Pallet Logistics of America, LLC

Work Injury Benefit Summary Plan Description

PLAN NO. 502

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Work Injury Benefit Summary Plan Description List of Benefits

Company Information:

1. **Company Name: Pallet Logistics of America, LLC**

2. **Company Address:** 4100 Platinum Way, Dallas Tx 75237

3. **Company Telephone Number: 972-850-5000**

4. **Federal Tax Identification Number: 20-2869278**

5. **Name and telephone number of contact person for Participant questions:**
   SCOTT JENKINS 972-850-5000

6. **Name and address of agent for service of legal process:**
   SCOTT JENKINS 4100 Platinum Way, Dallas Tx 75237

7. **Plan number: 502**

8. **Period of time for "Plan Term" or "Plan Year" shall be a 12 calendar month period commencing on the date set forth on #9 below and ending on that same date the following calendar year.**

Benefit Limits:

9. **Commencement Date of Plan: 5/30/2017**

10. **Medical Expense and Disability Benefit Period: 116 weeks from the date of the Occurrence.**

11. **Disability Benefits:**
    - **(a) Waiting Period: 5 DAYS**
    - **(b) Percentage of Average Weekly Earnings: 75%**
    - **(c) Maximum Weekly Benefit: $900**

12. **Maximum Death and Dismemberment Benefit: $150,000**

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Work Injury Benefit Plan
Summary Plan Description

PROGRAM DETAIL

The following Summary Plan Description is intended to generally explain and give an overview of the various benefits offered by the Plan and the terms and conditions under which benefits will be payable. A description of benefits, exclusions, and requirements is also contained in the Occupational Injury Benefit Plan. If there is a discrepancy between the Plan and this Summary Plan Description, the Plan controls. Participants are eligible to receive benefits as described herein under the Plan. However, initial receipt and continuing receipt of benefits is contingent upon compliance with the terms and conditions of the Plan. A Participant who fails to comply with the conditions and requirements of the Plan shall not be entitled to receive or continue to receive benefits.

PLAN ADMINISTRATOR

The Company shall serve as the Plan Administrator for all purposes under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, though it may appoint an individual or committee to act as Plan Administrator as stated herein. A Claims Administrator may be appointed by the Company or Plan Administrator to carry out the day-to-day responsibility for administration of the Plan.

FIDUCIARIES AND PLAN RESPONSIBILITIES

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

FUNDING POLICY

The Company shall have no obligation, but shall have the right to obtain insurance contracts with one or more insurers in order to provide funds to the Company to reimburse the Company for or to pay certain benefits under this Plan. Any such insurance contract shall be owned by the Company and no Participant shall have any interest in or right to any benefits payable under such contract. The Company shall have no obligation to establish any fund or trust for the payment of benefits under this Plan.

ARTICLE I
DEFINITIONS

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

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“Accidental Injury” means an injury to a covered Participant which: (1) was unforeseen and unexpected; (2) occurred at a specifically identifiable time and place; (3) occurred by chance, unexpectedly, and/or not in the usual course of events; (4) resulted directly in bodily injury to the covered Participant; (5) occurred in Scope of Employment; (6) occurred during the pendency of this Plan; and (7) for which medical treatment was initiated within 30 days of the injury producing event. Accidental Injury does not include Occupational Disease or Cumulative Trauma. Accidental Injury does not include injuries which arise from an accident or ordinary diseases of life to which the general public is exposed outside the Participant's assigned duties in his scope of employment.

"Active Service" means a Participant is either 1) actively at work performing all regular duties on a full-time basis either at the Company’s place of business or someplace the Company requires him or her to be; or 2) actively at work performing restricted or modified duty work at the direction of the Company in the course of his or her Scope of Employment.

"Appropriate Care" means the determination of an accurate and medically supported diagnosis and on going medical treatment and care of the Participant's condition or disability by a Doctor that conforms to generally-accepted medical standards, including frequency of treatment and care.

“Average Weekly Earnings,” for purposes of calculating a disability loss, means the average gross compensation paid to an employee as reported by the Company to the Internal Revenue Service, exclusive of discretionary bonuses, for the 13 week period preceding the Occurrence giving rise to the disability, or a shorter period if employed less than 13 weeks. For salaried employees, the Hourly Wage shall be the stated salary, exclusive of discretionary bonuses, for the employee divided by the number of work hours applicable to that salary. The Hourly Wage does not include tip income of participants.

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

"Covered Expense" means expenses actually incurred by or on behalf of a Participant for treatment, services and supplies covered by the Plan from a Provider. An eligible medical expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

"Covered Loss" or **"Covered Losses"** means an Accidental Injury, Occupational Disease or Cumulative Trauma covered under the Plan.

“Cumulative Trauma” means damage to the physical structure of the body of an Employee occurring as a result of repetitious, physically traumatic activities that occurs within the Scope of Employment and is reported during the pendency of this Plan. Cumulative Trauma does not include Accidental Injury or Occupational Disease.

"Doctor," "Treating Physician," "Treating Provider," or **"Provider"** means an authorized health care provider approved by the Company and who is a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Participant that is appropriate for the conditions and locality. It does not include a Participant or a member of the Participant's Immediate Family or household.

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“Employee” means a person who is employed by the Company in its regular business and receives pay by means of a salary, wage or commission directly from the Company and for whom the Company files a W2 with the Internal Revenue Service. Employee does not include an independent contractor or third-party agent. An Employee must be in Active Service and employed to work in Texas in the Company’s regular business; however, it includes those Employees working temporarily outside the State of Texas but only under the Company’s direction and control and in its regular business.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

“Hospital” means a lawful institution that: (1) is licensed as a hospital if required in its location; (2) is open at all times; (3) functions chiefly for the care and treatment of sick and injured persons as admitted inpatients; (4) has a staff of one or more licensed physicians present at all times; (5) provides 24 hour services of nurses; and (6) has on its premises or available on a prearranged basis, organized facilities for diagnosis and major surgery. An institution which provides for the care and treatment of mentally ill, emotionally ill or retarded persons, or persons confined for alcoholism or substances abuse may be considered a hospital, whether or not it has an organized facilities on the premises for major surgery, so long as it meets the rest of the requirements listed above.

"Immediate Family" means a Participant's parent, grandparent, spouse, child, brother, sister or in-laws.

"Injury" means identifiable damage or harm to the physical structure of the body that is incurred solely as the result of a covered Occurrence. The term does not include: 1) any mental trauma, emotional distress or similar injury; or 2) a heart attack, stroke or aneurysm. The Injury must be caused solely by an accident. All injuries sustained by one Participant in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

“Intoxicated” means being influenced, impaired or testing positive for any alcohol, illegal drug or prescription drug for which either the Participant does not have a valid, current prescription or takes an amount in excess of the prescribed dosage.

"Medical Emergency" means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

“Medical Expense” means the Usual and Customary amounts available for payment under this Plan for Medically Necessary services as a result of Accidental Injury, Occupational Disease, or Cumulative Trauma to a Participant.

"Medically Necessary” means medical services, procedures or supplies which are: (1) required, recognized and professionally accepted nationally by physicians as the usual, customary and effective means of diagnosing or treating the condition; (2) the most economical supplies or levels of service that are appropriate and available for the safe and effective treatment of the Participant; and (3) not primarily for the convenience of the Participant, the Participant’s family or the Participant’s physician or other provider of medical services, supplies or procedures.

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“Occupational Disease” means a Disease arising out of an Employee’s assigned duties in the Scope of Employment, is reported during the pendency of this Plan and causes damage or harm to the physical structure of the body. Occupational Disease does not include Accidental Injury or Cumulative Trauma.

“Occurrence” means an Accidental Injury or series of Accidental Injuries arising out of one event or incident. As respects Occupational Disease or Cumulative Trauma, Occurrence means the Employee’s last day of last injurious exposure to the conditions causing or aggravating such Occupational Disease.

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

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

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

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

"Participant" means an Employee of the Company who has signed a Receipt and Acknowledgment Form.

“Physician” means a duly qualified physician who is legally licensed to practice medicine in the state where the service is performed.

"Plan" means this Plan, including all subsequent amendments.

"Plan Administrator" means the Plan Administrator appointed by the Company to administer the Plan.

"Plan Term" or **"Plan Year"** means the period of time set forth in Item 8 of the Benefits List.

"Pre-existing Condition" means a condition caused by, or diagnosed to be, the aggravation or re-injury of a condition or injury for which the Participant received medical treatment, care or advice prior to the date the Participant's coverage became effective under the Plan.

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“Rehabilitation” means only those Medically Necessary services which are performed for the purpose of restoring the functions of motion, speech or vision lost as a result of an Accidental Injury, Occupational Disease, or Cumulative Trauma.

“Scope of Employment” means an activity of any kind or character that involves has to do with and originates in the work, business, trade or profession of the Company and that is performed by an employee while engaged in or about the furtherance of the affairs or business of the Company in Texas or while temporarily away from the Company's regular workplace in Texas in furtherance of the Company's business, trade or profession. Scope of Employment does not include a Participants transportation to and from the Company's or the Participant's regular workplace and includes only an activity in which a Participant engages in the carrying out of the Company’s business which is reasonably foreseeable by the Company.

"**Sponsor"** means the Company.

"Supervisor" means an Employee's immediate supervisor or the person in charge at the time of an Accidental Injury.

"Third Party Administrator" means an agent retained by the Company to process claims under the Plan. The Company may change the company or agent serving in this capacity from time to time at its sole discretion.

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

ARTICLE II
ELIGIBILITY AND BENEFITS

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

2. **Benefits.** Plan Benefits shall consist of the provision of Medical Expense Benefits for eligible medical treatment rendered by a Provider, Disability Benefits for periods of disability resulting from Accidental Injury and applicable Accidental Death and Dismemberment Benefits.

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

a. which were incurred prior to the (i) Commencement Date of Plan set forth at Item 9 of the List of Benefits or (ii) the date on which the Participant enrolls in the Plan(whichever is later); or after the Plan is terminated;

b. incurred as a result of revolt, war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country;

c. resulting from or occurring during the commission or attempted commission of a crime by the Participant; or while engaged in an illegal act, illegal occupation or felonious act or aggravated assault or due to taking part in a riot, rebellion, civil disturbance or insurrection;

d. incurred in connection with committing or attempting to commit suicide or any intentionally self inflicted injury;

e. incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or expenses actually incurred by other persons;

f. incurred in connection with the care or treatment of, or surgery performed for, a Cosmetic Procedure, including that portion of breast surgery which involved the implanting or injecting or any substance into the body for restoring breast shape, except for charges which result from an Injury, which occurs while the Participant is covered under the Plan. Also, this exclusion shall not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury, sustained while covered under the Plan;

g. incurred in connection with services and supplies which are not necessary for the direct treatment of the Injury, or which are in excess of Usual and Customary charges, or which are not recommended and approved by Approved Provider;

h. for services, supplies, medicines or treatments, including surgery, which are considered experimental or research by nature, and not recognized by the American Medical Association or any governmental, regulatory authority or law or the Food and Drug Administration as generally accepted and Medically Necessary for the diagnosis and/or treatment of an Injury, or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value;

i. for services rendered by a Physician, Nurse or licensed therapist if such Physician, Nurse or licensed therapist is the Participant or is the Participant's Spouse, son, father, mother or sister;

j. incurred outside the United States if the Participant traveled to such a destination for the purpose of obtaining medical services, drugs or supplies; and charges incurred outside the State of Texas, with the exception of initial emergency care or care expressly approved by the Plan Administrator;

k. for routine physical examinations or tests not connected with an actual compensable Injury under this Plan;

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l. for Physician's fees for any treatment which is not rendered by or in the physical presence of a Physician; benefits will be paid only for eligible charges incurred by an Participant under the direct care of a Provider;

m. incurred in connection with eye refractions, the purchase or fitting of eyeglasses (with the exception of eye wear to be worn in connection with the Participant's assigned job task), contact lenses, hearing aids, or such similar aid devices. This exclusion shall not apply to the initial purchase of a hearing aid or eyewear if the loss of hearing or eyesight is a result of a surgical procedure performed as a result of an Injury, while the Plan is in effect;

n. incurred for treatment on or to the teeth, gums, the nerves or roots of the teeth, gingival tissue or alveolar processes or supplies used in such treatment or for dental appliances; however, benefits will be payable for charges incurred for treatment required because of Injury, to natural and sound teeth sustained while covered under the Plan. Such expenses must be incurred within six (6) months of the date of the Accident and shall not, in any event, be deemed to include charges for treatment for the repair or replacement of a denture;

o. for any Accident that occurs while a Participant has been determined to be intoxicated, or under the influence of any alcohol, narcotic, barbiturate or hallucinogen. An Injured Participant may be subject to drug testing at an approved facility at the time of the Accident;

p. for professional nursing services if rendered by other than a Nurse unless such care is vital as a safeguard of the Participant's life, and unless such care is specifically listed as a covered expense elsewhere in the Plan;

q. in connection with ptomaine or bacterial infection other than bacterial infection occurring as a consequence of a covered accidental cut or wound;

r. with regard to aircraft, incurred while:

i. boarding, alighting from, riding or being struck by any aircraft owned, operated or leased by the Company, the Participant or a member of the Participant's household;
ii. riding as a pilot, operator or crew member in any aircraft.
iii. flying in any aircraft which is rocket propelled
iv. flying in any aircraft being used for aerobatics, racing or an endurance test,
v. crop dusting, seeding, fertilizing, or spraying, fighting a fire, any exploration or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting or any test or experimental cause.
vi. flying when a special permit or waiver from the proper authority has to be issued;

s. incurred while traveling to and from work;

t. incurred while practicing for or participating in organized competitive games;

u. incurred while driving in any race or speed contest or while testing any vehicle on a track or speedway;

v. incurred for or in connection with Custodial Care, hydrotherapy, education or training, or Work Hardening;

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w. incurred for a Pre-Existing Condition or Injury;

x. incurred for any mental, emotional or psychological condition not directly attributable to post traumatic stress disorder from a Bodily Injury;

y. incurred for any and all types of Herpes, Simplex Type 2 Genital Herpes, Syphilis, Gonorrhea, Pollution Related Disease and pollution related sickness, or death;

z. incurred by independent contractors, sub-contractors or anyone else who does not qualify as a Participant;

aa. which result from or are related to nuclear incidents, radioactive contamination war, or acts of terrorism;

bb. any charges for:

- (i) biofeedback an other forms of self-care or self-help training or any related diagnostic testing;
- (ii) hypnosis, acupuncture, chiropractic treatment or chiropractic therapy;
- (iii) the purchase, rental or repair of environmental control devices, including but not limited to, air conditioners, humidifiers or air purifiers; or
- (iv) services performed by a person who normally lives with an injured employee, the spouse of an injured employee, a parent of an injured employee or the injured employee's spouse, a child of the injured employee or the injured employee's spouse or a brother or a sister of the injured employee or of the injured employee's spouse.

cc. liability under the Federal Employer's Liability Act, the Longshore and Harbor Workers Compensation Act, the Jones Act, the Migrant Seasonal Agricultural Workers Protection Act, the Non-Appropriated Instrumentalities Act, the Defense Base Act, the Federal Coal Mine Health and Safety Act of 1969 or any other federal laws or regulations obligating an employer to pay damages to an employee for a workplace injury;

dd. charges incurred by an Participant for which he or she is entitled to receive benefits under any federal or state worker's compensation law, occupational disease law, unemployment compensation, disability benefits law or other similar law;

ee. the use of or exposure to asbestos, asbestos fibers or asbestos products; asbestos, asbestos fibers or asbestos products; lead or lead based products; the hazardous properties, including radioactive, toxic or explosive properties, of Nuclear Material; or any and all medical conditions that are associated with silica related conditions, this is to include exposure to any/all material, which also is known as silica dust, exposures to respirable crystalline silica, exposure to silicosis, exposure to material that may cause lung cancer, pulmonary tuberculosis, and airway Diseases, autoimmune disorders, chronic renal Disease, or other health conditions that are associated with exposure to silica based materials;

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ff. Osteoarthritis, arthritis, and/or any other degenerative process of the joints, bones, tendons or ligaments;

gg. the medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity when the loss results directly or indirectly from the treatment of: (i) stroke; or (ii) cerebrovascular accident or event; or (iii) cardiovascular accident or event; or myocardial infarction or heart attack; or (iv) coronary thrombosis; or (v) aneurysm;

hh. for fees or services from Physicians or Providers that have not been prior approved or directed by the Plan;

ii. Hernia, unless such hernia is an inguinal and/or umbilical hernia that: (i) appeared suddenly and immediately following Bodily Injury; (ii) did not exist in any degree prior to the Bodily Injury; and (iii) was accompanied by pain;

jj. Any claim not timely reported.

kk. Services or supplies for which there is no legal obligation to pay or for which no charge would be made in absence of Plan benefits.

ll. Charges paid or payable in accordance with the laws of any foreign or domestic government.

mm. Charges for services or supplies not necessary for treatment of an injury or disease.

nn. Charges for broken appointments when no emergency prevented the person from canceling the appointment 24 hours in advance.

oo. Charges for completion of claim forms or filing of claim forms.

2. **Medical Expense Benefit**. A Participant is eligible for Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from Injury that results from an Accidental Injury, Cumulative Trauma and/or Occupational Disease.

Accident Medical Expense Benefits are only payable:

a. for Usual, Customary and Reasonable Charges incurred for the Appropriate Care of a Participant; and

b. for Covered Expenses that are Medically Necessary; and

c. for Covered Expenses incurred as a result of Accidental Injury that took place during the Plan Year,

d. if the initial medical expense is incurred from a Provider within 30 days of the date of the Accidental Injury; and

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

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Medically Necessary and care must be provided by a Provider. In considering the amount of benefits you can receive, the Plan Administrator will consider the most economical way to treat a particular problem.

With regard to Medical Expense Benefits, Covered Expenses are:

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

f. Medical, surgical, podiatric, optometric, dental (limited to Injury to sound natural teeth), Nurse, and physical therapy services provided by an authorized Provider;

g. Physical rehabilitation services performed by a licensed occupational therapist provided by or at the direction of an authorized Provider;

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

i. Charges for Medical Emergency ambulance services.

Medical Expense Benefits shall cease upon the earliest of:

j. The date maximum medical improvement is achieved.

k. The expiration of the Medical Expense Benefit Period set forth at Item 10 of the Benefits List.

l. Upon Participant’s voluntary separation of employment or separation of employment for cause with the Company, all medical benefits shall cease.

m. if the Participant does not receive medical treatment from a Provider for more than ninety (90) days from the date of the previous covered treatment from a medical Provider for an Accidental Injury.

n. any other limitation, exclusion or terminating event in this Plan.

3.**Disability Benefits**. A Participant is eligible for Disability Benefits provided that the Participant is disabled from performing his or her work for the Company by an Accidental Injury, Occupational Disease and/or Cumulative Trauma. Said disability must be diagnosed by a Provider. If these, as well as the other conditions and limitations contained in this Plan are met, the Plan will pay, up to the Disability Benefit Period set forth in Item 10 of the List of Benefits, disability payments in an amount not to exceed the Maximum Weekly Benefits set forth in Item 11(c) of the List of Benefits per week or the percentage of Average Weekly Earnings set forth in Item 11(b) of the List of Benefits, whichever is lower. Disability Benefits payments are subject further to the following limitations:

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a. The Waiting Period set forth in Item 11(a) of the List of Benefits. For the Waiting Period, only days for which the Participant would typically work count towards satisfying this period.

b. Only the Participant's normal, scheduled workdays shall be considered in the calculation of disability payments.

c. The Participant must provide the Plan Administrator with satisfactory proof of disability and of being under the care of an authorized Provider.

d. Disability Benefits are not payable to a Participant (or his/her Estate) receiving Accidental Death and Dismemberment Benefits.

e. If the Participant is released to return to work by a Provider, but the Participant does not return to work (whether regular or light duty, provided it is available) Disability Benefits shall cease.

f. Should the Participant become incarcerated, Disability Benefits shall cease.

g. If the Participant remains disabled from working full time, but is able to return to work on a part-time basis or earning less than his or her Hourly Wage, he or she will be deemed partially disabled and Disability Benefit will be reduced by the amount of the Participant's earnings during the period of partial disability.

h. Disability Benefits cease on the date the Participant dies.

i. Disability Benefits cease on the date the Participant voluntarily leaves the employment of the Company or is discharged for cause.

j. Disability Benefits cease on the date the Participant refuses to participate in any medically recommended rehabilitation program or if the disability is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo and the Participant has not availed himself or herself of the treatment.

k. Disability Benefits are subject to any other limitation, exclusion or terminating event contained in the Plan.

6. Accidental Death and Dismemberment Benefits. If Accidental Injury to the Participant results in any of the losses shown below within 365 days of the Occurrence, the Participant (or his designated beneficiary in the case of death) is eligible for Accidental Death and Dismemberment Benefits. Such benefit is the lesser of 10 times the Participant's annualized Average Weekly Wage or the percentage of the Death and Dismemberment Benefit set forth at Item 12 of the List of Benefits shown in the table below for that loss. If multiple losses occur, only one benefit amount (the largest) will be paid.

These benefits shall be payable as follows: the initial payment shall be in an amount equal to twenty percent of the total benefit owed. The remainder of the benefit amount shall be paid in 35 equal monthly installments. No interest shall be owed on the benefit.

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

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

"Member" means Loss of Hand or Foot, Loss of Sight, Loss of Speech, and Loss of Hearing. "Loss of Hand or Foot" means complete Severance through or above the wrist or ankle joint. "Loss of Sight" means the total, permanent Loss of Sight of at least one eye. "Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of Hearing" means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means. "Loss of a Thumb and Index Finger of the Same Hand" or "Loss of Four Fingers of the Same Hand" means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). "Severance" means the complete and permanent separation and dismemberment of the part from the body.

Accidental Death and Dismemberment Benefits are subject to any other limitation, exclusion or terminating event contained in the Plan.

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

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

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

10. Medical Advice. The Company will provide for the continuing medical care of an injured or ill Participant as described in this Plan only if the Participant follows fully and completely the advice of and/or the course of treatment prescribed by the Provider including, but not limited to, keeping all scheduled appointments and fulfilling the recommended treatment Plan. The failure by

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a Participant to satisfy these (and all other) Plan conditions shall relieve the Company of any obligation to provide continuing benefits under this Plan.

11. **Subrogation.** This provision shall apply to all benefits provided under any section of this Plan. A Participant may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the Participant may have a claim against that other person or Another Party for payment of the medical expenses or other charges. In that event, the Plan will be Subrogated to all rights the Participant may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures or may be entitled to procure regardless of whether the Participant has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits or collectibility or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Participant agrees that acceptance of benefits is constructive notice of this provision.

The Participant must:

(A) Execute and deliver a Subrogation and Reimbursement Agreement;

(B) Authorize the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Participant's rights to Recovery when this provision applies;

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

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

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

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injuries or illness. If the Plan pays any medical or other benefits for the injuries or illness before these papers are signed, the Plan still will be entitled to

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Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

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

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

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

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

(I) "Subrogation" shall mean the Plan's right to pursue the Participant's claims for medical or other charges paid by the Plan against Another Party.

(J) "Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this benefit amount.

(K) **When a Participant Retains an Attorney.** If the Participant retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the Participant's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Participant's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Participant or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Participant or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the

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Recovery in constructive trust for the Plan, because the Participant or his attorney is not the rightful owner of the Recovery and should not he in possession of the Recovery until the Plan has been fully reimbursed.

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

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

12. Health Care Providers. The Company may designate one or more Providers to administer medical treatment to Participants, and the Company may change designated Providers at any time. At a Participant's request, any health care provider that has not been designated as a Provider may be approved by the Plan Administrator prior to the time a Participant incurs an expense that is payable or reimbursable under the Plan. Notwithstanding the foregoing, a health care provider that has not been designated as an authorized Provider may be utilized to provide emergency medical treatment if an injury occurs when the Participant is not at his regular place of employment or if an emergency vehicle takes the injured Participant to a health care provider that has not been designated as a Provider. Any continued medical treatment after emergency medical treatment, however, shall be administered by a designated authorized Provider. Except as provided above, benefits shall not be paid under this Plan for treatment received from a health care provider that has not been designated as an authorized Provider in accordance with this Plan.

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

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

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15. <u>Right to Receive and Release Necessary Information.</u> The Plan Administrator may, without the consent of or notice to any person or organization, release to or obtain from any person or organization, information needed to implement Plan provisions. When a Participant requests benefits, the Participant must furnish all information requested by the Plan Administrator, Claims Administrator or Third Party Administrator.

16. <u>Physical Examination and Autopsy</u>. The Company at its own expense, shall have the right to have a Participant examined when and as often as reasonably necessary while a claim under this Plan is pending. In the case of a weekly indemnity claim, the Company also has the right to require the Participant, at the Company=s expense, to submit to an occupational assessment and/or a functional capacity examination. Failure to submit to the examination may result in termination of benefits relating to the Participant. The Company also can have an autopsy performed, at its expense, unless prohibited by law.

ARTICLE III
OPERATIONAL PROVISIONS

1. <u>Reporting</u>. A Participant must *immediately* report in writing any Accidental Injury, Occupational Disease or Cumulative Trauma to his Supervisor or other person designated by the Company. The Participant must report every Accidental Injury, regardless of the nature or severity. Failure to immediately report an Accidental Injury, Occupational Disease or Cumulative Trauma may subject the Participant to disciplinary action up to and including termination and preclusion of benefits. For purposes of this requirement "Immediately," with regard to an Injury due to an Accident or for a known exposure to an Occupational Disease, means no later than 24 hours after the end of the Participant's scheduled shift during which the Occurrence took place. For an actual Injury due to Cumulative Trauma or Occupational Disease, written notice must be provided within the earliest of (1) 24 hours after being medically diagnosed, or (2) 24 hours after the Participant should have known of the Injury, or (3) 24 hours from the date of the Occurrence.

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

3. <u>Medical Treatment</u>. The Participant's treatment and care will be conducted as follows: The Participant will be sent to an authorized Provider. Participant will be required to accept referral to an authorized Provider. If a Participant chooses to go to a Physician of his choice, the Company will not be responsible for the expenses incurred by the Participant in so doing. In addition, the Company reserves the right to require that a Participant undergo an initial and subsequent evaluation by an authorized Provider prior to allowing the Participant to return to work after an Occurrence.

4. <u>Second Opinion</u>. Additional medical opinions relating to any Occurrence may be required prior to benefits being paid or benefits being continued. Failure of a Participant to submit to an additional opinion upon request may result in denial of benefits under this Plan.

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

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6. **Weekly Contact**. A Participant must contact the Third Party Administrator while receiving benefits to report on his progress and expected recovery time. Failure to do so will cause the Participant's entitlement to continuing benefits under the Plan to be discontinued.

ARTICLE IV
ADMINISTRATION OF THE PLAN

1. **Plan Administrator.** The Company shall appoint a Plan Administrator to administer this Plan. The Plan Administrator shall serve until its resignation, death, or removal. The Plan Administrator may resign at any time by mailing or delivering a written resignation to the Company. The Plan Administrator may be removed by the Company, with or without cause. The vacancy may be filled by the Company from time to time. The Plan Administrator may appoint a Third Party Administrator to handle claims made under this Plan.

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

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

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

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

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5. **Bond.** The Plan Administrator is not required to give bond for the performance of its duties unless required by a law that cannot be waived.

6. **Sponsor.** For all purposes of ERISA, the Sponsor is the Company.

ARTICLE V
CLAIMS

1. **Claim Procedure.** When a Benefit is due, the Participant should submit his claim to the person or office designated by the Plan Administrator to receive claims. Under normal circumstances, a final decision shall be made as to a claim within 15 calendar days for a pre-service claim, 30 calendar days for a post-service claim, or 45 days for a disability claim, after receipt of the claim. If the claim is for urgent care, a final decision shall be made as to the claim within 72 hours after receipt of the claim. If a claim is denied during the claims period, the Plan Administrator must notify the Participant in writing. The denial must include the specific reasons for it, the Plan provisions upon which the denial is based, and the claims review procedure. If no action is taken during the claims period, the claim is treated as if it were denied on the last day of the claims period.

2. **Notice of Denial**. In the event that a claim for benefits is to be denied in whole or in part, then the Plan Administrator shall provide the Participant or the Participant's representative with written or electronic notification of the Plan's adverse determination. The notice of denial shall contain the following:

(i) the specific reason for the adverse determination;

(ii) reference the specific Plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;

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

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

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

(vi) in the case of an adverse benefit determination involving a claim for urgent care, a description of the expedited review process applicable to urgent claims.

If the notice of denial of a claim for benefits relates to a claim involving urgent care, the notice may be provided to the Participant or the Participant's representative orally, provided that a written or electronic notification is furnished to the Participant or the Participant's representative no later than three days after the oral notification.

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3. <u>Timing of the Notice of Denial</u>. The deadline for providing the notice of a claims denial depends on the type of claim being denied and the reason the claim is being denied, as set forth below.

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

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

(c) If the Participant or the Participant's representative has followed Plan procedures and has submitted sufficient information for a determination to be made, but the Third Party Administrator has determined that the claim is to be denied, then the deadline for the Third Party Administrator to provide the notice of denial is 15 calendar days for a pre-service claim, 30 calendar days for a post-service claim, or 45 days for a disability claim, after receipt of the claim.. *Exception for Urgent Care*: If the claim being denied is for urgent care, then the deadline for providing the notice of denial is 72 hours after receipt of the claim.

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

5. <u>Manner of Giving Notice</u>. Notice given in writing shall either be sent by first class mail or by hand delivery. Notice may only be given electronically (that is, by email) if the Plan

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Administrator insures that the message is received by using the return-receipt electronic mail feature and if the Participant is advised in the text of the notice of the Participant's right to receive, free of charge a paper copy of the notice.

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

7. **Appeal Procedure**. Once an initial denial is issued, the Plan Administrator shall not give any further consideration to the claim. The Participant may then appeal the initial claim denial. If a claim has been denied, the Participant or the Participant's representative has the right to appeal the denial, as described below.

8. **Right to Reconsideration.** Within 180 days after the date of the notice of denial is received, the Participant, or the Participant's representative, may request further review of the original claim by filing a written request for reconsideration with the Plan Administrator, by hand delivery or first class mail. *Exception for Urgent Care*: If an appeal relates to an urgent care claim, the appeal may be verbal.

9. **Right to Submit Comments.** Within 180 days after the date the notice of denial is received, in addition to having the original claim reviewed, the Participant or the Participant's representative may also submit written comments, documents, records, and other information related to the claim, even if the Participant had not previously submitted those documents or information.

10. **Right to Review Documents.** During the period that a claim is being reconsidered, the Participant or the Participant's representative may have access to and copies of all documents, records, and other information relevant to the claim that has been denied.

11. **Decision by Plan Administrator.** The Plan Administrator shall notify the Participant or the Participant's representative of the Plan Administrator's findings within 30 days for a pre-service claim, 60 days for a post-service claim, or 45 days for a disability claim, after receipt of the request for review of the claim. *Exception for Urgent Care*: If the claim being reviewed involves urgent care, the Plan Administrator shall notify the Participant or the Participant's representative of the Plan Administrator's finding within 72 hours after receipt of the request for review.

12. **Contents of the Plan Administrator's Notification.** If, upon review, the claim is again denied, the Plan Administrator shall provide a written notice of the denial containing:

(i) the specific reasons for the adverse determination;

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(ii) reference to the specific Plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the benefit determination is based;

(iii) a statement that the Participant is entitled to receive, upon request, reasonable access to and copies of, all documents and records relevant to the review of the claim, including any reports, and the identities, of any experts whose advice was obtained;

(iv) a statement that if the Participant disagrees with the benefit determination, the dispute shall then be submitted to non-binding arbitration; and

(v) a statement of the Participant's right to bring civil action under section 502(a) of ERISA following an adverse arbitration of the benefit determination.

13. Right to Bring Civil Action. If the appeal of the original decision is denied upon review and upon arbitration, the Participant shall have the right to bring a civil action against the Plan under section 502(a) of the Participant Retirement Income Security Act of 1974 (ERISA).

14. Exhaustion of Administrative Remedies. No legal action may be brought by the Participant with respect to benefits under this Plan until and unless the aforementioned claims procedure has been exhausted. There shall be no de novo review by an arbitrator or court of any decision by the Plan Administrator and any review shall be limited to determining whether the decision was so arbitrary and capricious so as to be an abuse of discretion.

ARTICLE VI
AMENDMENT AND TERMINATION

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

2. Termination. The Sponsor may terminate this Plan by executing and delivering to the Plan Administrator a notice of termination specifying the date of termination. Likewise, this Plan shall automatically terminate if there is a general assignment to or for the benefit of the creditors of the Sponsor. This Plan shall also terminate upon any action by the Company or an insurance carrier to cancel, non-renew, or otherwise fail to renew an insurance policy that was purchased in conjunction with the adoption of this Plan document.

ARTICLE VII
MISCELLANEOUS

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1. **Creditors.** None of the payments, benefits, or rights of any Participant under this Plan shall be subject to any claim of any creditor, and, in particular, to the fullest extent permitted by law, all such payments, benefits, and rights shall be free from attachment, garnishment, trustee's process, or any other legal or equitable process available to any creditor of such Participant. No Participant shall have the right to alienate, anticipate, pledge, encumber, hypothecate, or assign any Benefit or payment, contingent or otherwise, which he or she may expect to receive under this Plan.

2. **No Contract of Employment.** Neither the establishment of this Plan nor any modification hereof, nor the creation of any fund, trust, or account, nor the maintenance of the Plan, nor the payment of any Benefit hereunder, shall be construed as giving any Participant or Employee, or any person, the right to be retained in the service of the Company or an Employer, and all Participants and other Employees shall remain subject to discharge at will, to the same extent as if this Plan had never been adopted and the Plan never obtained.

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

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

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

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

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

8. **Expenses**. All expenses for management and administration of this Plan shall be paid by the Company.

9. **Offset.** The purpose of the Plan is to provide wage and medical benefits to eligible Participants. Additionally, the purpose of the Plan is to reduce any damage award which may result from a work place injury. All benefits shall be construed as an offset by a court of law. Benefits paid under this Plan shall not be considered payment from a collateral source as that term is defined by statute or case law.

10. **No Admission of Liability.** Payments made under this Plan shall not in any way constitute an admission of liability or responsibility by the Company for an injury.

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

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ARTICLE VIII
ADOPTION OF PLAN BY AFFILIATED CORPORATION

1. **Affiliated Entities.** An affiliated corporation or other entity to the Company may, with the approval of the Company, adopt this Plan by agreeing to be bound as a Company by limitations in this Plan, as applied to its eligible Participants, except as to those terms, if any, specifically described in the adopting resolutions or agreement.

2. **Obligation**. The Sponsor shall not be liable for any obligations under the Plan of an adopting affiliated corporation; and an adopting affiliated corporation shall not be liable for any obligations of the Sponsor under this Plan.

ARTICLE IX
PARTICIPANT'S RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

You may examine, without charge, all documents governing the Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. You may obtain copies of these documents upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

ERISA also imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

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

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

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in

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obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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