents, including a subcontractor, to whom Reliable Staffing Corporation provides PHI received from the Plan agree to the same restrictions and conditions that apply to Reliable Staffing Corporation with respect to PHI received or created on behalf of the Plan;

(c) Not use or disclose an Individual's PHI for employment-related actions and decisions unless authorized by the Individual;

(d) To report to the Plan any use or disclosure of PHI that is inconsistent with this Appendix A, if it becomes aware of an inconsistent use or disclosure;

(e) To provide Individuals with access to PHI in accordance with 45 C.F.R. § 164.524;

(f) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

(g) To make available the information required to provide an accounting of disclosure in accordance with 45 C.F.R.§ 164.528;

(h) To make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

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

0) To ensure adequate separation between the Plan and Reliable Staffing Corporation.

1.3 Designated Employees Who May Receive PHI. In accordance with the Privacy Rules, only certain Employees who perform Plan Administrative Functions may be given access to PHI. Those Employees who have access to PHI from the Plan are listed in the Privacy Notice, either by name or individual position. The Employees who have access to PHI listed in the Privacy Notice may only use and disclose PHI for Plan Administration Functions that Reliable Staffing Corporation performs for the Plan, as set forth in the Privacy Notice.

1.4 Policies and Procedures. Reliable Staffing Corporation has implemented policies and procedures setting forth operating rules to implement the provisions

hereof.

1.5 Privacy Official. The "Privacy Official" for the Plan shall be the Vice President, Benefits of Reliable Staffing Corporation.

1.6 Hybrid Entity Designation. The Plan is hereby designated as a "Hybrid Entity." The following Benefits are designated as "Covered Functions" as defined under 45 C.F.R. § 164.501:

{a) Medical Benefits

(b) Dental Benefits

In addition to the above listed, the Plan Administrator may from time to time determine, as its exclusive discretion, other Benefits to constitute Covered Functions under the Privacy Rules.

1.7 Organized Health Care Arrangement. It is intended that the Plan may form part of an Organized Health Care Arrangement with other HIPAA-covered benefits offered by Reliable Staffing Corporation.

1.8 Security of Electronic PHI. The Plan shall comply with this Appendix A with the "Standards for the Protection of Electronic Protected Health Information" ("HIPAA Security Rules"), as specified under 45 C.F.R. Part 164, Subpart C.

1.8 HIPAA Definitions. As used in this Appendix A, each of the following capitalized terms shall have the respective meaning given below:

"Hybrid Entity" means hybrid entity as defined in 45 C.F.R. §164.504(a).

"Individual" means the person who is the subject of the health information created, received, or maintained by the Plan or Reliable Staffing Corporation.

"Organized Health Care Arrangement" means organized health care arrangement as defined in 45 C.F.R. § 164.501.

"Privacy Notice" means the notice of the Plan's privacy practices distributed to Plan participants in accordance with 45 C.F.R. § 164.520.

"Privacy Rules" means the privacy provisions of HIPAA and the regulations in 45 C.F.R. Parts 160 and 164.

"Protected Health Information (PHil" means protected health information as defined in 45 C.F.R. § 164.501.

"Required by Law" means required by law as defined in 45 C.F.R. § 164.501.

APPENDIX B

NOTICE OF PREEXISTING CONDITION EXCLUSION AND CREDITABLE COVERAGE RIGHTS

The Plan imposes a Preexisting Condition exclusion. This means that a Participant will not be eligible for Medical Benefits coverage for any Preexisting Condition until the Participant has been continuously eligible for the Plan for twelve (12) months. For purposes of this exclusion, a "Preexisting Condition" is considered to be any illness, injury, disease, impairment or other physical or mental condition, whether or not work-related, for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the Participant's first day of Plan coverage.

The Preexisting Condition exclusion will not apply to pregnancy. In addition, a Participant can reduce the length of this exclusion period by the number of days of any prior "creditable coverage" that he or she has had under any previous similar non-subscriber health coverage. This creditable coverage can be used to reduce the Plan's Preexisting Condition exclusion as long as the Participant has not experienced a break in coverage of at least 63 consecutive days. To reduce the Plan's 12-month Preexisting Condition exclusion period by any creditable coverage that the Participant may have, he or she must provide a copy of any certificates of creditable coverage he or she has to the Plan's Claims Administrator. If the Participant does not have a certificate of creditable coverage, but does have prior nonsubscriber health coverage, the Claims Administrator can help the Participant obtain a certificate of creditable coverage from the prior plan or issuer. There are also other ways that the Participant can show that he or she have creditable coverage.

Please note, however, that a reduction or elimination of the Preexisting Condition limitation under this Plan does not prevent the Plan from otherwise determining in accordance with the terms of the Plan that Plan benefits are not payable – including, but not limited to, a determination that your Preexisting Condition did not arise from your Course and Scope of Employment with the Company.

All questions about the Plan's preexisting condition exclusion and creditable coverage requirements should be directed to the Plan's Claims Administrator c/o Manager – Workers' Compensation, Reliable Staffing Corporation, 14603 Huebner Rd. Building 8, San Antonio, TX 78230, or call 210-530-9675.

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APPENDIXC

COBRA CONTINUATION COVERAGE

NOTICE: The following provisions have been provided for purposes of complying with the Consolidated Omnibus Budget Reconciliation Act of 1985. as amended ("COBRA"). Please note. however. that group health benefits provided under the Plan are limited to treatment of injuries which are sustained during the Course and Scope of Employment with an Employer. Therefore.continuation of group health coverage would not be practical If a Participant experienced a termination of employment with the Company for whatever reason.

In addition.if a Participant has a covered Injury during his or her employment with an Employer.the Plan would continue to provide the Participant with health benefits for that Inlurv following his or her termination of employment (subject to the terms and limits in this Plan). unless such employment was terminated based upon Gross Misconduct (as defined in Section 1.22 of the Plan). Therefore. termination of employment in this situation would not constitute a "Qualifying Event" under COBRA because the termination does not result in a loss of coverage under the Plan.

Finally, the Plan does not provide coverage for dependents. Therefore, any continuation coverage provided under COBRA with respect to dependents would not be applicable to this Plan.

1.1 Right to COBRA Coverage. A Participant who is a Qualified Beneficiary (as hereafter defined) will have the right to continue health coverage under the terms of the Plan, as limited by this Appendix, if such Participant experiences a Qualifying Event (as hereafter defined). To the extent required by Federal law, the Plan Administrator or its duly authorized representative shall provide each Participant written notice of his or her right to apply for continued coverage. Such notice will be provided by the Plan Administrator or its duly authorized representative immediately following commencement of participation in the Plan and within 14 days following the later of (i) the date of the Qualifying Event or (ii) the date that the Administrator receives notice of a Qualifying Event (provided notice is given to the Administrator within the timeframe required by law). Notification in any form and manner permitted by COBRA shall be deemed to satisfy this requirement.

1.2 Individual Election of Coverage. Each Qualified Beneficiary will have an independent right to elect continued coverage under the Plan on his or her behalf. A Qualified Beneficiary can also elect to continue coverage under the Plan on behalf of any other Qualified Beneficiary that resides at the same address.

1.3 Election Deadline.

(a) General Rule. An election to continue coverage under the Plan must be made by such means of making an effective election as established by the

COBRA Administrator. Such election must be made with the COBRA Administrator within 60 days following the later of (i) the date coverage ends because of the Qualifying Event, or (ii) the date on which the Qualified Beneficiary received notification of the right to continue coverage. Failure to elect continued coverage within that 60 day period will mean a permanent loss of the Qualified Beneficiary's right to continue coverage under this Article.

(b) Election After Waiver. If a Qualified Beneficiary waived continuation coverage rights, the Qualified Beneficiary can revoke the waiver and elect continuation coverage at any time during the 60 day period described in paragraph (a) of this Section by making an affirmative election in the manner established by the COBRA Administrator.

1.4 Date Continued Coverage Begins. If a Qualified Beneficiary elects coverage in accordance with Section 1.3, the Qualified Beneficiary's continued coverage will begin on the date that coverage otherwise would have ceased, provided the Qualified Beneficiary timely pays the premium as required in Section 1.6. If a Qualified Beneficiary elects coverage in accordance with Section 1.3(b) after a waiver of coverage, such Qualified Beneficiary's continued coverage will start no earlier than the first day of the month in which the Qualified Beneficiary makes the second election (i.e. the affirmative election of coverage) or the day the Qualified Beneficiary makes the second election (i.e. the affirmative election of coverage).

1.5 Cost of Continued Coverage. The person electing continued coverage must pay 102% (up to 150% for a disabled person) of the full cost (employer and employee portions) of such coverage for similarly situated Participants with respect to whom a Qualifying Event has not occurred. The cost of continued coverage will be established prior to the beginning of each Plan Year and may only be changed during a Plan Year as provided in Code Section 4980B-8 and Treasury Regulation Section 54.4980B-8.

1.6 Premium Payment.

(a) Payment Deadline.

(1) Initial Premium. The due date for payment of a Qualified Beneficiary's initial COBRA premium is 45 days from the date of his or her election to continue coverage. Failure to make a timely payment of the Qualified Beneficiary's first premium will result in a permanent loss of the Qualified Beneficiary's continued coverage rights.

(2) Subsequent Premiums. Premium payments subsequent to the initial payment will be due and payable to the Administrator prior to the first day of each month, with a 45-day grace period.

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(b) No Coverage Until Premium Paid. Even though the Qualified Beneficiary has a 45-day period to pay the Qualified Beneficiary's first premium and a 45-day grace period to pay each subsequent monthly premium, a Qualified Beneficiary will not be considered to have continued coverage under the Plan for any period until the Qualified Beneficiary pays the premium with respect to that period. A Qualified Beneficiary's continued coverage will be retroactively reinstated if the Qualified Beneficiary pays the Qualified Beneficiary's premium within the appropriate period described in this Article.

1.7 When Coverage Ends. Continued coverage will end on the earliest to occur of the events described in this Section. Continued coverage will end on the last day of the month in which the event occurs, except in the case of the events described in paragraph (f) under which continued coverage will end on the date of such event.

(a) Maximum Period - General Rule. If a Qualifying Event occurs, coverage terminates 18 months from the date of the Qualifying Event, subject to the exceptions provided in this Section.

(b) Disability Extension. If a Qualifying Event occurs and the Qualified Beneficiary notifies the COBRA Administrator that a determination has been made under Title II or XVI of the Social Security Act that the Qualified Beneficiary was disabled at the time of the Qualifying Event (or at any time during the first 60 days of the 18-month coverage period), an additional 11 months of coverage is available after the normal termination date provided in paragraph (a) (i.e. coverage terminates 29 months from the date of the Qualifying Event), but only if the Qualified Beneficiary has provided timely notice of such determination as required by Section 1.8 before the end of the original 18-month period.

(c) Coverage Under Another Nonsubscriber Plan. Coverage terminates if the Qualified Beneficiary first becomes covered (as an employee or otherwise) after the date of his or her COBRA election under any other nonsubscriber group health plan or Workers' Compensation insurance coverage made available to such individual pursuant to the Texas Labor Code that does not contain any exclusion or limitation (other than an exclusion or limitation that does not apply or is satisfied by such Qualified Beneficiary by reason of Code Section 9801) with respect to any actual Preexisting Condition of such Qualified Beneficiary. Regardless of whether such nonsubscriber plan or Workers' Compensation insurance coverage contains such an exclusion or limitation with respect to an actual Preexisting Condition of the Qualified Beneficiary, coverage will terminate when such exclusion or limitation no longer applies to the Qualified Beneficiary.

(d) Entitlement to Medicare. Coverage terminates on the date on which the Qualified Beneficiary first becomes enrolled under Medicare Parts A orB as provided under Title XVIII of the Social Security Act after the date of the COBRA election.

(e) Failure to Pay Premium. Continued coverage terminates as of the first day of any coverage period for which the applicable premium is not paid by the due date (including any 45 day extension of the due date caused by the grace period).

(f) Termination of Group Health Coverage. Coverage terminates on the date the Company ceases to provide any nonsubscription plan to any Employee.

(g) End of Disability. With respect to each Qualified Beneficiary whose coverage is extended an additional 11 months under Section 1.7(b), coverage terminates on the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary is no longer disabled. Upon such final determination, coverage terminates for the formerly disabled Qualified Beneficiary.

1.8 Participant's Responsibility to Provide Notice. Any Qualified Beneficiary who is determined at the time of a Qualifying Event to have been disabled under title II or XVI of the Social Security Act must notify the COBRA Administrator within 60 days of such determination, and within 60 days of the date of any final determination under such title(s) that the Qualified Beneficiary is no longer disabled. Failure to give such notice within that 60 day period will result in a permanent loss of the right to continued coverage, or to additional continued coverage if the Qualified Beneficiary is on continued coverage at the time of the occurrence of such Qualifying Event.

1.9 Obllaations of COBRA Participants. Elections, notices and payments must be delivered to the office of the COBRA Administrator as set forth on the notification of the right to continue coverage. Delivery of documents and payment of premiums relating to continued coverage will be considered to occur on the earlier of (i) the date of actual receipt by the COBRA Administrator, or (ii) the date deposited in the United States Mail, properly addressed and postage prepaid.

In order to receive continuing coverage under this Appendix, each Qualified Beneficiary must (i) pay monthly premiums by the due date; (ii) promptly notify the COBRA Administrator of any address change; (iii) submit claims in the standard fashion as required by the Plan; (iv) elect desired plan changes during annual enrollment as appropriate, in accordance with the applicable procedure; (v) report enrollment in any other group health coverage to the COBRA Administrator; and (vi) comply with any other requirements established by the COBRA Administrator from time to time.

1.10 Definitions Used in this Aooendix. For purposes of this Appendix, each of the following terms will have the meaning assigned to it, unless the context clearly requires otherwise:

(a) "COBRA Administrator" means any entity or individual(s) engaged to provide administrative services to the Plan with respect to COBRA continuation coverage. The COBRA Administrator may, but need not be, a Claims Administrator under the Plan.

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(b) "Qualified Beneficiary" means an Employee covered by the Plan.

(c) "Qualifying Event" means, with respect to any Employee, the last day of the month in which the following event occurs if, but for continued coverage provided under this Article, the occurrence of the event would result in loss of Plan coverage for a Qualified Beneficiary: the Employee's termination of employment (other than for Gross Misconduct (as defined in Section 1.22 of the Plan)).

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