OEP HOLDINGS, LLC.

Work Related Injury Plan

January 1, 2015

(revised December 1, 2020)

SUMMARY PLAN DESCRIPTION

PLAN NO. 502

OEP HOLDINGS, LLC
Work Related Injury Plan
Summary Plan Description

PROGRAM DETAIL

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

I. CONTACT INFORMATION

Who Is The Plan Administrator?

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

COMPANY's name, address, telephone number, and Employer Identification Number are as follows:

OEP Holdings, LLC
1155 N Zaragoza, Suite C106.
El Paso, Texas 79907
575- 524-2835
FEIN: 45-4920375

The contact person for any questions you may have about the Plan content is:

Francisco Jorge
Workers Comp Administrator
P.O. Box 1230
Fairacres, NM 88033
575-524-2835 - Telephone
575-525-4954 - Facsimile

The Plan Number assigned to the Plan is 502.

The agent for service of legal process is:

Mr. Rudy Mata
5715 Cromo Drive
El Paso, Texas 79912

II. DEFINITIONS

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

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

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

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

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

"Business Day" means any day in which the location or office where the Participant works is open for business.

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

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

"Covered Loss" or **"Covered Losses"** means an accidental death, dismemberment or other Injury, Occupational Disease or Cumulative Trauma covered under the Plan.

"**Communicable Disease**" means a disease that:

(1) May be transmitted directly or indirectly by one person or other life form to another; and

(2) Is due to:

(a) A virus, pathogen or other infectious agent, including without limitation any Coronavirus Disease, or any mutation thereof. Coronavirus Disease includes, without limitation, SARS-CoV-2 (the novel coronavirus that causes coronavirus disease 2019, or COVID-19), MERS-CoV (also known as Middle East Respiratory Syndrome or MERS), SARS-CoV (also known as severe acute respiratory syndrome, or SARS), any other human Coronavirus, and any disease caused by such viruses, including without limitation, COVID-19; or

(b) A toxic product produced by such virus, pathogen or other infectious agent.

"Cumulative Trauma" means damage to the physical structure of the Participant's body occurring as a result of repetitious, physically traumatic activities that occur in the scope of employment with the Company and independent of all other causes. To qualify as Cumulative Trauma, the Participant's last day of last injurious exposure to the conditions causing or aggravating such Cumulative Trauma must take place during the pendency of this Plan. Cumulative Trauma does not include Accidental Injury or Occupational Disease.

"Effective Date" means the later of January 1, 2015 or the date the employee elects to participate in the Plan and become a Participant.

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

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

"Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body.

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

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

"Injury" means identifiable damage or harm to the physical structure of the body that is incurred solely as the result of a covered Occurrence. The term does not include: 1) any mental trauma, emotional distress or similar injury; or (2) the medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity when the loss results directly or indirectly from the treatment of: (a) stroke; or (b) cerebrovascular accident or event; or (c) cardiovascular accident or event; or myocardial infarction or heart attack; or (d) coronary thrombosis; or (e) aneurysm. The Injury must be caused solely by an accident. All injuries sustained by one Participant in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

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

"Loss of Hand or Foot" means complete Severance through or above the wrist or ankle joint.

"Loss of Hearing" means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means.

"Loss of Sight" means the total, permanent Loss of Sight of at least one eye.

"Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical, or artificial means.

"Loss of a Thumb and Index Finger of the Same Hand" or "Loss of Four Fingers of the Same Hand" means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

"Maximum Medical Improvement" means a treatment plateau at which no fundamental, functional or physiological change can be expected within reasonable medical probability in spite of continuing medical or rehabilitative procedure.

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

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

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

"Member" means Loss of Hand or Foot, Loss of Sight, Loss of Speech, and Loss of Hearing.

"Occupational Disease" means a disease arising solely out of a Participant's assigned duties in the scope of employment with the Company that 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 the Participant's assigned duties in his scope of employment by the Company. To be covered under this Plan, the Occupational Disease must manifest itself and be diagnosed by a Provider as an Occupational Disease during the Plan Year and the Claim is reported to the Company in accordance with the terms of this Plan. Occupational Disease does not include Accidental Injury or Cumulative Trauma.

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

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

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

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

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

4. charges incurred by a Participant for which he or she is entitled to receive benefits under any state worker's compensation law, occupational disease law, unemployment compensation, disability benefits law or other similar law including the Federal Employer's Liability Act, United Longshore and Harbor Workers Compensation Act, the Jones Act or the Migrant Seasonal Agricultural Workers Protection Act;

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

"Participant" means an Employee of the Company.

"Physician" means a duly qualified physician who is legally licensed to practice medicine in the state where the service is performed, and who is at such time acting within the scope of such license with respect to such service.

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

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

"Plan Term" or **"Plan Year"** means calendar year.

"Pollution Related Disease" means any injury or disease caused by hazardous contaminants in air or water, or by sound.

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

"Pre-Injury Pay," for purposes of calculating a disability loss, means the average gross compensation paid to an employee as reported by the Company to the Internal Revenue Service, exclusive of discretionary bonuses, for the most recent thirteen-week period preceding the Occurrence giving rise to the disability, or shorter period if employed less than thirteen weeks. For salaried employees, the Hourly Wage shall be the stated salary, exclusive of bonuses or incentive pay or other compensation, for the employee divided by forty work hours per week.

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

"Quadriplegia" means total Paralysis of both upper and lower limbs

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

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

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

"Severance" means the complete and permanent separation and dismemberment of the part from the body.

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

“Skilled Nursing Facility” means a health care institution that meets federal criteria for Medicaid and Medicare reimbursement for nursing care including the supervision of the care of every patient by a physician, the maintenance of records concerning the care and condition of every patient, the availability of nursing care 24 hours a day and the implementation of a utilization review plan.

"**Sponsor**" means the Company.

“Subrogation” shall mean the Plan’s right to pursue the Participant’s claims for medical or other charges paid by the Plan against Another Party.

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

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

“Tier 1 Benefits” means those benefits payable to those Participants who elect to receive Tier One Benefits by executing an election form and electing to receive Tier 1 benefits.

“Tier 2 Benefits” means those benefits payable to those Participants who have not elected to receive Tier One Benefits by executing an election form and electing to receive Tier 2 benefits.

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

“Work Hardening” means a treatment program to prepare a Participant to return to work.

III. ELIGIBILITY AND BENEFITS

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

An Employee who is eligible for the Plan becomes a Participant in the Plan upon his or her actual enrollment in the Plan, which includes written acknowledgment of receipt of the SPD and any additional terms set forth by the Plan Administrator.

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

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

1. Which were incurred prior to the Effective Date of coverage (including prior to the date on which the Participant enrolls in the Plan) or after the Plan is terminated;

2. resulting from or occurring during the commission or attempted commission of a crime by the Participant; or due to taking part in a riot, rebellion, civil disturbance or insurrection;

3. any intentionally self inflicted injury;

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

5. incurred in connection with the care or treatment of, or surgery performed for, a Cosmetic Procedure, except for charges which result from an Injury, which occurs while the Participant is covered under the Plan;

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

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

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

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

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

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

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

13. for any Accidental Injury that occurs while a Participant has been determined to be intoxicated, or under the influence of any alcohol, narcotic, barbiturate, hallucinogen or any other illegal drugs or any legal drugs which prohibit Participant from engaging in certain activities at the time of the Accident. A Participant may be subject to drug testing at an approved facility when being treated for an Accidental Injury;

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

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

16. with regard to aircraft, incurred while:

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

17. incurred while traveling to and from work;

18. incurred while practicing for or participating in sports or games; regardless of whether Company sponsors the event or not;

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

20. incurred for or in connection with custodial care, hydrotherapy, education or training, or Work Hardening;

21. incurred for a Pre-Existing Condition;

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

23. incurred for any and all types of Herpes, Simplex Type 2 Genital Herpes, Syphilis, Gonorrhea, Pollution Related Disease;

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

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

26. charges incurred by a Participant for which he or she is entitled to receive Other Income Benefits.

27. The use of, or exposure to: 1) asbestos, asbestos fibers, or asbestos products; or 2) the hazardous properties of nuclear material; or 3) silicon, silicate dust; 4) radon; 5) lead; 6) mercury;

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

29. the medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity when the loss results directly or indirectly from the treatment of: (a) stroke; or (b) cerebrovascular accident or event; or (c) cardiovascular accident or event; or myocardial infarction or heart attack; or (d) coronary thrombosis; or (e) aneurysm;

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

31. Any claim not timely reported.

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

33. Charges for broken appointments when no emergency prevented the Participant from cancelling the appointment 24 hours in advance;

34. An act of a third person intended to injure the Participant because of personal reasons and not directed at the Participant because of his or her employment;

35. Voluntary participation in an off-duty recreational, social, or athletic activity not constituting part of the Participant's Scope of Employment;

36. Participation in any activity or hazard not specifically within the Participant's Scope of Employment;

37. An act of God, unless employment exposed the Participant to a greater risk of Injury from an act of God than ordinarily applies to the general public;

38. Any Injury occurring while the Participant was legally intoxicated;

39. The Participant being under the influence of drugs unless taken under the advice of and as directed by a Doctor;

40. Occupational Disease;

41. Mental trauma and mental, nervous, emotional, or psychological conditions or disorders;

42. Communicable Disease

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

Accident Medical Expense Benefits are only payable:

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

2. for Covered Expenses that are Medically Necessary; and

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

No benefits will be paid for any expenses incurred that are in excess of Usual, Customary and Reasonable Charges, are not Medically Necessary or any expenses that are eligible for payment or reimbursement under any other medical expense plan or policy. All Covered Expenses must be Medically Necessary, and care must be provided by a Provider. In considering the amount of benefits you can receive; the Plan Administrator will consider the most economical way to treat a particular problem.

With regard to Medical Expense Benefits, Covered Expenses are:

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

2. Medical, surgical, podiatric, optometric, dental (limited to Injury to sound natural teeth), nurse, and physical therapy services provided by a Provider;

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

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

5. Charges for Medical Emergency ambulance services.

Tier 1 Medical Expense Benefits shall cease upon the earliest of:

1. The expiration of 110 weeks from the date of the Occurrence.

2. The date maximum medical improvement is achieved.

3. any other limitation or terminating event in this Plan.

4. the payment of $300,000 in Medical Expenses Benefits for a Participant arising from an Occurrence.

Tier 2 Medical Expense Benefits shall cease upon the earliest of:

1. The expiration of 104 weeks from the date of the Occurrence.

2. The date maximum medical improvement is achieved.

3. any other limitation or terminating event in this Plan.

4. the payment of $300,000 in Medical Expense Benefits for a Participant arising from an Occurrence.

E. **Accidental Death and Dismemberment Benefits.** If Accidental Injury to the Participant results in any of the losses shown below within 365 days of the Occurrence, the Participant (or his designated beneficiary in the case of death) is eligible for Accidental Death and Dismemberment Benefits. If multiple losses occur, only one benefit amount will be paid.

Loss	Tier 1 Benefit	Tier 2 Benefit
Life	$125,000	$100,000
Quadriplegia	$125,000	$100,000
Member	$125,000	$100,000

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

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

F. **Disability Benefits**. A Participant is eligible for the Disability Benefits provided that the Participant is not able to perform his or her work for the Company as the result of an Accidental Injury, Occupational Disease, and/or Cumulative Trauma. The determination that the Participant is unable to work as a result of the Injury must be made by a Provider. If these, as well as the other conditions and limitations contained in this Plan are met, the Plan will pay for Tier 1 Participants up to 110 weeks of disability payments in an amount not to exceed $700 per week or 70% of the Participant's Pre-Injury Pay, whichever is lower. Tier 2 Participants will receive up to 104 weeks of disability payments in an amount not to exceed $500 per week or 70% of the Participant's Pre-Injury Pay, whichever is lower. This benefit is taxable. Disability Benefits payments are subject further to the following limitations:

1. A waiting period of seven (7) days, starting on the day of the Occurrence. For this period of time, Disability Benefits are generally not paid. If the Participant is eligible for benefits under this Plan

and is off work for more than seven (7) days from the date of the Occurrence, the waiting period is waived, and the Participant receives Disability Benefits for the Waiting Period.

2. The Participant must provide the Plan Administrator with satisfactory proof of disability and of being under the care of a Provider.

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

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

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

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

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

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

9. Disability Benefits cease on the date any limit stated in Article II.3 is reached.

10. Disability Benefits are subject to any other limitation or exclusion contained in the Plan.

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

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

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

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

K. **When Coverage Ends.** In general, your coverage under this Plan ends on the last day of the month in during which you cease to be eligible for the Plan for any reason.

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

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

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

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

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

IV. SUBROGATION

This provision shall apply to all benefits provided under any section of this Plan. A Participant may incur medical or other charges related to injuries or illness caused by the act or omission of Another Person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the Participant may have a claim against or Another Party for payment of the medical expenses or other charges. In that event, the Plan will be Subrogated to all rights the Participant may have against Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first

Reimbursement out of any Recovery the Participant procures or may be entitled to procure regardless of whether the Participant has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits or collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Participant agrees that acceptance of benefits is constructive notice of this provision.

A. The Participant must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;

2. Authorize the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Participant's rights to Recovery when this provision applies;
3. Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the injuries or illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

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

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

B. **When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injuries or illness.** If the Plan pays any medical or other benefits for the injuries or illness before these papers are signed, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

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

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

A Participant or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Participant or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Participant or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

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

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

V. OPERATIONAL PROVISIONS

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

B. **Drug and Alcohol Screen.** Upon reporting an Accident, a drug and alcohol screen of Participant may be requested should the facts and circumstances warrant a test. Failure of a Participant to submit to a drug and alcohol screen upon request will result in a denial of benefits under this Plan.

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

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

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

F. **Failure to Return to Work.** If, after treatment, whether emergency or long term, the authorized Provider releases the Participant to return to work, whether at full capacity, part-time, or light duty, (provided it is available) and the Participant fails to return to work, all benefits will immediately cease.

G. **Investigation.** Participant will complete an Employee's Report of Injury form which will provide information as to what happened and what Injury the Participant incurred, including the specific body parts affected. Participant, if requested, will also agree to submit to a recorded statement under oath. Finally, Participant will execute a medical release for records pertaining to the Injury. Failure to provide any of the above will cause the Participant's entitlement to benefits under the Plan to be discontinued.

H. **Termination.** Upon Participant's voluntary separation of employment or separation of employment for cause with the Company, all Disability Benefits shall cease.

VI. ADMINISTRATION OF THE PLAN

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

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

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

D. **Indemnification.** The Plan Administrator shall not be liable for any act or omission of its own unless required by ERISA or another applicable state or federal law under which liability cannot be waived. The

Company shall indemnify the Plan Administrator from any and all losses, costs, expenses, and damages arising out of the Plan Administrator's administration of this Plan, unless the Plan Administrator is determined by a non-appealable final order of a court of competent jurisdiction to have been guilty of gross negligence or willful misconduct.

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

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

VII. CLAIMS

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

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

1. the specific reason for the adverse determination;

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

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

4. a description of the Plan's review procedures and the time limits applicable to those procedures;

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

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

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

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

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

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

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

D. **When a Claim is Received.** The Plan will be deemed to have received a claim for benefits when the Company's Third-Party Administrator actually receives the Employee's First Report of Injury and Supervisor's Accident Investigation Report. The Third-Party Administrator's contact information will be provided to Participant. In the case of urgent care, the claim may be communicated orally, reasonably calculated to bring a request for a claim to the attention of the Third-Party Administrator.

E. **Manner of Giving Notice to Plan Administrator.** Notice required by this Plan to be sent to Company of the Plan Administrator will be in writing and will be mailed by registered or certified mail, return receipt requested, postage prepaid, addressed as follows:

Francisco Jorge
Worker's Comp Administrator
P.O. Box 1230
Fairacres, NM 88033
575-524-2835 - Telephone
575-525-4954 - Facsimile

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

provided that individual applies the judgment of a reasonable individual who is not a trained health professional.

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

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

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

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

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

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

1. the specific reasons for the adverse determination;

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

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

4. any new or additional evidence considered, relied upon or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan insurer or such other person) in connection with the claim;

5. any new or additional rationale for the adverse benefit determination;

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

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

M. **Right to Bring Civil Action.** If the appeal of the original decision is denied upon review and upon arbitration, the Participant shall have the right to bring a civil action against the Plan under section 502(a) of the Participant Retirement Income Security Act of 1974 (ERISA). Notice required by this Plan to be sent to Company of the Plan Administrator will be in writing and will be mailed by first-class, registered, or certified mail, return receipt requested, postage prepaid, sent by a reputable, national, over-night courier service (with a requirement for receipt of delivery) or transmitted by hand delivery, or facsimile transmission addressed as follows:

Dean Rigg
President
P.O. Box 1230
Fairacres, New Mexico 88033
575-524-2835 - Telephone
575-525-4956 - Facsimile

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

VIII. AMENDMENT AND TERMINATION

A. **Amendment.** The Sponsor has the right to prospectively amend this Plan. Amendment may be made by (i) a certified resolution or consent of the Company, or (ii) by an instrument in writing executed by the appropriate officer or employee of the Sponsor. The amendment must describe the nature of the amendment and its effective date. Modification of the Plan is not effective for claims which occurred prior to the date of the modification. Modification is also not effective until fifteen (15) days after reasonable notice is given to Claimant.

B. **Termination.** The Sponsor may prospectively terminate this Plan by executing and delivering to the Plan Administrator a notice of termination specifying the date of termination. Termination of the Plan is not effective for claims which occurred prior to the date of the termination. Termination of the Plan is also not effective until fifteen (15) days after reasonable notice is given to Claimant.

IX. MISCELLANEOUS

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

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

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

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

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

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

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

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

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

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

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

X. ADOPTION OF PLAN BY AFFILIATED CORPORATION

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

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

XI. ARBITRATION PROVISION

A. **This Agreement Is Not A Contract of Employment**

Company has adopted this Plan which offers its employees, who agree to participate, additional benefits in excess of the minimum benefits mandated by the Texas Department of Transportation for certain nonsubscribers for injuries that their employees may incur at work. As part of this voluntary and optional election for higher benefits, Participants and Company agree to resolve any disputes regarding workplace injuries under the terms and conditions of this Agreement.

Claimant's election to be or not to be a Participant for the higher benefit limit in the Plan ("Tier One Benefits") and a party to this Agreement is voluntary and optional. This Arbitration provision applies to those Participants who have elected to receive Tier 1 benefits ("Tier 1 Participants").

Once the election is made, it is irrevocable.

Company and Tier 1 Participants agree to resolve Covered Claims according to the terms and conditions of this Nonsubscriber Agreement to Arbitrate Claims for Texas Employees. ("Agreement").

Company and Tier 1 Participants agree that this Agreement is not a contract of employment. This Agreement is not conditioned on Tier 1 Participant's commencement of or continued employment with the entities or individuals included within the definition of Company below. The terms of this Agreement do not modify any person's employment status or alter the terms of his or her employment.

B. Additional Definitions Applicable To This Provision

1. **"Company"** means OEP and each of its affiliates, related entities, subsidiaries, officers, directors and employees.

2. **"Tier 1 Participant"** means a person who is employed by Company, has a Covered Claim and has elected to receive Tier 1 benefits under this Plan. The term also includes a Tier 1 Participant's spouse, children, parents, estate, successors and assigns.

3. **"Covered Claim"** or **"Covered Claims"** means any and all claims included or described in Paragraph 5(a) of this Provision.

C. Federal Arbitration Act Applies

Company is engaged in "commerce" as that term is defined in Section 1 of the Federal Arbitration Act ("FAA"). The FAA governs all aspects of this Agreement.

D. Arbitration is the Exclusive Remedy for Covered Claims

1. Covered Claims shall be exclusively resolved by binding arbitration. While both Tier 1 Participants and Company retain all substantive legal rights and remedies under this Agreement, Tier 1 Participants and Company are both waiving all rights which either may have with regard to trial, whether jury or non-jury, in state or federal court for any Covered Claim.

2. Claims for benefits under this Plan shall be resolved by the procedures set forth in Article V of this Plan.

E. Scope of Arbitration Agreement

1. Claims Covered by This Agreement

   This Agreement covers any personal injury suffered by Tier 1 Participants while in the Course and Scope of their employment with Company, including but not limited to, claims for negligence, gross negligence, physical impairment, disfigurement, pain and suffering, mental anguish, wrongful death, survival actions, loss of consortium and/or services, medical and hospital expenses, expenses of transportation for medical treatment, expenses of drugs and medical appliances, emotional distress, exemplary or punitive damages arising out of or related to any personal injury.

2. Claims Not Covered by This Agreement

This Agreement does not apply to:

a Workers' Compensation Benefits under the Texas Workers' Compensation Act or any other similar state or federal law;

b. Claims covered by a collective bargaining agreement, in which case the terms, conditions and procedures of that collective bargaining agreement shall control.

3. Arbitrability of Particular Dispute

Any question as to the arbitrability of any particular claim shall be arbitrated pursuant to the procedures set forth in this Agreement.

F. <u>Procedure</u>

1. Who Shall Arbitrate?

a. All arbitrations under this Agreement shall be administered by Judicial Workplace Arbitrations under its rules for the resolution of disputes. In the event that Judicial Workplace Arbitrations is unable or unwilling to administer the arbitration, United Judicial Arbitrations, Inc. shall administer the arbitration under its rules for the resolution of disputes. Should United Judicial Arbitrations be unwilling or unable to administer the arbitration, then the American Arbitration Association will administer the arbitration under its then existing rules for the resolution of employment disputes from its Dallas, Texas Panel, or the parties may utilize any other arbitrator that is agreeable to Claimant and Company. For any arbitration under this Agreement, a single arbitrator shall be appointed. Company and Claimant are to participate in the selection of a neutral arbitrator as follows: The parties shall be presented a panel with a minimum of three different arbitrators. Company and Claimant may agree to the selection of one arbitrator from the panel. If agreement is not reached, Company and Claimant shall have an equal number of strikes. The parties shall continue to strike arbitrators from the panel until one arbitrator remains. That person shall then arbitrate the claim. Any arbitrator must be neutral as to all parties. Standards for the recusal of an arbitrator shall be the same standards under which trial judges are recused under Texas law.

2. Where Shall the Arbitration Take Place?

a. If Tier 1 Participant lives within 50 miles of Dallas, Texas, the arbitration shall be held in Dallas, Texas. If Tier 1 Participant lives more than 50 miles from Dallas, Texas, Tier 1 Participant may elect to have the arbitration held in Dallas or at a location within 50 miles of Tier 1 Participant's residence.

3. Payment of Fees and Expenses

a. Company shall be responsible for the fees of the arbitrator and the cost of a stenographic record of the arbitration hearing.

4. Discovery and Pre-Arbitration Motions

a. All parties are entitled to pre-arbitration discovery under the Texas Rules of Civil Procedure. The same discovery devices and scope of discovery as set forth in those rules

shall apply. All parties are entitled to file any motions, including dispositive motions, set forth in the Texas Rules of Civil Procedure.

5. Remedies and Defenses

   a. All parties are entitled to allege any claim, obtain any remedy and assert any legal or equitable defense that the party could allege, obtain or assert in a Texas state or federal court.

6. Record

   a. A stenographic record shall be taken of the arbitration hearing.

7. Written Award

   a. Within a reasonable time after the conclusion of the arbitration hearing, the arbitrator shall issue an award and send a copy to all parties.

8. Judgment

   a. Any party to an arbitration award may file the award in court of competent jurisdiction and move that a judgment be entered on the arbitration award.

9. Judicial Review

   a. Judicial review shall be governed by the Federal Arbitration Act. The decision of the Arbitrator may be entered and enforced as a final judgment in any court of competent jurisdiction.

G. Consideration

In addition to any other consideration that may exist for the agreement to arbitrate, Company's and Tier 1 Participant's promise to resolve claims and controversies by arbitration in accordance with the provisions of this Agreement constitutes consideration for this Agreement. Finally, this Agreement is presented in connection with Company's Employee Injury Benefit Plan. The higher payments made under that Plan to Tier 1 Participant also constitute consideration for this Agreement.

H. Enforceability

If any provision of this Arbitration Program is adjudged to be invalid, illegal or unenforceable, in whole or in part, the balance of this Agreement shall remain in effect.

I. At Will Employment Preserved

This Agreement is not and shall not be construed in any way to change the employment status of any employee of Company from at-will status.

J. Termination of Agreement

Company shall have the right to prospectively terminate this Agreement. Termination is not effective for Covered Claims which accrued or occurred prior to the date of the termination. Modification or Termination is also not effective until fifteen (15) days after reasonable notice is given to Claimant.

K. Term

This provision commences on the Acceptance Date and applies to all Covered Claims which occur on or after January 1, 2015.

This provision shall survive the employer-employee relationship between the Company and the Tier 1 Participant and shall apply to any Covered Claim whether it arises or is asserted during or after termination of the Tier 1 Participant's employment with the Company or the expiration of any benefit plan.

L. Sole and Entire Agreement

This Agreement constitutes the parties' complete agreement regarding arbitration and supersedes any prior agreement regarding arbitration of Covered Claims during the Term of this Agreement.

M. Applicability of This Agreement to Others

Company and Tier 1 Participant intend and expressly agree that any Covered Claim of Claimant's spouse, children, parents, estate, successors and/or assigns that now exists or that may come into existence in the future which arises from, relates to, or is derivative of any Covered Claim, shall be resolved according to the terms and conditions of this Agreement.

Company and Tier 1 Participant intend and expressly agree that any Covered Claim of Company's officers, directors, agents, predecessors, successors, and affiliated companies that arises from, relates to, or is derivative of any Covered Claim of Company, shall be resolved according to the terms and conditions of this Agreement.

XII. PARTICIPANT'S RIGHTS

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

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

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

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

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

may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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