

NOTICE TO ENGLISH SPEAKING EMPLOYEES: This booklet contains a summary in English of your plan rights and benefits under the Silver Eagle Distributors Houston, LLC Texas Injury Benefit Plan. If you have difficulty understanding any part of this booklet, or would like a Spanish version of this booklet, contact the Director of Health, Safety & Environment at 7777 Washington Avenue, Houston Texas 77007, 713.869.4361. Office hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday.

AVISO A LOS EMPLEADOS QUE NO HABLAN INGLES: Este folleto contiene un resumen en inglés de sus derechos y beneficios del plan de Silver Eagle Distributors Houston, LLC Texas Injury Benefit Plan. Si tiene dificultad en entender cualquier parte de este folleto o quiere obtener una copia del folleto en español, comuníquese con el Director of Health, Safety & Environment en el 7777 Washington Avenue, Houston Texas 77007, 713.869.4361. El horario de oficina es de 8:00 a.m. a 5:00 p.m., de lunes a viernes.

Dear Employee:

Although safety is a top priority at Silver Eagle Distributors Houston, LLC, we all understand that work-related injuries will occur from time to time. When they do, you deserve prompt, professional medical treatment without any inconvenience, and salary continuation if you need to recover at home.

In 2016, we developed a program called the Silver Eagle Distributors Houston, LLC Texas Injury Benefit Plan with those goals in mind. We believe that the Plan has resulted in prompt, efficient, and fair claims service for our Texas employees who sustain an eligible work-related injury. To ensure that this Plan continues to provide these substantial benefits and that employee satisfaction remains high, the Plan has been updated effective January 15, 2022.

As a reminder, you do not pay for any coverage under the Plan. The coverage provided is funded entirely by the Employer.

We sincerely hope you never need to make a claim for such benefits. However, if you are injured at work, you can rest assured that this valuable benefit plan is available to protect you and your family.

Sincerely,

Director of Health, Safety, & Environment

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PLAN BENEFITS

Maximum Benefit Limit

Maximum amount for all benefits combined for a work-related injury **\$350,000** per participant

Medical Benefits

Pays for care from Approved Medical Providers for a work-related injury **100%** of covered charges for up to **126 weeks**

Wage Benefits

Pays you weekly income if you have to miss work for a work-related injury Starting on the **first full calendar day** of disability, pays **85%** of your “lost wages” for up to **126 weeks**

Death Benefits

Provides payment to eligible beneficiaries if you have a work-related death **\$100,000** (paid 20% down and remainder over 24 months)

Burial Benefit

Provides reimbursement for burial expenses Up to **\$10,000**

Dismemberment Benefits

Provides a payment for loss (or loss of use) of a member of the body Up to **\$100,000**, based upon the severity of the injury (paid 20% down and remainder over 24 months)

Please see the Program Detail section of this booklet for a more complete description of benefits, taxation issues, applicable exclusions, and limitations and requirements you must satisfy in order to receive benefits.

PROGRAM DETAIL

INTRODUCTION

Silver Eagle Distributors Houston, LLC (the "Company") is committed to providing loss of income protection and helping you pay medical expenses that might otherwise present a financial burden to you if you are injured on the job. To accomplish this, the Company has implemented a benefit program called the Silver Eagle Distributors Houston, LLC Texas Injury Benefit Plan (the "Plan"). **The Plan has been adopted for the benefit of the Texas employees of Silver Eagle Distributors Houston, LLC and its parents, subsidiaries and affiliated employers (individually and collectively referred to as the "Employer").** This booklet has been prepared to help you understand your benefits under the Plan. Please read it carefully.

If any conflict arises between the information contained in this booklet and the provisions of the formal Plan document, the Plan document will control. Certain terms used in this booklet are capitalized and defined in the DEFINITIONS section of this booklet.

Except as otherwise provided in this booklet, benefits and other requirements described in this booklet are effective for all covered injuries occurring on or after January 15, 2022. References in this booklet to "you" or "your" shall mean a person who satisfies the requirements of the ELIGIBILITY section of this booklet.

NOTICE TO EMPLOYEES CONCERNING WORKERS'

COMPENSATION IN TEXAS

The following notice is being provided in English and Spanish as required by Texas law:

COVERAGE: Silver Eagle Distributors Houston, LLC and its affiliated employers do not have workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered (non-subscribing) employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits for a work-related injury or occupational disease. In addition, you may have rights under the common law of Texas should you have an on the job injury or occupational disease. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY VIOLATIONS HOTLINE: The Division has established a 24-hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or

discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

This notice applies to all Employers participating in the Plan.

COBERTURA: Silver Eagle Distributors Houston, LLC y sus empleadores afiliados no cuentan con una cobertura de seguro de compensación para trabajadores. Como empleado de un empleador que no cuenta con una cobertura, usted no es elegible para recibir beneficios de compensación para trabajadores bajo la Ley de Compensación para Trabajadores de Texas. Sin embargo, un empleador no cubierto (no suscriptor) puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener información sobre la disponibilidad de otros beneficios por una lesión o enfermedad ocupacional relacionada con el trabajo. Además, usted podría tener derechos bajo la ley de "Derecho Común de Texas" (Common Law of Texas, por su nombre en inglés), en caso de que usted llegara a sufrir una lesión o enfermedad ocupacional relacionada con el trabajo. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

Este aviso se aplica a todas las Empresas participantes en el Plan.

Your Injury Benefit Plan: The Employer **DOES PROVIDE** to all Texas employees, without cost, the Plan described in this booklet.

Our Safety Program: Our success largely depends upon you following all of our safety standards and procedures and immediately notifying your supervisor first of any unsafe working condition, safety violation or on-the-job injury, no matter how minor. As mentioned above, you will not be suspended, terminated, or discriminated against because you in good faith report an unsafe working condition, on-the-job injury or potential occupational health or safety violation.

ELIGIBILITY

You automatically become a participant in the Plan if you are an employee of the Employer and your employment with the Employer is Principally Located within the State of Texas. You must be either:

- a person who is employed in the regular business of, is under the direction and control of, and receive your pay by means of a salary, wage or commission directly from, the Employer and for whom the Employer files a Form W-2 with the Internal Revenue Service; or
- a person determined to be a common law employee of the Employer by a court of competent jurisdiction or arbitrator.

This Plan does not cover a leased employee, a temporary staffing employee, an independent contractor or other third-party agent.

COVERED AND NON-COVERED INJURIES

Covered Injuries

The Plan pays benefits only on account of an **"Injury."** An "Injury" means identifiable damage or harm to the physical structure of the body (or mental or emotional state with respect to a Traumatic Event) resulting from either an Accident, Occupational Disease or Cumulative Trauma. Any such damage or harm must directly and solely result from your Course and Scope of Employment with the Employer (see the DEFINITIONS section of this booklet).

- An **"Accident"** means an event involving factors external to you that:
 - was sudden, unplanned and unexpected; and
 - occurred at a specifically identifiable time and place.

The term "Accident" shall include a Traumatic Event (for example, a robbery) or a known Occupational Disease exposure (for example, a needlestick puncture).

- An **"Occupational Disease"** means a condition that (1) is marked by a pronounced deviation from your normal healthy state arising out of your assigned duties in your Course and Scope of Employment and (2) causes damage or harm to the physical structure of the body.
 - Occupational Disease includes other diseases or infections that naturally result from the work-related disease.
 - Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of your assigned duties in your Course and Scope of Employment.
- A **"Cumulative Trauma"** means damage to the physical structure of your 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 or general aches and pain that may have been caused or exacerbated by your Course and Scope of Employment.
- If you report an injury before you have completed at least 180 days of continuous, active employment with the Employer, the Plan will presume that this injury is not “Cumulative Trauma” and may deny Plan benefits. However, you can overcome this presumption if you establish by a preponderance of objective medical evidence that the injury does meet this “Cumulative Trauma” definition.

Any such damage or harm must directly and solely result from your Course and Scope of Employment with the Employer (see the DEFINITIONS section of this booklet. In order to be subject to the provisions of this booklet, **the date of the Injury must be on or after January 15, 2022.**

All injuries relating to (1) an Accident or related series of Accidents, (2) exposure to an environmental or physical hazard that causes Occupational Disease, or (3) rapid, repetitious, physically traumatic activities that result in Cumulative Trauma, will be considered a single Injury.

Types of Non-Covered Injuries

The term "Injury," as used in this booklet, does not include:

- Any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure, or other body part resulting from:
 - poor or inappropriate posture;
 - the natural results of aging;
 - osteoarthritis, arthritis, or degenerative process; or
 - other circumstances prescribed by the Claims Administrator which do not directly and solely result from your Course and Scope of Employment.
- 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;
- Except to the limited extent provided with respect to a Traumatic Event, any mental injury, emotional distress, mental trauma or similar injury to your mental or emotional state, 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.

- Damage or harm resulting from airborne contaminants not commonly found in the Employer's normal working environment, including, but not limited to, pollen, fungi, and mold;
- Damage or harm resulting from job stress;
- Any heart attack, stroke, or aneurysm (an "attack"), unless:
 - the attack can be identified as:
 - occurring at a definite time and place; and
 - caused by a specific event related to, and occurring in, the Course and Scope of Employment.
 - in all Medical Probability your Course and Scope of Employment rather than the natural progression of a preexisting heart condition or disease was the Major Contributing Cause of the attack; and
 - the attack was not triggered solely by emotional or mental stress factors, unless it was precipitated by a sudden work-related stimulus.
- Hernia, unless such hernia:
 - appeared suddenly and immediately following the Injury;
 - was accompanied by pain; and
 - in all Medical Probability your Course and Scope of Employment was the Major Contributing Cause of the hernia.
- Any Preexisting Condition, except to the limited extent (if any) that an Approved Physician clearly confirms an identifiable and significant aggravation that occurred in the Course and Scope of Employment. Subject to medical management, coverage for such aggravation can be provided if:
 - an Approved Physician identifies that, in all Medical Probability, the Preexisting Condition has been aggravated; and
 - the Preexisting Condition was not the Major Contributing Cause of the aggravation.

For purposes of this Plan, an "aggravation" means new damage or harm to a Preexisting Condition that alters the physical structure of the body (or mental or emotional state with respect to a Traumatic Event) and is identifiable and measurable through diagnostic testing. An "aggravation" does not mean an exacerbation or other temporary worsening of symptoms related to a Preexisting Condition.

Non-Covered Injury Circumstances

Furthermore, no benefits will be payable under the Plan if:

- the Injury occurred while you were in a state of intoxication, or had otherwise lost the normal use of your mental or physical faculties as a result of the use of a drug or

alcohol. For this purpose, you shall be deemed to have been in a state of intoxication at the time of the Injury if any drug or alcohol test required by the Employer following the Injury finds a violation of the Employer's Substance Abuse Testing Standard (SED-CORP-HSE-02-005);

- if you are found to have been in a state of intoxication, refuse to undergo the drug and alcohol testing required by the Employer, or otherwise violate the Employer's Substance Abuse Testing Standard (SED-CORP-HSE-02-005), there shall be a rebuttable presumption that you were intoxicated or otherwise did not have the normal use of your mental or physical faculties at the time of the Injury.
 - the presumption in the above paragraph may only be overcome if you prove by a preponderance of the evidence that at the time of the Injury, you were not intoxicated or had not otherwise lost the use of your mental or physical faculties as a result of a drug or alcohol.
- the Injury occurred under circumstances where your employment did not place you at a greater risk of Injury than you would have been exposed to as a member of the general public;
 - 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 you have not availed yourself of such treatment;
 - the Injury was caused by your willful intention or attempt to injure yourself or another person, whether you were sane or insane;
 - the Injury occurred while you were employed in violation of any law;
 - your horseplay, fighting, or similar inappropriate behavior was a proximate cause of the Injury;
 - the Injury arose out of an act of a third person intended to injure you because of personal reasons and not directed at you as an employee or because of your employment;
 - the Injury arose out of your participation in a recreational, social or athletic activity not constituting part of your Course and Scope of Employment, except where these activities are expressly required in writing by the Employer (more than an invitation or request to participate or attend);
 - the Injury arose out of an act of God, unless your employment exposes you to a greater risk of Injury from an act of God than ordinarily applies to the general public;
 - the alleged Injury is feigned or an attempt to defraud the Employer;
 - the Injury arose out of your participation in:

- a riot or act of civil disturbance;
 - a war, declared or undeclared;
 - any act of war or terrorism;
 - any illegal act;
 - a felony or an assault, except an assault committed in defense of the Employer's business or property; or
 - service in the military of any country or any civilian non-combatant unit serving with such forces;
- any damage or harm arising out of the use of or caused by:
- asbestos, asbestos fibers or asbestos products; or
 - the hazardous properties of nuclear material or biological contaminants.
- the Injury arose out of your participation in the commission, or attempted commission, of any crime;
- the Injury occurred while you were traveling or flying in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation if you are:

REQUESTING BENEFITS

The following is a summary of the procedures for requesting benefits under this Plan. Also see the DETAILED CLAIM PROCEDURES in the next section of this booklet.

Notice of Injury

You (or your Representative) must provide notice of an Injury **immediately** to the Silver Eagle Emergency Call Center at 1-877-211-5663 and your Supervisor.

- **For an Injury due to an Accident, notice must be provided within 24 hours following the date of the accident.**
- **For an actual Injury due to Occupational Disease or Cumulative Trauma, this notice must be provided by the earlier of the following: (1) 24 hours after being medically diagnosed with an Occupational Disease or Cumulative Trauma, or (2) 30 calendar days after you should have known of the Occupational Disease or Cumulative Trauma, whichever is earlier.**
- No benefits will be payable under the Plan if notice of injury is not provided as required above, **unless the Claims Administrator determines that Good Cause exists.**
- **Good Cause** exists when your conduct is reasonable based on the circumstances and information within your knowledge or control and as compared to what an ordinary and prudent person having the same or similar knowledge or control would do under the same or similar circumstances.

- *As part of its investigation, the Claims Administrator shall request you and the Employer provide evidence relevant to determining the existence of Good Cause. **You can also voluntarily provide information to the Claims Administrator if you believe that you have Good Cause for not meeting the Plan's injury notice, required information, or Approved Medical Provider treatment requirements.***
- *The Claims Administrator shall consider all evidence of Good Cause, provided or obtained, during its investigation, in order to determine whether Good Cause exists in a particular circumstance.*
- **Examples of Good Cause include, but are not limited to:**
 - The Supervisor or member of management was not available during the time within which you were required to report your injury;
 - The Supervisor or member of management was aware of your Injury within the time period you were required to report your Injury;
 - Your injury compromised your ability to timely report your injury (such as being unconscious from a head injury);
 - The Claims Administrator determines that the seriousness of your injury only became reasonably apparent after the injury reporting timeframe had expired;

Providing Required Information

- You must provide verbal, written, or recorded statements, and provide such proof and demonstrations (relating to the Injury or any prior or subsequent damage or harm you suffered, in or out of the Course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may direct from time to time.
- You must provide relevant medical records or a release of medical records as requested by the claims administrator to verify benefit coverage or administer and pay Covered Charges.

Initial Medical Treatment

You must receive medical treatment from an Approved Medical Provider within 14 calendar days from the date you report the Accident and/or Injury.

MEDICAL BENEFITS

Subject to the medical management provisions in this section and the other provisions of this Plan, the Plan pays medical benefits for an Injury in an amount equal to 100% of all **Covered Charges**.

Covered Charges

The cost of a medical service or supply is a **Covered Charge** if it satisfies the following requirements:

- The medical service or supply is medically necessary, based on the nature of the Injury as and when provided, and does one or more of the following:
 - cures or relieves the effects naturally resulting from the Injury;
 - promotes recovery from the Injury; or
 - otherwise enhances your ability to return to or retain employment following the Injury.

- The medical service or supply is furnished by or under the direction of an Approved Medical Provider, acting within the scope of the Approved Medical Provider's license, unless:
 - The medical service or supply is provided as Emergency Care;
 - The Claims Administrator receives notification of such Emergency Care by the Claims Administrator's next business day after the date you receive Emergency Care; and
 - After receiving primary Emergency Care, subsequent treatments are provided by, or at the direction of, an Approved Medical Provider.
 - **An Emergency Care determination solely relates to consideration of an exception to the Plan's Approved Medical Provider requirements. Any decision by you to seek treatment from an urgent care clinic or hospital emergency room does not necessarily involve Emergency Care.**
 - **An Emergency Care 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.**

- The medical service or supply is pre-authorized by the Claims Administrator in the following manner (except where the Claims Administrator determines that prior approval was impossible under the circumstances):
 - **Covered Charges That Can Be Verbally Authorized.** Subject to the restrictions and limitations set out elsewhere in this booklet, Covered Charges that can be verbally authorized will include the cost of the following:
 - 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 your home. Such Covered Charges shall also include (1) charges for a registered nurse, x-rays, and laboratory tests conducted as part of an

- Approved Physician visit, and (2) second medical opinion services requested by the Claims Administrator;
- Speech, occupational and physical therapy provided by an Approved Physician or a licensed speech therapist, licensed occupational therapist or licensed physical therapist;
 - Reasonable travel, meal and lodging expenses related to medical treatment that requires travel greater than 20 miles from your residence (one way), unless the Claims Administrator determines Good Cause exists for travel that is 20 miles or less. Mileage will be reimbursed at the Internal Revenue Service identified “Medical Purposes” rate, as periodically updated;
 - Medical supplies approved by the treating Approved Physician, including the following:
 - 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;
 - 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);
 - Oxygen and its administration;
 - 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;
 - Surgical dressings, bandages, splints, casts, crutches, syringes, needles, trusses, and braces dispensed by an Approved Medical Provider; and
 - Similar medical supplies approved by the Claims Administrator.
 - Professional ground ambulance service, or if no other means of transportation can reasonably suffice to deliver the individual to the closest appropriate Approved Facility, air ambulance, regularly scheduled railroad, or airlines;
 - Eyeglasses or contact lenses: one pair per Injury, inclusive of professional office visit charges;
 - External hearing aids: one pair per Injury, inclusive of professional office visit charges; and
 - Orthotics, arch supports, corrective shoes, special bras or girdles, corrective appliances, prosthesis, or any similar item.
- **Covered Charges Requiring Written Authorization.** 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 (including electronic notice):**

- Admission to a hospital or other Approved Facility on an inpatient or outpatient basis, including semi-private room and board, ambulatory day surgery, anesthesia and its administration, and similar services;
- MRI, CAT Scan, nuclear medicine, radiology and pathology (including interpretive services) and similar testing;
- Inpatient rehabilitation services provided in a medical rehabilitation hospital;
- Limited or temporary pain management services (for example, epidural steroid injections), but not including pain management programs;
- Surgery that restores a reasonable, normal pre-Injury functioning;
- Services of a dentist or licensed oral surgeon for treatment and repair of broken teeth, fractures and dislocations of the jaw, or the replacement of teeth (excluding temporomandibular junction dysfunction services);
- Home health care (with respect to physical needs only);
- Skilled nursing care, provided that an Approved Physician monitors your progress at least once during each 30-day period of confinement;
- Mental health services, but only when such services are provided for mental or emotional damage or harm resulting from you being the victim of, or witness to, a Traumatic Event occurring during your Course and Scope of Employment; and
- Services rendered primarily for training, testing, evaluation, counseling, or educational purposes.

Non-Covered Charges

While the Plan provides benefits for many medical expenses, the following expenses are **not** covered by the Plan:

- 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 your geographic area;
- Acupuncture, behavior modification, 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;
- Chiropractic treatment, chiropractic therapy or spinal manipulation services;
- Substance abuse services;
- Pain management programs;
- 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 permanent structural changes to your residence or moving expenses; and
- Charges for services performed by an immediate or extended family member.

Treatment Prior to Denial

Any provision of this Plan to the contrary notwithstanding, the Employer may render first aid, or the Plan may pay for Emergency Care, pay Wage Benefits or pay for a medical evaluation or treatment, and the Plan can still make a subsequent determination that you have not suffered a covered Injury or otherwise deny any or all further benefits under the provisions of this Plan.

Medical Provider Referrals

If the treating Approved Physician finds it necessary to refer you to another health care provider, the treating Approved Physician must notify you 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.

No Interference with Patient-Provider Relationship

Although benefits under this Plan are conditioned on your use of only Approved Medical Providers, you remain entitled to seek any medical care that you deem appropriate from any health care provider of your choice at your own expense. **However, any medical expenses for this medical care will not be payable under this Plan.** The Employer, Claims Administrator, Appeals Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other health care services provided by any Approved Medical Provider or other designated health care service provider. Health care providers are not agents of the Plan, Employer, Claims Administrator, or Appeals Committee. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of the attending Approved Physician and other health care providers based on their independent judgment for the provision of health care.

Medical Records Review or Independent Medical Examination

The Plan reserves the right to require a medical records review or independent medical examination (IME) from an Approved Physician selected by the Claims Administrator for purposes of determining benefits under this Plan. The Claims Administrator will weigh the findings of the treating Approved Physician and the Approved Physician providing the medical records review or IME and make a benefit determination under the Plan.

Your Right to a Second Medical Opinion

If you disagree with the diagnosis or treatment recommended by the Approved Physician whose opinion is accepted by the Claims Administrator ("Physician A"), then you may request a second medical opinion. **You 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 you provide advance notice to the Claims Administrator, then you shall have the right to a one-time examination at your own expense by another

physician ("Physician B"). This examination by Physician B will be solely for the purpose of evaluating your condition and making a treatment recommendation.

- 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 you refuse 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 you will have the option of paying up to one-half of such fees and expenses).

When Medical Benefits Cease

Medical Benefits will cease upon the earliest of:

- the expiration of 126 weeks from the date of the Injury;
- the date you reach the Maximum Benefit Limit;
- involuntary termination of your employment with the Employer for Gross Misconduct;
- the date you do not receive medical treatment from an Approved Medical Provider for a period of more than 60 calendar days, unless the Claims Administrator determines that Good Cause exists or as otherwise specified in this booklet;
- the date you reach Maximum Rehabilitative Capacity; or
- the date you fail to comply with the requirements specified under the CONTINUING BENEFITS section of this booklet.

WAGE BENEFITS

Eligibility

Subject to the medical management and other provisions of this Plan, if an Approved Physician (or a physician who provided you Emergency Care as determined by the Claims Administrator) determines that you are Temporarily Totally Disabled or Temporarily Partially Disabled due to a covered injury, the Plan will pay Wage Benefits in accordance with the following provisions:

- **“Temporary Totally Disabled” or “Temporary Total Disability”** (lost time injury) means a medically demonstrable anatomical or physiological abnormality caused by an Injury, which causes you to be temporarily:
 - unable to perform the normal duties for which you were employed;

- under the regular care of an Approved Physician; and
 - unable to engage in Modified Duty or any other occupation for wage or profit.
- **“Temporary Partially Disabled” or “Temporary Partial Disability”** (restricted duty injury) means a medically demonstrable anatomical or physiological abnormality caused by an Injury that results in you being temporarily:
- unable to fully perform the normal duties for which you were employed;
 - under the regular care of an Approved Physician; and
 - released by an Approved Physician to work a Modified Duty position either for the Employer or at another location designated by the Employer.

When Wage Benefits Begin

- **Temporary Total Disability.** From the first full calendar day that you become Temporarily Totally Disabled due to a covered Injury, the Plan shall pay Wage Benefits equal to 85% of your Pre-Injury Pay.
- **Temporary Partial Disability.** From the first full calendar day that you become Temporarily Partially Disabled, the Plan shall pay Wage Benefits up to 85% of your Pre-Injury Pay (due to the Approved Physician’s restrictions) while working Modified Duty.
- If you have a Temporary Partial Disability and are released to Modified Duty, but (i) the Employer has no Modified Duty position available, and (ii) an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment, then you will be considered to be Temporarily Totally Disabled and Wage Benefits shall be payable in the manner specified above under “Temporary Total Disability.”
 - **The Employer’s ability to provide a Modified Duty position while you are under work restrictions determined by the Approved Physician does not imply or create a permanent Modified Duty position for the purposes of the Americans with Disabilities Act (“ADA”).**
- **Payment Terms.** Wage Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week shall be prorated. Only your normal, scheduled workdays shall be considered in calculating benefits (based upon your employment status as of the date of Injury). Wage Benefit payments shall be reduced as described in the “Offset For Other Benefits” section of this booklet.

When Wage Benefits Cease

Wage Benefits will continue until the earliest of:

- the expiration of 126 weeks from the date of the Injury. This 126-week maximum period for Wage Benefits is calculated continuously from the date of the Injury, regardless of whether or not you qualify as Disabled at all times during such period or receive Wage Benefits continuously throughout such period;

- the date you are determined by the treating Approved Physician to no longer be Disabled, without regard to whether you return to regular or Modified Duty on that date;
- the date that the Maximum Benefit Limit is met;
- termination of all your employment with the Employer; provided, however, that this paragraph will not apply if termination of employment is solely due to:
 - application of a duration limit in the Employer’s leave of absence policy; or
 - the complete elimination of the type of employment position that you were working at the time of your Injury.
- the date you are placed in jail, are deported or detained by or at the request of any government agency or foreign government, have left the local area for an extended period of time, or are similarly unavailable for work; provided, however, that this paragraph shall operate to cease Wage Benefits only for such period of time that you are unavailable for work;
- the date you reach Maximum Rehabilitative Capacity or permanent restrictions have been assigned; or
- the date you fail to comply with the requirements under the CONTINUING BENEFITS section below.

DISMEMBERMENT BENEFITS

If you suffer 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 will pay you an amount equal to the applicable percentage from the schedule below times \$100,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Plan's Maximum Benefit Limit.

The Dismemberment Benefit will be paid as follows: (1) 20% will be paid in a lump sum cash payment as soon as administratively possible following the date of loss; and (2) the remainder will be paid in 24 equal monthly installments (without interest) commencing on the first day of the month following the initial lump sum payment.

SCHEDULE OF LOSSES

<u>Loss of:</u>	<u>Benefit Amount:</u>
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%

- If a loss of One Hand is associated with your dominant hand, the above calculated benefit for loss of One Hand shall be increased by an additional 10%.
- If you suffer more than one Injury described above from any one Accident, related series of Accidents, or Occupational Disease exposure 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.
- 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.
- 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.
- 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.
- Dismemberment Benefits shall be in addition to Wage Benefits and Medical Benefits; provided, however, that payment of Dismemberment Benefits will cease in the event of your death, which may result in the payment of Death Benefits.

DEATH BENEFITS

If you die as the direct and sole result of, and within 365 days of, an Work-Related Injury, then the Plan will pay your Beneficiary a Death Benefit equal to \$100,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Plan's Maximum Benefit Limit.

The Death Benefit will be paid to your Beneficiary as follows: (1) 20% will be paid in a lump sum cash payment as soon as administratively possible following your death; and (2) the remainder will be paid in 24 equal monthly installments (without interest) commencing on the first day of the month following the initial lump sum payment.

- Death Benefits will be in addition to Dismemberment Benefits, Wage Benefits, and Medical Benefits payable with respect to any one Injury; provided, however, that no interest in future Dismemberment Benefits survives after your death if your Beneficiary then becomes entitled to Death Benefits under this Plan.
- In addition to the Death Benefits set forth above, the Plan shall reimburse reasonable burial expenses to any person who incurs liability therefore, up to \$10,000.

CONTINUING BENEFITS

Suspension or Termination of Benefits

The Claims Administrator may suspend or terminate the payment of ongoing Plan benefits with respect to a claim under the following circumstances:

- You do not submit to any requested drug and/or alcohol testing in accordance with the Employer's Substance Abuse Testing Standard (SED-CORP-HSE-02-005), or do not authorize the Employer to gain access to this information related to an Injury;
- You are not truthful or you demonstrate bad faith in connection with the administration of the Plan;
- You have a non-work related condition, or intervening event subsequent to an Injury, that prevents continuous care of, or prevents recovery from the Injury. For purpose of this subsection, a "non-work related condition" includes, without limitation, a medical condition or personal habit that you are unable (or refuse) to correct through behavioral modification despite a recommendation by your Approved Physician;
- There is a greater than 60-calendar day lapse since your last treatment with an Approved Medical Provider, unless:
 - The Claims Administrator determines that Good Cause exists;
 - The Claims Administrator has approved scheduled medical treatment with an Approved Medical Provider during the applicable 60-calendar day period, even if such medical treatment occurs beyond the 60-calendar day period (for example, surgery for hardware removal); or
 - Additional medical services or supplies are in the form of testing or follow up vaccination with respect to an Injury that involves a potential occupational exposure to a bloodborne pathogen.

Suspension or Termination of Benefits Subject to Written Warning

The Claims Administrator may suspend or terminate the payment of ongoing Plan benefits with respect to a claim if you violate one or more of the following provisions. **Unless the Claims Administrator determines that Good Cause exists, (1) a first violation shall result in a written warning and/or suspension of benefits, and (2) a second violation shall result in termination of Plan benefits:**

- You do not receive prior approval for all medical care (other than for Emergency Care);
- You utilize ongoing or concurrent medical treatment with a non-approved health care provider, with respect to the Injury (other than for Emergency Care);
- You refuse to submit to an independent medical examination by an 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;
- You do not provide accurate information to, and 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;
- You do not keep a scheduled appointment with an Approved Medical Provider;
- You do not (1) timely inform your Supervisor that you have been released by an Approved Physician to return to full or Modified Duty, (2) timely report to work in accordance with such work release, or (3) perform Modified Duty in accordance with the Approved Physician's assigned work restrictions;
- You fail to fully cooperate with the Claims Administrator in connection with providing information to the Plan, including, but not limited to, providing incident reports and relevant medical records, submitting to a recorded statement, and complying with the Plan's subrogation or coordination of benefits procedures; and
- You fail to comply with the provisions of this summary plan description, the official Plan document, and the rules and procedures adopted by the Claims Administrator for the administration of the Plan.

DETAILED CLAIM PROCEDURES

Filing a Claim for Benefits

An initial claim for Medical Benefits, Wage Benefits, or Dismemberment Benefits under the Plan shall be initiated by you (or your Representative) complying with the injury notice and medical treatment requirements found in the REQUESTING BENEFITS and MEDICAL BENEFITS sections of this booklet. A claim for Medical Benefits can also be

directly submitted to the Claims Administrator by a health care provider (for example, submitting a written pre-authorization request for your medical treatment or submitting invoices for medical treatment you have already received). A claim for Death Benefits under the Plan shall be initiated by a Beneficiary providing written or electronic notice of entitlement thereto to the Claims Administrator within 90 days after the date of your death.

- **What is a Claim:** Each (1) medical service or supply for which payment is requested, (2) Wage Benefit for a particular payroll period, or (3) claim for Dismemberment Benefits or Death 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. 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.
- **Who is a Claimant:** A claimant may file a claim for benefits under the Plan, as well as an appeal of an Adverse Benefit Determination. References in this DETAILED CLAIM PROCEDURES section to "claimant" may include you, a health care provider seeking payment for a service or supply, 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 your behalf. However, with respect to an Urgent Care Claim, a physician or other health care professional (1) licensed, accredited or certified to perform specified health services consistent with state law, and (2) with knowledge of a claimant's medical condition shall be permitted to act as the authorized Representative of the claimant.
- **Information to Submit:** Claims must include the information required by the REQUESTING BENEFITS section above 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 that provides that the amounts requested for payment under this Plan have not been reimbursed, or are not reimbursable under any other plan or program. See the OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFITS section of this booklet. 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.
- **Submission of Medical Bills for Payment:** Approved Medical Providers shall be requested to invoice all health-care-related charges directly to the Claims Administrator (or the Employer, which shall immediately transmit such invoice to the Claims Administrator). However, in the event that you receive such an invoice or pay such a charge, you must file all requests for payment or reimbursement of covered charges with the Claims Administrator within 30 days from the date such expenses are incurred

or, if later, the date you receive an invoice from an Approved Medical Provider, or other health care provider (in the case of Emergency Care) for such expenses.

- **Incomplete Claim Submissions:** If 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. Subject to the applicable provisions of this DETAILED CLAIM PROCEDURES section, **if 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.**
- **Impartiality:** The Plan shall ensure that all claims and appeals for benefits are determined in a manner designed to ensure independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual (such as a claims adjuster or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Timing of Notice for Initial Adverse Benefit Determination

An initial benefit determination that approves Plan benefits can be communicated verbally, in writing or by electronic notice. Except as described below with respect to an Urgent Care Claim, an initial benefit determination that is an Adverse Benefit Determination must be provided in writing or by electronic notice. The Claims Administrator shall provide notice to the claimant of its initial benefit determination as follows:

- **Urgent Care Medical Benefit Claims:** In the case of an Urgent Care Claim for Medical Benefits, 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.
 - Notification of an Adverse Benefit Determination for 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 3 days after the oral notification.
 - If the claimant (1) fails to follow the Plan's procedures for filing an Urgent Care Claim, or (2) 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 the Claims Administrator shall have the following additional notice requirement. 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.

- 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 written notice.
- 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.
- 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 (1) the Claims Administrator's receipt of the specified information necessary to complete the claim, or (2) the end of the time period given the claimant to provide such information.

➤ **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:

- 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.
- Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is an Urgent Care Claim will be decided as soon as possible, taking into account the medical exigencies of the claim, as follows:
 - 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.
 - 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 “Manner and Content of Adverse Benefit Determinations” section of the booklet.

➤ **Pre-Service Medical Benefit Claims:** In the case of a Pre-Service Claim for Medical Benefits, 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.

- If the claimant fails to follow the Plan's procedures for filing a 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 procedure to follow. 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.
 - 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 additional information is 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.
- **Post-Service Medical Benefit Claims and Wage Benefit Claims:** In the case of a Post-Service Claim for Medical Benefits or a claim for Wage 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 (1) the special circumstances requiring the extension, and (2) the date by which the Plan expects to render a decision.
 - If the extension relates to a claim for Wage Benefits, such notice shall also state (1) the standards on which entitlement to benefits is based, and (2) 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 upon which the claimant responds to the request for additional information.
- **Dismemberment Benefit Claims and Death Benefit Claims:** In the case of a claim for Dismember Benefits or Death Benefits, the Claims Administrator shall notify the

claimant of an Adverse Benefit Determination within 90 days after its receipt of the claim.

- The Claims Administrator may extend this period up to an additional 90 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 90-day period and state (1) the special circumstances requiring the extension, and (2) the date by which the Plan expects to render a decision.

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. Any electronic notice shall comply with ERISA regulations that specify the standards for electronic disclosure of benefit plan information.

➤ **General Requirements:** The notification to the claimant shall be written in a manner calculated to be understood by the claimant and shall include:

- The specific reason or reasons for the Adverse Benefit Determination;
- References to the specific Plan provisions on which the Adverse Benefit Determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures; and
- A statement that following an Adverse Benefit Determination on review by the Appeals Committee, the Plan offers no further voluntary levels of appeal and that the claimant has a right to bring a legal action under ERISA section 502(a).

➤ **Additional Requirements for Medical Benefit Claims:** If the Adverse Benefit Determination is in response to a claim for Medical Benefits, the notice shall include the following additional information:

- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy thereof shall be provided free of charge to the claimant upon request;
- If the Adverse Benefit Determination is based upon medical necessity, an experimental treatment or similar exclusion or limit, 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 shall be provided free of charge upon request; and

- If the initial Adverse Benefit Determination is in response to an Urgent Care Claim, a description of the expedited review process applicable to such claims.

➤ **Additional Requirements for Wage Benefit Claims:** If the Adverse Benefit Determination is in response to a claim for Wage Benefits, the notice shall be provided in a culturally and linguistically appropriate manner (as described in this DETAILED CLAIM PROCEDURES section) and shall include the following additional information:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant;
 - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.
- If the Adverse Benefit Determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- A statement 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 benefits.

Filing an Appeal

Except as otherwise provided below, the claimant may appeal in writing an initial Adverse Benefit Determination to the Appeals Committee within 180 days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator.

➤ 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 reviewing the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

- 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).
- In the case of an Adverse Benefit Determination of 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, will be transmitted between the Plan and the claimant by telephone, facsimile or other available expeditious method.
- In the case of an Adverse Benefit Determination of a Dismemberment Benefit Claim or a Death Benefit Claim, the claimant may appeal in writing an initial Adverse Benefit Determination to the Appeals Committee within 60 days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator.

Appeal Committee Review

When reviewing the appeal of an Adverse Benefit Determination for Medical Benefits or Wage Benefits, the Appeals Committee shall comply with the following requirements:

- The Appeals Committee review shall not give any deference to the claimant's initial Adverse Benefit Determination.
- If the appeal request, 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.
- 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 Wage Benefits, without regard to whether the advice of such experts was relied upon in making the benefit determination.
- Before the Plan issues an Adverse Benefit Determination on review, the Appeals Committee shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided to the claimant, in order to give the claimant a reasonable opportunity to respond prior to the date.

- Before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, the Appeals Committee shall provide the claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided to the claimant, in order to give the claimant a reasonable opportunity to respond prior to that date.

Timing of Notice of Benefit Determination on Appeals Committee Review

The Appeals Committee shall provide notice to the claimant, as described below, of the Plan's benefit determination on review in accordance with the following timeframes:

- **Urgent Care Medical Benefit Claims:** In the case of 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.
- **Pre-Service Medical Benefit Claims:** In the case of a Pre-Service Claim for Medical Benefits, the Appeals Committee shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after its receipt of the appeal request.
- **Post-Service Medical Benefit Claims and Wage Benefit Claims:** In the case of a Post-Service Claim for Medical Benefits or a claim for Wage 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. The Appeals Committee may extend this period up to an additional 45 days Wage Benefits if the Appeals Committee determines that an extension is necessary due to matters beyond the control of the Plan. Written or electronic notification of an extension must be provided to the claimant prior to the expiration of the initial 45-day period and indicate (1) the special circumstances requiring the extension and (2) the date by which the Plan expects to render a decision.
- **Dismemberment Benefit Claims and Death Benefit Claims:** In the case of a claim for Dismemberment Benefits or Death Benefits, the Appeals Committee shall notify the claimant of the Plan's benefit determination on review within 60 days after its receipt of the appeal request. The Appeals Committee may extend this period up to an additional 60 days if the Appeals Committee determines that an extension is necessary due to matters beyond the control of the Plan. Written or electronic notification of an extension must be provided to the claimant prior to the expiration of the initial 60-day period and indicated (1) the special circumstances requiring the extension and (2) the date by which the Plan expects to render a decision.

Manner and Content of Benefit Determination on Appeals Committee Review

The Appeals Committee shall provide a claimant with written or electronic notification of the Plan's benefit determination on review. Any electronic notice shall comply with ERISA regulations that specify the standard for electronic disclosure of benefit plan information.

- **General Requirements:** If the determination on review is an Adverse Benefit Determination, the notice shall be written in a manner calculated to be understood by the claimant and shall include:
 - The specific reason or reasons for the Adverse Benefit Determination;
 - References to the specific Plan provisions on which the Adverse Benefit Determination is based; and
 - A statement of the claimant's right to bring an action under ERISA section 502(a).
- **Additional Requirements for Medical Benefit Claims:** If the Adverse Benefit Determination on review is in response to a claim for Medical Benefits, the notice shall include the following additional information:
 - The additional requirements for Medical Benefit claims described in this DETAILED CLAIM PROCEDURES section for the notice of initial benefit determinations; and
 - The following statement (if applicable): "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency."
- **Additional Requirements for Wage Benefit Claims:** If the Adverse Benefit Determination on review is in response to a claim for Wage Benefits, the notice shall include the following additional information:
 - The additional requirements for Wage Benefit claims described in this DETAILED CLAIM PROCEDURES section for the notice of initial benefit determinations; and
 - With respect to the statement of claimant's right to bring an action under ERISA section 502(a), any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

Standards for Culturally and Linguistically Appropriate Notices

The Plan shall comply with the following standards for culturally and linguistically appropriate notices:

- **Claims Assistance:** The Plan shall provide oral language services that include answering questions in any applicable non-English language and shall provide assistance with filing claims and appeals in any applicable non-English language.

- **Claimant Requests:** The Plan shall provide, upon request, a notice in any applicable non-English language.
- **Notice:** The Plan shall include in the English version of all notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

Extension of Time Frames Allowed by Law or Agreement

In the event that ERISA rules and regulations permit additional time for decisions or actions by the Claims Administrator or Appeals Committee, the Claims Administrator or Appeals Committee may exercise their discretion to utilize (but not exceed) those extended timeframes.

- 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 (for example, additional time is needed to obtain an appointment and results of a medical examination).
- Upon request by the Plan, a claimant may also voluntarily agree to an extension or further extension of any time period within which the Plan must decide a claim.

Exhaustion of Administrative Remedies

No legal action can be brought by or with respect to you to recover benefits under the Plan before the foregoing claim procedures have been exhausted. Every ERISA right of action by you, your Representative, Beneficiary or estate against the Plan, or any Plan fiduciary, must be brought no later than one (1) year from the date that the foregoing claim procedures have been exhausted (due to claimant inaction, claimant receipt of a final Adverse Benefit Determination on appeal, or otherwise). Unless contrary to applicable law, any ERISA right of action or other legal action challenging a Plan decision shall be brought in the United States District Court for the Southern District of Texas, Houston Division.

VOLUNTARY FINAL COMPROMISE AND SETTLEMENT

Not earlier than the tenth business day after the date of the initial report of Injury and after you have received a medical evaluation from a non-emergency care physician, the Claims Administrator may notify you of the Plan's desire to be released from any further known and unknown benefit (and all other injury-related claims) by you and pay a final claim settlement to, or with respect to you. If you agree to this release, no additional claims will be subsequently accepted with respect to such Injury.

OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFIT

Offset for Other Benefits

Wage Benefit payments under this Plan shall be reduced by:

- the amount of any applicable federal or state income, employment, or other taxes that are required by law to be withheld;
- your earnings from any employment obtained after disability begins, amounts legally garnished, and your 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; and
- except as otherwise specified in the Plan's "Coordination of Benefits" section, any amount paid or available with respect to your Injury under the following: workers' compensation law, unemployment compensation law, disabilities benefits law or any other similar law.

Coordination of Benefits

If you are covered under this Plan and one or more other benefit plans, then (unless otherwise subject to the "Subrogation and Reimbursement Rights" section) any Medical Benefits and Wage 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. **Nothing in this Article shall be construed to coordinate benefits under the Plan with benefits under a group health plan.**

- Except as otherwise specified above with respect to group health plans, "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 trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans, (5) benefits coverage in a group, group-type and individual policy or policies of automobile coverage (including, but not limited to medical payment coverage, personal injury protection coverage, uninsured motorists coverage and underinsured motorists coverage, and (6) any other group-type contracts – that is, those contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

- Except as specified below, 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:
 - 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;
 - The plan under which the person is covered other than as a dependent (for example, active employee, former employee, inactive employee, COBRA participant or retiree) will be the primary plan over a plan which covers the person as a dependent;
 - 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 participant or retiree; or
 - 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.

- Consistent with Medicare Secondary Payer rules for no-fault and/or liability forms of coverage, 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.

- The fact that a person is eligible for or provided (1) medical assistance under a state plan, or (2) disability benefits, survivor benefits or retirement benefits under the Social Security Act, will not be taken into account in making Plan payments.

- You must notify the Claims Administrator of such other benefit plans and cooperate with the Claims Administrator in (1) furnishing copies of other policies, coverage 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, coverage or plans which may cover or be applicable to you.

Subrogation and Reimbursement Rights

For purposes of “Subrogation and Reimbursement Rights”, “Notice of Legal Proceedings,” and “Assignment of Rights” sections of this Plan, the term “Payee” means you or your Beneficiary or your respective family members, heirs, estate, or other Representative (in their individual or representative capacity), singularly or collectively as the context may require to give the Plan the broadest possible rights of recovery.

- **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, the Employer), and is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury (including, but not limited to, damages for negligence,

survival, wrongful death or other legal or equitable action), whether by insurance, litigation, settlement or other proceeding, the Payee shall automatically be required to (i) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation to the extent of the Plan benefits paid to, or with respect to, the Payee and (ii) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation for all medical management, investigation, attorneys' fees, costs of recovery, and other expenses related to the claim for benefits (including any subrogation proceeding). The subrogation rights of this Plan even apply with respect to a Payee who is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury but has not and will not receive any Plan benefits if such person's claim for damages or other compensation is dependent on whether the participant had or has a valid claim against a third party.

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

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, attorneys' fees, costs of recovery, and other expenses incurred by the Plan.

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, the "Subrogation and Reimbursement Rights," "Notice of Legal Proceedings," and "Assignment of Rights" sections 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 the "Subrogation and Reimbursement Rights, and "Notice of Legal Proceedings," sections, and to use the name of such party for such purpose. The Plan shall have the right to select legal counsel of its own choice and such counsel shall have complete control over the conduct of any such lawsuit, settlement discussion, or other proceeding without the consent or participation of any such Payee. Whenever the Plan shall intervene in or institute any lawsuit or other proceeding as permitted by the provisions of this section, the Plan may pursue same to a final determination and the Plan expressly reserves the right to appeal from any adverse judgment or decision. The Payee shall give the Plan all reasonable aid in any such lawsuit, settlement discussion, or other proceeding in effecting settlement, in securing evidence, in obtaining witnesses, or as may otherwise be requested by the Claims Administrator. The Payee shall release the Plan, the Employer, the Plan Administrator, the Claims Administrator, the 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.

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. This Plan is exempt from the group health plan requirements of:

- **HIPAA:** Part 7 of ERISA by operation of one or a combination of the excepted benefits listed in ERISA Section 733(c)(1) and is therefore exempt from the standards, rules, regulations and other requirements of the Health Insurance Portability and Accountability Act;
- **PPACA:** The Public Health Service Act by operation of one or a combination of the excepted benefits listed in Title 42 of the United States Code Section 300gg-91(c)(1) and is therefore exempt from the standards, rules, regulations and other requirements of the Patient Protection and Affordable Care Act; and
- **Other Group Health Laws:** Any other standards, rules, regulations or other requirements that utilize or reference the excepted benefits definition listed in ERISA Section 733(c)(1).
- **COBRA Continuation Coverage:** The Consolidated Omnibus Budget Reconciliation Act (“COBRA”) requires group health plans to provide continuation coverage upon the occurrence of a “qualifying event” that would result in a loss of coverage. To the extent that the Department of Labor, Internal Revenue Service or court of competent jurisdiction determines that the Employer is mandated to provide continuation coverage for Medical Benefits provided under this Plan, then no provision of the Plan will be construed to preclude offering COBRA continuation coverage. However, continuation of Medical Benefit coverage should not apply to this Plan because:
 - Medical 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 necessary if you experienced a termination of employment with the Employer for whatever reason.
 - If you have a covered Injury during your employment with an Employer, the Plan would continue to provide you with Medical Benefits for that Injury following your termination of employment (subject to the terms and limits in this Plan), unless such employment was terminated based upon Gross Misconduct. Therefore, termination of employment in this situation would not be a “qualifying event” under COBRA because it would not result in a loss of coverage under the Plan.
- 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.

AMENDMENT OR TERMINATION OF PLAN

The Company presently intends to continue the Plan indefinitely, but the Company reserves the right to amend or terminate the Plan at any time; provided, however, that no such amendment or termination will reduce the amount of any benefit payable to, or with respect to, you under the Plan in connection with an Injury occurring prior to the date of such amendment or termination. Any such amendment or termination will be adopted pursuant to formal written action of a representative authorized to act on behalf of the Company.

DEFINITIONS

This section defines specific terms used in this booklet. These definitions should not be interpreted to extend coverage unless specifically provided for in the other sections of this booklet and the Plan document.

Adverse Benefit Determination

A denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Plan benefit. An “Adverse Benefit Determination” may also be a denial, reduction, termination, or failure to provide or make payment that is based on a determination of your or your Beneficiary’s eligibility to participate in the Plan.

- With respect to a claim for Medical Benefits, the term “Adverse Benefit Determination” includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service (for which benefits are otherwise provided) because the item or service is determined to be experimental, investigational or not medically necessary or appropriate.
- With respect to a claim for Wage Benefits, the term “Adverse Benefit Determination” also means any rescission of your Wage Benefit coverage (whether or not, in connection with the rescission, there is an adverse effect on a particular benefit at that time). For this purpose, the term “rescission” means a cancellation or discontinuance of coverage that has retroactive effect.

Appeals Committee

The designated decision maker appointed by the Plan Administrator to make Determinations on appeal of benefit claims. The Appeals Committee’s fiduciary responsibility is limited to discretionary authority and ultimate decision-making authority with respect to any final appeals of denied claims. The Appeals Committee shall otherwise hold no further authority, responsibility or liability as related to the administration of the Plan.

Approved Facility

A hospital, urgent care center, medical rehabilitation hospital, skilled nursing facility, or other health care facility either expressly approved by the Claims Administrator or included on an approved list of facilities adopted by the Claims Administrator.

Approved Medical Provider

An Approved Facility, Approved Physician or other health care service or supply provider either expressly approved by the Claims Administrator or included on the approved list of medical providers adopted by the Claims Administrator. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any list of Approved Medical Providers at any time.

Approved Physician

A person duly licensed under applicable state law as a Medical Doctor or Doctor of Osteopathy and either expressly approved by the Claims Administrator or included on an approved list of physicians adopted by the Claims Administrator.

Beneficiary

The person or persons determined in the following priority:

- If there is an Eligible Spouse, Death Benefits shall be paid to the Eligible Spouse.
- If there is no Eligible Spouse, Death Benefits shall be paid in equal shares to the Eligible Children.
- If you are not survived by an Eligible Spouse or Eligible Child, Death Benefits shall be paid to your surviving dependents (as determined in accordance with the support criteria set forth in Internal Revenue Code section 152 and such other rules as the Claims Administrator may prescribe) who is your parent, sibling or grandparent. If more than one of those dependents survives you, Death Benefits shall be divided among them in equal shares.
- If you are not survived by an Eligible Spouse, Eligible Child, or other surviving dependent who is your parent, sibling or grandparent, no Death Benefits shall be payable.
- “Eligible Spouse” means your surviving Spouse or Domestic Partner:
 - “Spouse” means a person (whether of the opposite gender or the same gender) who is lawfully married to you under the laws of the state or country in which the relationship was created (regardless of where the married couple is currently domiciled).

- “Domestic Partner” means (i) a person (whether of the opposite gender or same gender) who has entered with you into a registered domestic partnership, civil union, or other similar formal relationship recognized under the laws of the state or country in which the relationship was created, and (ii) such formal relationship is not denominated as a marriage under the laws of the state or country in which the relationship was created.
- "Eligible Child" means your surviving child, whether by blood, marriage, or legal adoption, and for which the parent-child relationship has been legally established prior to the date of your death by evidence of birth certificate, adoption decree, or other court decree of paternity or maternity, if the child is:
- Under 18 years of age;
 - Enrolled as a full-time student in an accredited educational institution and is less than 26 years of age; or
 - Because of a physical or mental handicap, your 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) at the time of your death.

Claims Administrator

The individual, individuals or entity appointed by the Plan Administrator to make initial determinations of benefit claims under this Plan.

Course and Scope of Employment

An activity of any kind or character for which you were hired and that has to do with, and originates in, the work, business, trade or profession of the Employer, and that is performed by you in the furtherance of the affairs or business of the Employer. The term includes activities conducted on the premises of the Employer or at other locations designated by the Employer. This term does not include:

- transportation to and from your place of employment, unless:
- the transportation is furnished as part of your employment arrangement or is paid for by the Employer; provided, however, that this exception does not include commuting to or from your usual place of employment;
 - the means of the transportation are under the control of an Employer;
 - you are directed in your employment to proceed from one place to another place. Commuting to the place where you begin Employer business and commuting away from the place where you cease Employer business will not be covered if such transportation is not paid for by the Employer or otherwise under Employer control; or
 - your home residence is considered your usual place of employment. In this situation, transportation to or from your residence shall not be considered commuting if the purposes of such travel is for the furtherance of Employer business.

- travel by you in furtherance of the affairs or business of the Employer if such travel is also in furtherance of personal or private affairs by you, unless:
 - the travel to the place where the Injury occurred would have been made even had there been no personal or private affairs by you to be furthered by the travel; and
 - the travel would not have been made had there been no affairs or business of the Employer to be furthered by the travel.

- any injury occurring before you clock in or otherwise begin work for the Employer, while on a permitted work break, or after you clock out or otherwise cease work for an Employer unless:
 - the injury occurs while you are on the Employer’s premises (or other area for which an Employer is responsible for maintenance); and
 - such injury is not otherwise excluded under the personal property or personal deviation exclusions referenced below.

- any injury that results from personal property that does not originate in the Employer’s workplace and is not specifically required for your work activities.

- any injury occurring as a result of personal errands or similar personal deviations from your work activities, as determined by the Claims Administrator.

Disabled or Disability

A Temporary Total Disability or a Temporary Partial Disability:

- A “Temporary Total Disability” means a medically demonstrable anatomical or physiological abnormality caused by an Injury, which causes you to be temporarily:
 - unable to perform the normal duties for which you were employed;
 - under the regular care of an Approved Physician; and
 - unable to engage in Modified Duty or any other occupation for wage or profit.

- A “Temporary Partial Disability” means a medically demonstrable anatomical or physiological abnormality caused by an Injury that results in you being temporarily:
 - unable to fully perform the normal duties for which you were employed;
 - under the regular care of an Approved Physician;
 - released to Modified Duty by such Approved Physician; and
 - working for the Employer in a Modified Duty position approved by the Employer.

Emergency Care

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 (1) result in death,

disfigurement, or permanent disability, or (2) result in substantial impairment of any bodily organ, part, or function.

Employee Self-Service

The internal web portal located at <https://access.paylocity.com/> on which an Employee can find information regarding the Employer and his or her employment with the Employer.

Good Cause

Your conduct is reasonable based on the circumstances and information within your knowledge or control and as compared to what an ordinary and prudent person having the same or similar knowledge or control would do under the same or similar circumstances.

- As part of its investigation, the Claims Administrator shall request you and the Employer to provide evidence relevant to determining the existence of Good Cause. **You can also voluntarily provide information to the Claims Administrator to support Good Cause exists to excuse your non-compliance with a particular Plan requirement to which a Good Cause exception applies.**
- The Claims Administrator shall consider all evidence of Good Cause, provided or obtained, during its investigation, in order to determine whether Good Cause exists in a particular circumstance.

Gross Misconduct

Your gross misconduct within the meaning of Section 4980B of the Internal Revenue Code, or any successor provision of law. Gross misconduct means more than momentary thoughtlessness, inadvertence, or error of judgment. It means such an entire want of care as to establish that the act or omission in question was the result of actual conscious indifference to the rights, welfare, or safety of the persons or Employer affected by it.

Major Contributing Cause

More than fifty percent (50%) of the resulting injury, disease or illness.

Maximum Benefit Limit

The maximum amount of all benefits payable to you under the Plan with respect to an Injury. Payments made for each form of benefit will be counted towards the Maximum Benefit Limit amount. The Maximum Benefit Limit for this Plan is \$350,000 provided, however, 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, will not exceed \$700,000. This

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.

Maximum Rehabilitative Capacity

The earliest date after which, based upon reasonable Medical Probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Medically Probable or Medical Probability

A medical determination that is more likely than not accurate, based upon objective medical evidence. A medical determination is more likely than not if the probability of its occurrence or validity is determined with a fifty-one percent (51%) or greater degree of probability.

Modified Duty

A temporary accommodation that allows you to perform your regular job, or an alternate, temporary job that complies with your work restrictions and the Employer's needs.

Plan

Silver Eagle Distributors Houston, LLC Texas Injury Benefit Plan

Plan Administrator

The Company is the plan administrator of the Plan for purposes of ERISA. The Plan is administered on behalf of the Company by the Claims Administrator and Appeals Committee.

Subject to the Plan claim procedures, both the Claims Administrator and the Appeals Committee have discretionary authority to interpret and implement the provisions of the Plan. 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 of authority by the Claims Administrator or Appeals Committee will be binding upon all affected parties, 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 Claims Administrator or 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 or Appeals Committee may adopt any rules and procedures it considers necessary or appropriate for the administration of the Plan.

Post-Service Claim

Any claim for a Medical Benefit that is not an Urgent Care Claim or a Pre-Service Claim. A Post-Service Claim shall include, but not be limited to, a determination involving (1) initial eligibility for Plan benefits, or (2) termination of ongoing eligibility for Plan benefits.

Preexisting Condition

Your illness, injury, disease, impairment or other physical or mental condition, whether or not work-related, which originated or existed prior to the date of the Injury.

Pre-Injury Pay

- For a salaried participant, regular bi-weekly salary from the Employer at the time of the Injury; and
- for hourly Participants, the average earnings from the Employer for the 14 consecutive weeks immediately preceding the date of Injury; provided, however, that if such a Participant has worked for the Employer for less than 14 consecutive weeks, or if his or her earnings as of such date cannot be reasonably determined (in the judgment of the Claims Administrator), such 14-week average will be based upon the earnings received over such period by a similar employee of the Employer; or
- for participants who receive a base salary with quota pay and pay for performance, the regular bi-weekly base salary plus the average earnings under the quota and pay for performance programs from the Employer for the 14 consecutive weeks immediately preceding the day of Injury; provided, however, that if such a Participant has worked for the Employer for less than 14 consecutive weeks, or if his or her earnings as of such date cannot be reasonably determined (in the judgment of the Claims Administrator, such 14-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 commissions reported to the Internal Revenue Service, and participant contributions (through salary reduction or otherwise) to a 401(k) arrangement, cafeteria plan, or other pre-tax salary deferral employee benefit plan. The Claims Administrator may prescribe special rules for commissions. "Pre-Injury Pay" **shall not include** any benefits (including, but not limited to, Employer contributions to any employee benefit plans or matching contributions to a retirement plan) or other extraordinary remuneration.

Pre-Service Claim

Any claim for Medical Benefits related to a specific diagnostic test, procedure, hospital admission or similar medical treatment with respect to which this Plan requires Claims Administrator approval in advance of obtaining medical care. A Pre-Service Claim shall not include any determination involving (1) initial eligibility for Plan benefits, or (2) termination of ongoing eligibility for Plan benefits.

Principally Located

You are assigned by the Employer to, and regularly work at a Texas location of, the Employer. The Claims Administrator may also rely upon additional facts and circumstances to determine where you are Principally Located, such as your inclusion on the Employer's Texas payroll records.

Representative

A person that you authorize in writing to act on your behalf. The Plan will also recognize a legally valid power of attorney or a court or administrative agency order giving a person authority to take an act on your behalf. In the case of an Urgent Care Claim, a physician with knowledge of your condition may act as your Representative.

Traumatic Event

Any act involving, or of the nature of, violent crime or any other incident that would result in severe shock to a reasonable person.

Urgent Care Claim

Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent Pre-Service Claim determinations (generally, 15 days after the Claims Administrator's receipt of the claim):

- could seriously jeopardize your life or health or your ability to regain maximum function; or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject you 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 as described 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, the Plan shall treat the claim 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 processing benefit claims and in no way changes this Plan's Approved Medical Provider requirements, pre-authorization requirements, or other medical management requirements. Urgent Care Claims may not arise to the level of involving Emergency Care. Your 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. See the MEDICAL BENEFITS and DETAILED CLAIM PROCEDURES sections of this booklet for more information.

Usual and Customary

A charge that is not more than the amount charged by a health care provider when there is no insurance or other third party reimbursement, and is not more than the prevailing and customary charge in the “locality” for a “like treatment”, “service” or “supply”.

GENERAL INFORMATION

Type of Plan and Administration

The Plan is a welfare benefit plan providing wage, death, dismemberment and medical benefits (including certain dental and vision benefits) due to an Injury. The Plan is administered by the Claims Administrator and Appeals Committee to the extent such duties have been delegated to the Claims Administrator and Appeals Committee by the Plan Administrator.

Name and Address of Plan Sponsor

Silver Eagle Distributors Houston, LLC
7777 Washington Avenue
Houston Texas 77007

A list of any additional participating employers of Silver Eagle Distributors Houston, LLC in this Plan is available from the Plan Administrator upon request.

Name and Address of Plan Administrator

Any questions you may have about the Plan may be posed to the Plan Administrator by mail, c/o Director of Health, Safety & Environment, Silver Eagle Distributors Houston, LLC, 7777 Washington Avenue, Houston Texas 77007, or by telephone at 713.869.4361.

Name and Address of Person Designated as Agent for Service of Legal Process

CT Corporation
1999 Bryan Street
Suite 900
Dallas, Texas 75201- 4234
Service of legal process may also be made upon the Plan Administrator.

Employer and Plan Identification Numbers

The employer identification number assigned by the Internal Revenue Service to Silver Eagle Distributors Houston, LLC is 83-4526800. The plan number of the Plan is 503.

Plan Year

The Plan operates and keeps its records on the basis of the 12-month period ending each December 31.

ERISA RIGHTS STATEMENT

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites) all documents governing the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$147 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 brought a claim against to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

January 15, 2022

APPENDIX A
ARBITRATION OF CERTAIN INJURY-RELATED DISPUTES

ARBITRATION POLICY OVERVIEW

The Employer hereby adopts a mandatory company policy requiring that certain claims or disputes must be submitted to final and binding arbitration under this arbitration requirement ("Policy"). **This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.** To the extent the Employee is covered by the Employer's Dispute Resolution Claim (Jury Trial Waiver), this Arbitration Policy shall take precedence with respect to Covered Claims.

(a) Definitions:

- (1) **"Company"** means Silver Eagle Distributors Houston, LLC, a limited liability corporation whose principal place of business is located in Houston, Texas, or any successor thereto.
- (2) **"Employee"** means either:
 - (a) any person who is employed in the regular business of, is under the direction and control 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; or
 - (b) any person who is determined to be a common law Employee of an Employer by a court of competent jurisdiction or arbitrator.

This term does not include a leased employee, a temporary staffing employee, an independent contractor or other third-party agent.

- (3) **"Employer"** means the Company and any incorporated or unincorporated trade or business that (1) is a member of a control group (with the meaning of Section 3(40) of ERISA) with respect to which the Company is also a member, and (2) maintains Employees whose employment with the Employer is principally located within the State of Texas.
- (4) **"Plan"** means the Silver Eagle Distributors Houston, LLC Texas Injury Benefit Plan.

(b) Covered Claims:

- (1) 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, an Employee training program, or this Policy; and
- (2) 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 actual or alleged accident, occupational disease, or cumulative trauma (including, but not limited to, claims of negligence or gross negligence or discrimination; claims for intentional acts, assault, battery, negligent hiring/ training/ supervision/ retention,

emotional distress, retaliatory discharge, or violation of any other noncriminal federal, state or other governmental common law, statute, regulation or ordinance in connection with a job-related injury, regardless of whether the common law doctrine was recognized or whether the statute, regulation or ordinance was enacted before or after the effective date of this Policy).

- (3) The determination of whether a claim is covered by this Policy.

This arbitration requirement includes all claims listed above that an Employee has now or in the future against an Employer, its officers, directors, owners, Employees, representatives, agents, subsidiaries, affiliates, successors, or assigns (even if such claim relates to matters occurring before the effective date of this Policy, if the Employee has not filed a legal action in any court or with any governmental agency prior to such date).

(c) Excluded Claims: This arbitration requirement does not, however, include the following claims:

- (1) **any legal or equitable claim under ERISA for benefits, fiduciary breach, or other problem or relief solely relating to benefits payable under this Plan.** If an Employee wishes to appeal a denial of benefits under the Plan, such Employee must follow the process described in ARTICLE VI of the Plan. After exhausting the appeal process outlined in ARTICLE VI of the Plan, any action challenging a Plan decision, or any other ERISA right of action, must be brought in the United States District Court for the Southern District of Texas, Houston Division.
- (2) Any claim filed with an administrative agency in accordance with applicable law.
- (3) Any criminal act or complaint, including but not limited to, restitution by an Employee for a criminal act for which he or she has been found guilty or no contest, or if the criminal proceedings have been resolved by deferred adjudication.

(d) Covered Parties: Neither an Employee nor an Employer shall be entitled to a bench or jury trial on any claim covered by this Policy. This Policy applies to all Employees without regard to whether they have completed a Receipt, Safety Pledge and Arbitration Acknowledgement form or similar written receipt. These provisions also apply to any claims that may be brought by an Employee's spouse, children, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns (including, but not limited to, any survival or wrongful-death claims).

(e) Effective Date: For Texas Employees that were hired by the Employer before January 15, 2022, any changes included in this updated Policy shall be effective on the later of (1) January 15, 2022, or (2) the fifteenth (15th) calendar day following the date that the Employer provided notice of this updated Policy to such Texas Employees. For Texas Employees that are hired by the Employer on or after January 15, 2022, any changes included in this updated Policy shall be effective January 15, 2022.

ARBITRATION PROCESS

- (a) Required Notice of All Claims:** When a party seeks arbitration, such party must give written notice of any claim to the American Arbitration Association **and** the other party

within the applicable statute of limitations for such claim. The day the act complained of occurred will be counted for purposes of determining the applicable period. If such notice is not given timely and in the manner described above, the claim shall be void and deemed waived. **The filing of a lawsuit will not toll the running of the applicable statute of limitations to request arbitration of a claim, nor will the doctrine of equitable tolling apply to extend the limitations period for the party to request arbitration.**

- (1) The party requesting arbitration must send written notice in triplicate to the American Arbitration Association, Attention: Regional Claims Administrator, at 13727 Noel Road, North Tower II, Suite 700, Dallas, Texas 75240. If an Employee wishes to invoke arbitration, the Employee must also send written notice to the Employer, in care of the General Counsel, Silver Eagle Distributors Houston, LLC, 7777 Washington Avenue, Houston Texas 77007 (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.
 - (2) 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 Policy.
 - (3) If after expiration of the applicable statute of limitation (i) a court has ordered the parties to arbitrate, and (ii) such court or arbitrator for whatever reason has determined that the claim is not void and deemed waived, then the party that is compelled to arbitrate must initiate a claim for arbitration regarding such claim with the AAA and serve the other party within 30 days or the party's claim shall be void and deemed waived. Such notice must be given in the manner described above.
 - (4) The identification of the American Arbitration Association as the designated arbitration provider is not integral to this arbitration policy so as to render the arbitration policy null and void. If for any reason the American Arbitration Association is no longer available for the administration of this arbitration policy, the Employee requesting arbitration shall provide written notice to the General Counsel, Silver Eagle Distributors Houston, LLC, 7777 Washington Avenue, Houston Texas 77007 via the Company's agent for service CT Corporation and obtain the proper Notice of Arbitration forms for forwarding to the independent arbitration firm approved by the Company.
- (b) Arbitration Filing Fees:** The Employee shall pay a nonrefundable arbitration filing fee equal to the standard Employee filing fee specified under then-current AAA Employment Arbitration Rules and Mediation Procedures. The Employee's filing fee must be paid when he or she submits a request for arbitration (or, if this process is challenged by an Employee, when arbitration is compelled by court order). The Employer shall pay a nonrefundable arbitration filing fee equal to the standard employer filing fee specified under then-current AAA Employment Arbitration Rules and Mediation Procedures. The Employer will also pay the arbitrator's entire fee and any other AAA administrative expenses; provided, however, that an Employee may elect to also pay up to one-half of these fees and expenses.

- (1) 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.
 - (2) 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 filing fees.
- (c) **Choosing an Arbitrator:** Once the AAA receives a request for arbitration and all administrative fees are paid, the AAA will send both parties a list of neutral arbitrator candidates who have been pre-screened by the AAA for potential conflicts of interest. **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 Harris County, Texas.** Any disclosures that are mandated by applicable law regarding the arbitrator candidates will be made at this time, and the AAA will also provide both parties with a brief description of the background and experience of each arbitrator candidate.
- (1) Either party may challenge an arbitrator candidate for cause, and the AAA will rule on such challenge. If a challenge for cause is upheld, a replacement name will be given to both parties.
 - (2) Following any challenges for cause, either party may strike three names from the final list and then rank the remaining arbitrator candidates in order of preference. If there is more than one candidate remaining after the strikes and the parties cannot agree on one of the remaining arbitrators, the candidate with the highest total ranking will become the arbitrator. If this process does not result in selection of an arbitrator, the AAA will designate the arbitrator.
 - (3) If a party to the arbitration fails to return a final list to the AAA within the timeframe specified by the AAA Rules, the AAA will consider all names on the list as being acceptable to that party.
 - (4) If the arbitrator so selected becomes unable to serve for any reason, the parties shall again go through the same selection process.
- (d) **Arbitrator Authority:** The arbitrator, and not any federal, state, or local court or agency, shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability or formation of this Policy including, but not limited to, any claim that all or any part of this Policy is void or voidable.
- (1) **At any time, 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.**
 - (2) 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 Policy or to make any award merely on the basis of what he or she determined to be just or fair.

- (3) **The arbitrator shall also not commingle the standards for state law determinations and remedies (for example, negligence claims and special damage awards) with the standards for federal law determinations and remedies that may or may not be subject to this Policy (for example, ERISA benefit eligibility and ERISA damage awards are not subject to arbitration).**
 - (4) **The arbitrator is not empowered to award punitive or exemplary damages, except where required by statute, and the parties waive any right to recover any such damages. In addition, the arbitrator may not award any incidental, indirect or consequential damages, including damages for lost profits.**
- (e) **Arbitration Procedures:** Any arbitration under this Policy will be administered by the American Arbitration Association ("AAA") under its then-current Employment Arbitration Rules and Mediation Procedures. However, in the event that AAA is unavailable, the parties agree to comply with the arbitration rules and procedures promulgated by the independent arbitration firm approved by the Company.
- (1) **Preliminary Hearing:** After arbitrator selection, a preliminary hearing may be scheduled upon request by the parties, the AAA or the selected arbitrator. At this hearing, the arbitrator will work with the parties to narrow the issues, establish a discovery schedule, arrange for an acceptable procedure for the filing of any motions and arrange for the earliest and most efficient arbitration hearing possible for the issues in dispute.
 - (2) **Discovery: Discovery:** Employer and Employee agree that discovery shall be limited as follows:
 - i. Each party shall make disclosures in compliance with Texas Rule of Civil Procedure 194, including pertaining to expert witnesses.
 - ii. Each party shall take no more than six (6) hours of fact witness deposition testimony and no more than (4) hours of expert witness deposition testimony. In all other respects, the depositions shall be conducted pursuant to the Texas Rules of Civil Procedure.
 - iii. Each party shall serve no more than ten (10) written interrogatories upon the other party. Interrogatories and the answers and objections to same shall be pursuant to the Texas Rules of Civil Procedure.
 - iv. Each party shall serve no more than ten (10) requests for production upon the other party. Requests for Production and the responses and objections to same shall be pursuant to the Texas Rules of Civil Procedure.

The arbitrator may authorize additional discovery beyond the above-stated limits if a party establishes that such discovery is necessary for a full and fair exploration of the issues in dispute, consistent with the expedited nature of arbitration. The arbitrator can issue protective orders as he or she deems necessary or appropriate to protect the privacy or other legal rights of the parties and/or witnesses.

- (3) **Recording the Hearing:** Either party may arrange for, and pay the cost of, a court reporter to provide a stenographic record of the proceedings. Otherwise, the arbitration hearing will not be recorded.
 - (4) **Attorneys' Fees:** Each party shall be responsible for their own attorneys' fees, if any. However, if any party prevails on a statutory claim which allows the prevailing party to be awarded attorneys' fees, or if there is a written agreement providing for such fees, the arbitrator may award reasonable attorneys' fees to the prevailing party.
 - (5) **Other Arbitration Expenses:** Each party shall also be responsible for any costs for witnesses called, any costs to produce evidence requested by the other party, deposition costs, and transcripts. The Employer will pay fees and expenses charged by the arbitrator or the AAA for the arbitration; however, the Employee may elect to pay up to one-half of these fees and expenses if requested.
 - (6) **Failure to Attend:** If an Employee or the Employer fail to attend a scheduled arbitration hearing without good cause (as determined by the arbitrator), any claim brought by the party failing to attend will be dismissed and cannot be pursued further.
- (f) **Arbitration Decision: Unless the parties agree otherwise, the arbitrator will make a final and binding decision within 30 days after the hearing is closed.** 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. Judgment on any award by the arbitrator may be entered into any court having jurisdiction over the claim and shall have the same legally binding effect as if the judgment had been rendered in such court.
- (1) **The arbitrator's decision shall be rendered in writing, shall include a reasoned opinion necessary to support the arbitrator's decision and shall be signed by the arbitrator.**
 - (2) The arbitrator shall assess the AAA filing fee, arbitrator fees and expenses, and attorneys' fees against a party upon a showing by the other party that the first party's claim is frivolous, or unreasonable, or factually or legally groundless.
 - (3) Except with respect to lawsuits or other proceedings seeking to enforce or vacate an arbitration award, all decisions rendered by an arbitrator under this Policy will be kept confidential by all parties. An arbitrator's decision shall not serve as binding, legal precedent with respect to subsequent claims or disputes under this Policy.
 - (4) **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.**

ADDITIONAL INFORMATION

- (a) **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, or traveling on interstate roadways) and the Employee's

employment involves such commerce. Except as provided in this Policy, the Federal Arbitration Act shall govern the interpretation, enforcement, and all proceedings under the arbitration provisions of this Policy. To the extent that the Federal Arbitration Act is not applicable, Texas common law shall apply. Unless contrary to applicable law, any lawsuits seeking to enforce or vacate an arbitration award shall be brought in the United States District Court for the Southern District of Texas, Houston Division.

- (b) **Binding Effect:** This Policy for resolving claims by arbitration is equally binding upon, and applies to any such claims that may be brought by, an Employer and each Employee and his/her spouse, children, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns (including, but not limited to, any survival or wrongful-death claim). This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.
- (1) This Policy applies to each Employee and the Employer without regard to whether they have completed and signed a Receipt, Safety Pledge and Arbitration Acknowledgement form or similar written receipt. Adequate consideration for this Policy is represented by, among other things, eligibility for (and not necessarily any receipt of) benefits under this Plan and the fact that it is mutually binding on both the Employer 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 Policy.** This Policy shall remain in effect with respect to the Employer and all Employees, without regard to any Employee refusal of benefits under this Plan, return of benefit payments under this Plan to an Employer, ineligibility for or cessation of benefits under this Plan in accordance with its terms, or any voluntary or involuntary termination of an Employee's employment with an Employer.
 - (2) This Policy 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 Policy also in no way change the "at will" employment status of any Employee not covered by a collective bargaining agreement.
 - (3) **If either party initiates a claim covered by this Policy by any means other than arbitration, the responding party shall be entitled to dismissal of such action, and the recovery of all costs and attorney's fees and expenses related to such action.**
- (c) **Amendment or Termination of Arbitration Policy:** The Company shall have the right and power at any time and from time to time to amend this Policy, in whole or in part, on behalf of Employer, and at any time to terminate this Policy or any Employer's participation hereunder; provided, however, that no such amendment or termination shall alter the arbitration requirements of this Policy with respect to an Injury occurring prior to the date of such amendment or termination. In addition, any such amendment or termination of this arbitration Policy shall not be effective until at least 14 days after written notice has been provided to the Employee. Any such amendment or termination shall be pursuant to formal written action of a representative authorized to act on behalf of the Company.

(d) Severability. If one or more of the provisions in this Policy are deemed void by law, then the remaining provisions will continue in full force and effect.

Electronic OR Hardcopy Signature

**APPENDIX B
RECEIPT, SAFETY PLEDGE AND ARBITRATION ACKNOWLEDGEMENT**

RECEIPT OF MATERIALS. By my signature below, I acknowledge that I have received and read (or had the opportunity to read) the Summary Plan Description (the "SPD") for the Silver Eagle Distributors Houston, LLC Texas Injury Benefit Plan, updated effective January 15, 2022.

CONSENT TO ELECTRONIC DISCLOSURE OF DOCUMENTS AND NOTICE. I understand that my Employer is required to provide me with a copy of certain work-related information, including a summary plan description and arbitration policy. As a convenience, I may access these documents electronically through either *Paylocity* or *HSE Safe Landing*. By signing below where indicated, I consent to electronic receipt of these materials. I understand that I may request a hard copy of the summary plan description and arbitration policy from my Supervisor, and that I may at any time provide my Supervisor with a written withdrawal of this electronic consent.

INJURY NOTICE AND MEDICAL PROVIDERS. I understand and agree that for an Injury related to an Accident, I must report my Injury to the Silver Eagle Emergency Call Center at 1-877-211-5663 and my Supervisor within 24 hours following the date of the Accident. I further understand that in order to receive Plan benefits, I must also (1) receive any and all medical care from Plan-Approved Medical Providers, and (2) receive my first medical treatment from an Approved Medical Provider within 14 calendar days following the date I report the Accident and/or Injury. I also understand that I can submit (and the claims administrator must investigate) information demonstrating that I had Good Cause for not reporting an Accident/Injury or receiving treatment with an Approved Medical Provider in the manner specified above.

SAFETY PLEDGE. I agree to familiarize myself with the safety program for the Employer and to perform my job according to the general and departmental safety rules of the Employer. I will also use any personal protective equipment that is provided to me. I also agree to immediately report to my supervisor any accident that involves another employee, a customer, a vendor, or me. I will also immediately report any unsafe act, condition or equipment. I will also cooperate with any accident investigations, and actively participate in any Employer safety training programs.

ARBITRATION. I also acknowledge that a mandatory employment policy is attached as Appendix A to the SPD for convenience of reference. This policy requires that **claims or disputes that (1) are covered under this arbitration program or the Mutual Arbitration Agreement, (2) cannot otherwise be resolved between the Employer and me, and (3) relate to an actual or alleged on-the-job injury must be submitted to an arbitrator** rather than a judge and jury in court. I understand that by receiving this SPD and becoming employed (or continuing my employment) with the Employer at any time on or after January 15, 2022, I am accepting and agreeing to comply with these arbitration requirements. I understand that the Employer is also accepting and agreeing to comply with these arbitration requirements. All covered claims brought by my spouse, children, parents, beneficiaries, Representatives, executors, administrators, guardians, heirs or assigns are also subject to the Employer's arbitration policy, and any decision of an arbitrator will be final and binding on such persons and the Employer. **I understand that the arbitrator, and not a judge or jury, has the exclusive authority to resolve any dispute about the enforceability of this arbitration process.**

X _____ Employee's Signature	_____ Date
_____ Print Employee's Name	_____ Employee's Identification Number
_____ Parent or Legal Guardian Signature (if Employee under age 18)	_____ Date
_____ Print Parent or Legal Guardian Name Department	_____ Employee's Work Location or Department

* In the event the Employer utilizes an online Receipt, Safety Pledge and Arbitration Acknowledgement for this Plan, such manner of acknowledgement shall be considered equivalent to signing this form.

APPENDIX C

PROGRAM HIGHLIGHTS

Why did the Company start this Plan?

Silver Eagle Distributors Houston, LLC (the "Company") created the Silver Eagle Distributors Houston, LLC Texas Injury Benefit Plan (the "Plan") because we wanted a better administrative system for helping employees who are hurt at work.

We believe that the Texas Workers' Compensation System does not provide our employees with the most efficient process for work-related injuries. Therefore, we have developed a program to provide more efficient, quality, and effective care than the care afforded by the current workers' compensation system. Many other businesses across Texas have adopted similar programs.

Who is covered by the Plan?

All Texas employees of Silver Eagle Distributors Houston, LLC and its parents, subsidiaries and affiliated employers will be covered by this program. **For the purposes of this Plan, these companies are individually and collectively referred to as "Employer".**

How does the Plan affect me?

If you are injured on the job, the Employer can provide you with many benefits under the Plan, including paying for your covered medical care and making sure you receive a paycheck if you need to stay at home to recover. The Employer pays the entire cost of the Plan.

What are the advantages of the Plan?

We believe the Plan better fits your needs in several ways, including:

- *Access to medical providers that (in some cases) won't accept patients covered by workers' compensation.*
- *Faster handling of your injury benefit claims.*
- *More personalized attention to you if you are hurt on the job.*

Is there a waiting period before my Wage Benefits will begin?

No. Instead of the seven-day waiting period that is required by Texas Workers' Compensation, the Plan can start replacing your wages with a paycheck from the first full calendar day that you miss work.

When do I need to report my injury?

All work-related injuries will need to be reported immediately – no matter how minor the accident or injury appears to be. There will be no repercussions for reporting injuries. Reporting an injury in a timely manner ensures that you will receive prompt and quality medical care.

- **For an injury due to an accident, you must report your injury within 24 hours from the date of the accident.**

- **For an injury due to an occupational disease or cumulative trauma, you must report your injury by the earliest of:**
 - **24 hours after you are medically diagnosed with an occupational disease or cumulative trauma, or**
 - **30 calendar days from the date you should have known of your occupational disease or cumulative trauma.**

Who do I report my injury to?

You should report your injury to the Silver Eagle Emergency Call Center (1-877-211-5663) and to your Supervisor.

How is medical care handled under the Plan?

To receive Plan benefits, you may only use physicians, hospitals and clinics that have been approved by the Claims Administrator (“Approved Medical Providers”).

- These Approved Medical Providers have been chosen for their ability to provide occupational injury medical services.
- If you are not satisfied with the decision or diagnosis by an approved physician, you can get a second medical opinion from another physician (as described later in this booklet).

You must also receive your first medical treatment from an Approved Medical Provider within 14 calendar days after the date you report your accident and/or injury.

What if I don’t report my injury timely or receive my first medical treatment timely?

You should still report your accident/injury and request medical treatment from an Approved Medical Provider. For injuries that don’t require immediate Emergency Care, your work location should direct you to its Approved Medical Facility – regardless of when you reported your accident and/or injury. In most cases, the Plan will pay for this first medical treatment even if the Claims Administrator later determines that you are not eligible for Plan benefits.

In this situation, the Claims Administrator will investigate your claim to determine if you have Good Cause for not timely reporting your injury and/or not timely receiving your first medical treatment from an Approved Medical Provider.

See “REQUESTING BENEFITS” on page 8 for more information on Good Cause.

What if my benefit claim is denied for some reason?

You have the opportunity to file an appeal with a separate Appeals Committee. On appeal, the Appeals Committee will conduct an independent review of the claim and you can submit additional information supporting payment of the claim.

What if I have other issues related to my injury?

This program includes arbitration procedures to resolve other injury-related disputes between you and the Employer quickly and fairly. Arbitration is a process in which a skilled, independent arbitrator (similar to a judge) hears both sides of the situation and then makes a final and binding decision.

What are the advantages of arbitration?

Protected Rights

Arbitration offers the same fundamental protections as a court of law. And the arbitrator, just like a judge or jury, may award you anything you might seek through a court of law.

Fast Decisions

When a problem is taken to court, it often takes years to conclude. During that time, your time, money and energy that could be better used are tied up with paying expensive legal fees and court costs, having delays and wading through endless paperwork. But with arbitration, hearings can be scheduled - and decisions can often be reached - much faster than with a court.

Fair Decisions

Courts hear all types of cases ranging from car accidents to divorces. Judges and juries do not specialize in solving work-related problems. But arbitrators do. More importantly, the arbitrator is objective and does not have any relationship with the Employer.

Does this Plan directly affect my health insurance or other benefits?

No. This Plan is a separate program from your health insurance and other benefits and applies only when you have a work-related injury. The Employer's group health insurance plan does not cover work-related injuries.

When does this updated Plan take effect?

It is effective for all work-related injuries involving Silver Eagle Distributors Houston, LLC employees that occur on or after January 15, 2022.