SUMMARY PLAN DESCRIPTION FOR OCCUPATIONAL INJURY BENEFIT PLAN

TXFM, INC.

SCHEDULE OF BENEFITS

1. TXFM, Inc., 5600 Nebraska Furniture Mart Drive, The Colony, Texas 75056 (the "Company")

2. Federal Tax Identification Number: 45-3751317

3. Contact person for Participant questions: Megan Berry Barlow, 5600 Nebraska Furniture Mart Drive, The Colony, Texas 75056.

4. Agent for service of legal process: Thomas E. Rosen, Glast, Phillips & Murray, P.C., 14801 Quorum Drive. Ste. 500, Dallas, Texas 75254

5. Effective Date of Plan: 1/1/14

6. Medical Benefit Period: 156 weeks from date of Occurrence causing the Occupational Injury

7. Disability Benefit Period: 156 weeks from date of Occurrence causing the Occupational Injury

8. **All Texas resident Employees of the Company who are in the Company's Active Service are eligible to Participate in the Plan.**

9. Weekly Disability Benefits:
- (a) Benefit Waiting Period: 7 days
- (b) Percentage Average Weekly Earnings: 85%
- (c) Maximum Weekly Disability Benefit Amount: $800
- (d) Benefit Period: 156 weeks beginning after 7-day Benefit Waiting Period
- (e) Time Period for Initial Loss: Temporary Disability must begin within 30 days after the date of the Occurrence causing the Occupational Injury

10. Medical Benefits:
- (a) Maximum Medical Expense Benefit**:** Subject to the Combined Limits for all Benefits under #13 below
- (b) Benefit Period: 156 weeks
- (c) Time Period for Initial Treatment: 14 days from the date of Occurrence causing the Occupational Injury
- (d) Any non-emergency Eligible Medical Expense requires Pre-Certification

11. Accidental Death, Dismemberment, and Paralysis Benefits: $150,000 or 10 times Base Annual Earnings, whichever is less.

12. Time Period of Loss: 365 days from the date of the Occurrence causing the Occupational Injury

13. Combined Limits for All Benefits:
- (a) Combined Single Limit Per Plan Participant Per Occurrence: $250,000
- (b) Aggregate Limit Per Occurrence: $2,500,000
- (c) Annual Plan Aggregate Limit: $10,000,000

14. Occupational Disease and Cumulative Trauma are covered by the Plan.

All benefits scheduled above are subject to the terms and conditions of the Summary Plan Description and the Plan Document. Please see those documents for other benefit conditions, limitations and exclusions.

TXFM, INC.

SUMMARY PLAN DESCRIPTION

1. GENERAL INFORMATION

TXFM, Inc. ("TXFM"), 5600 Nebraska Furniture Mart Drive, The Colony, Texas 75056 has established an Occupational Injury Benefit Plan, known as the "TXFM, Inc. Occupational Injury Benefit Plan" contained in a Plan Document for eligible Employees (the "Plan"). Effective at 1/1/2014 (the "Effective Date"), the Plan supersedes and renders void any previous employee welfare benefit plan sponsored by TXFM to the extent that plan provided benefits for occupational injuries. TXFM reserves the right to terminate or amend the Plan at any time and as often as TXFM deems appropriate.

This Summary Plan Description (this "SPD") briefly describes important provisions of the Plan, but does not present all the Plan provisions. This SPD is not the Plan Document; it is only a summary description of the Plan. In event of conflict between a statement in this SPD and one in the Plan Document, the terms of the Plan Document will control over this SPD. The Plan Administrator has sole discretion to interpret this SPD and the Plan Document, and interpretation of this SPD or the Plan by the Plan Administrator will be conclusive as to all matters concerning the Plan Document and this SPD Document, including not by limitation the kind of benefits, amount of benefits, and your right to any benefit under the Plan. Receipt of this SPD does not constitute an employment contract nor does availability or payment of a benefit under the Plan constitute an admission of liability by TXFM.

Megan Berry Barlow is the Plan Administrator (the "Administrator").

Service of legal process on the Plan may be served to: **Thomas E. Rosen, Glast, Phillips & Murray, P.C., 14801 Quorum Drive, Ste. 500, Dallas, Texas 75254**, or TXFM's Registered Agent as established and maintained with the Texas Secretary of State.

PARA LOS EMPLEADOS QUE HABLAN ESPAÑOL: ESTE RESUMEN DESCRIPTIVO DEL PLAN DE BENEFICIOS SOBRE LAS LESIONES OCUPACIONALES PARA LOS EMPLEADOS DE TXFM, INC. ESTÁ ESCRITO EN INGLÉS Y CONTIENE EL RESUMEN DE LOS DERECHOS Y BENEFICIOS PARA EL EMPLEADO. SI USTED TIENE DIFICULTAD ENTENDIENDO ALGUNA PARTE DE ESTE RESUMEN, SU SUPERVISOR LE PUEDE AYUDAR DURANTE LAS HORAS DE TRABAJO. USTED TAMBIEN PUEDE COMUNICARSE CON EL ADMINISTRADOR DEL PLAN TXFM, INC., AL TELÉFONO (402) 361-2094, O PUEDE LLAMAR AL NÚMERO DE TELÉFONO QUE SE ENCUENTRA EN ESTE RESUMEN DEL PLAN.

The Plan Year is the 12-month period ending on December 31 of each calendar year, or as otherwise set by TXFM. The first Plan Year will begin on the Effective Date. TXFM's central office address is 5600 Nebraska Furniture Mart Drive, The Colony, Texas 75056. TXFM's

telephone number is (402) 397-6100. The Administrator is responsible for providing Plan Participants with information and making determinations regarding rights and benefits under the Plan. The Plan Number assigned by the Plan Sponsor is 511.

2. WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN, AND WHEN?

Every Employee working for TXFM in the State of Texas on the Effective Date is eligible to participate in the Plan on the Effective Date. Each new Employee in Texas thereafter will be eligible to participate in the Plan at the later of: (a) the first date he or she is employed by an Employer; or (b), the date when he or she is classified as an Employee. You will cease to be a Plan Participant at the earliest of: (a) the date the Plan is terminated; (b), the first date when you are no longer an Employee; (c), the date your Medical Benefit Period, Disability Benefit Period or other eligibility period under the Plan ends; or (d), the date when you are no longer eligible to be a Participant.

3. WHAT BENEFITS ARE AVAILABLE FROM THE PLAN?

Generally, you are eligible for payment of: (a) medical benefits if you sustain an Occupational Injury as defined below; (b) in some cases, disability benefits if you sustain an Occupational Injury as defined below; (c) in some cases, defined Dismemberment/Paralysis benefits if you sustain an Occupational Injury as defined below; and (d), in some cases, death benefits to your designated or determined Beneficiary(s) if you die from an Occupational Injury as defined below.

4. PLAN DEFINITIONS

Terms capitalized in this SPD have the meaning given them below. Terms capitalized in this SPD, but not defined below, have the same meaning given them in the Plan Document:

"Accident" means an event which:

(i) was sudden, unforeseen, unplanned and unexpected;
(ii) occurred at a specifically identifiable time and place;
(iii) occurred by chance or from unknown causes;
(iv) occurred during the term of this Plan; and
(v) arose within the your Scope of Employment.

"Active Service" means you, as a Participant, are (i) actively at work performing all regular duties on a (a) Full-time, (b) Part-time, (c) Quarter-time, (d) On-call, and (e) Temporary basis, as defined under "Employment Classification" in the Nebraska Furniture Mart Staff Handbook, either at the Company's place of business or at some other place the Employer requires you to be; or (ii), actively at work performing restricted or modified duty work at the direction of the Employer within the your Scope of Employment. The foregoing Company employees are Plan Participants. Work At Home Associates are Plan Participants. All employees whose compensation is reported by the Company to the Internal Revenue Service on IRS Form 941 (Employer's Quarterly Federal Tax Return) are Plan Participants. Temporary personnel obtained by Company

from temporary staffing agencies are not Employees and are not Participants. Independent contractors whose compensation is reported by the Company to the Internal Revenue Service on IRS Form 1099-MISC (Miscellaneous Income) are not Employees and are not Participants. Travel by a Work At Home Associate traveling to or from Employer's premises for any reason is excluded from coverage under this Plan.

"Base Annual Earnings" means:

(i) For "commission-only" Participants, "salary-only" Participants, and "salary-plus commission" Participants, Base Annual Earnings means the Participant's average annual earnings over the most recent three (3) year period, or if shorter, over the period of employment with the Employer immediately preceding the Occurrence.

(ii) For "solely-hourly wage" Participants, Base Annual Earnings means the Participant's regular workweek earnings (40 hours or less) as reported on IRS Form 941 by the Employer for work performed during the fifty-two (52) weeks immediately prior to the Injury, based on all the weeks of service during that fifty-two (52) weeks period, and annualized.

(iii) For "hourly-plus commission" Participants, Base Annual Earnings means the Participant's regular workweek earnings (40 hours or less) plus commissions received, as reported on IRS Form 941 by the Employer for work performed during the fifty-two (52) weeks immediately prior to the Injury, based on all the weeks of service during that fifty-two (52) weeks period, and annualized.

(iv) For "salary plus incentive" Participants, Base Annual Earnings means the Participant's regular periodic salary plus incentive compensation received, as reported by the Employer on IRS Form 941 for work performed during the fifty-two (52) weeks immediately prior to the Injury, based on all the weeks of service during that fifty-two (52) weeks period, and annualized.

(v) Base Annual Earnings does not include amounts received as bonus, or commissions as to solely-wage or solely-salary Participants, nor other "extra" compensation received by those Participants.

"Cumulative Trauma" means Injury to you, occurring within your Scope of Employment, and which is caused by the combined effect of repetitious, physically traumatic activities that occur solely within your Scope of Employment, extending over a period of time longer than ninety (90) days. To be covered under this Plan, the last day of your last exposure to the conditions causing or aggravating your Cumulative Trauma must take place during the Plan Term and while you are covered under the Plan. You must be diagnosed by, and under the Appropriate Care of a Doctor for the Cumulative Trauma, in order to maintain coverage under the Plan for that claim. Cumulative Trauma and Occupational Injury are not mutually exclusive under the Plan. **The Plan includes coverage for Cumulative Trauma.**

"Disease" means a condition marked by a pronounced negative deviation from the normal healthy state of your body, when your condition is the basis of a claim.

"Doctor" means a licensed Medical Doctor or Doctor of Osteopathy acting within the scope of his or her license and rendering care or treatment which is Appropriate Care for your condition and locality. Doctor does not include a member of your Immediate Family.

"Eligible Medical Expense" means an expense incurred by or for you for treatment, services and supplies covered by this Plan. An Eligible Medical Expense is deemed incurred on the date such treatment, service or supply which established the charged amount was rendered to or obtained by you. Eligible Medical Expenses will only be paid only for treatment of an Occupational Injury which results directly, and from no other cause, from a Covered Accident. Eligible Medical Expenses are subject to the benefit amounts, benefit periods, and other terms or limits set forth elsewhere in the Plan. Eligible Medical Expense includes expenses incurred for medical care, treatment, services, and supplies for your Occupational Injury, to the extent such Medical Expense is for Medically Necessary services or supplies, and is a Usual, Customary, and Reasonable Charge**. You must receive Pre-Certification for any charge, other than an emergency service, for the charge to be deemed an Eligible Medical Expense. The first Eligible Medical Expense must be incurred within fourteen (14) days after the Occurrence** which caused the treated Occupational Injury, for any Medical Expense to be deemed or paid as an Eligible Medical Expense for that Injury. No benefits will be paid for any portion of a charge incurred which, in the Administrator's sole and absolute discretion, is deemed to exceed a Usual, Customary, and Reasonable Charge.

Subject to the foregoing conditions, Eligible Medical Expense includes medical expenses for:

(i) hospital or skilled nursing facility medical expenses (hospital room and board medical expenses are limited to the cost of a semi-private room unless confinement to a private room or intensive care unit is Medically Necessary);

(ii) medical, surgical, podiatric, optometric, dental (limited to injury to sound natural teeth), nursing, and physical therapy services provided by or at the direction of a Doctor;

(iii) subject to (ii) above, physical rehabilitation services performed by a licensed occupational therapist who is not affiliated with the prescribing Doctor, and for frequency of treatment not to exceed twenty-four (24) physical therapy sessions per Occupational Injury, with an aggregate Plan Year limit of forty-eight (48) physical therapy sessions;

(iv) medical and surgical supplies, appliances, braces, artificial members, and prostheses, including training in their use; and

(v) prescription drugs, medicines, and other remedies.

"Injury" means accidental bodily harm sustained by you which results directly, and independent from all other causes, from a Covered Accident. The Injury must be caused solely through external, violent and accidental means. Injury does not include any mental trauma, emotional distress, or similar injury, nor heart attack, nor stroke, nor aneurysm. The Injury must be caused solely by an Accident or Occurrence. Any Injury sustained by you in any one Accident or Occurrence, including all related conditions and recurrent symptoms of those injuries, are considered a single Injury.

"Medically Necessary" means a treatment, service or supply that is: (i) required to treat an Occupational Injury; and is (ii), prescribed or ordered by an approved Doctor or furnished by an approved Provider; and is (iii), performed in the least-costly setting required by your condition; and is (iv), consistent with the medical and surgical practices prevailing in the geographic area for treatment of the condition at the time rendered; and is (v) not experimental or investigational in nature. Purchasing or renting any of: (i) air conditioners; (ii) air purifiers; (iii) motorized transportation; (iv) escalators or elevators in private homes; (v) swimming pools or supplies for them; or (vi), general exercise equipment, are examples of items which are not Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. The Plan may, at the Administrator's sole discretion, consider the cost of the alternative to be the Eligible Medical Expense for a benefit, subject to a Medically Necessary determination under this definition.

"Occupational Accident" means an Accident which occurs while the Plan is in effect, and arises within your Scope of Employment.

"Occupational Disease" means Disease diagnosed by a Doctor, which is generally accepted as a Disease caused solely by exposure to environmental or physical hazards within your Scope of Employment, and not caused solely and independently by an Accident. Occupational Disease does not include Accidental Bodily Injury or Cumulative Trauma. In order to be covered by the Plan, an Occupational Disease must first manifest itself during the Plan Term while you are covered under the Plan. In addition, the Occupational Disease must be caused by a Disease-producing agent or agents found present in your occupational environment. Further, you must be diagnosed by, and under the Appropriate Care of, a Doctor for the Occupational Disease. **The Plan includes coverage for Occupational Disease.**

"Occupational Injury" means specifically identifiable damage or harm to the physical structure of your body, incurred solely as the direct result of an Occupational Accident, and which arose within your Scope of Employment. Occupational Injury includes Cumulative Trauma and Occupational Disease. All Occupational Injuries sustained by you in any one Occurrence, including all related conditions and recurrent symptoms of that Occupational Injury is considered a single Occupational Injury. Occupational Injury may include Occupational Disease and Cumulative Trauma, as limited above, but does not include other Diseases except those Diseases or infections naturally resulting from Occupational Disease or Cumulative Trauma covered as an Occupational Injury under the Plan.

"Occurrence" means an Occupational Accident or series of Occupational Accidents arising out of one event or incident occurring during the Plan Term within your Scope of Employment and resulting in one or more Occupational Injuries. For purposes of Occupational Injury, the date of an Occurrence is the date of an Occupational Accident or the date of the first in a series of Occupational Accidents. For purposes of Occupational Disease or Cumulative Trauma, the date of an Occurrence is the first date when the condition manifests itself and is diagnosed by a Doctor as an Occupational Disease or Cumulative Trauma. All Occupational Disease suffered by you due to exposure to the same or a related Disease-producing agent encountered within your Scope of Employment during the Plan Term will be considered a single Occurrence. All

Cumulative Trauma suffered by you due to the combined effect of the same or related physical activities within your Scope of Employment during the Plan Term will be considered a single Occurrence.

"Pre-Existing Condition" means an illness, Disease or other condition of yours, which existed during the sixty (60) months immediately preceding the your first date of coverage under the Plan, and which:

(i) first manifested itself, worsened, became acute, or exhibited symptoms which would have caused an ordinarily prudent person to seek diagnosis, care or treatment;

(ii) required taking a prescribed drug or medicine, unless the condition for which the prescribed drug or medicine was taken remains controlled with no change in the required prescription; or

(iii) was treated by a Doctor or treatment had been recommended by a Doctor in writing.

"Provider" means any health care provider or Doctor designated by TXFM to provide medical treatment for which payment or reimbursement is authorized by the Plan Document.

"Scope of Employment" means an activity of any kind or character that involves furtherance of TXFM's work, business, trade, or profession, performed by you at TXFM's regular workplace in Texas, while you are temporarily away from TXFM's regular workplace in furtherance of TXFM's business, trade or profession, or while working at a Work At Home Address as an agreed Work At Home Associate. Notwithstanding the foregoing, you are deemed outside your Scope of Employment if you are intoxicated or presumed intoxicated within the meaning of §401.013 of the Texas Labor Code at the time of the Occurrence causing an Occupational Injury. No benefits will be paid under the Plan in that event.

Scope of Employment does not include your transportation to or from your place of employment, unless:

(i) the transportation is furnished as part of the contract of employment, or is paid for by TXFM or the means of transportation is under TXFM 's control; or

(ii) you are directed in your Scope of Employment to proceed from one place to another place.

(iii) travel by a Work At Home Associate to or from Employer's business premises for any reason is excluded from coverage under the Plan.

"Usual, Customary, and Reasonable Charge" means the expense is:

(i) Usual when it is the fee regularly accepted, and the patient's responsibility to pay, in the absence of insurance or other third party reimbursement, by a health care Provider or Doctor for a given medical procedure, service, or supply;

(ii) Customary in relation to what other Doctors and health care Providers in the same geographic area accept as compensation for the same procedure, service or supply; and

(iii) Reasonable as a generally accepted medical practice to order the procedure, service or supply for your Injury or condition. Reimbursement rates for medical services under the prevailing Medicare fee schedule are considered to be Usual, Customary, and Reasonable Charges.

5. PLAN BENEFITS

A. Benefit Limits.

The maximum total amount payable for all benefits combined under the Plan with respect to you for any one Occurrence is $250,000 ("Combined Single Limit Per Participant Per Occurrence.") This amount is specified in Item 13(a) of the Schedule of Benefits.

The maximum total amount payable for all benefits combined under the Plan with respect to all Participants' Occupational Injury claims arising out of a single Occurrence occurring during the Plan Term, regardless of the total amount of claims or Participants, is $2,500,000 (the "Aggregate Limit Per Occurrence"). This amount is specified in Item 13(b) of the Schedule of Benefits.

The maximum total amount payable for all benefits combined under the Plan with respect to all Participant Occupational Injury claims occurring during the Plan Year, regardless of the amount of claims made by Participants, is $10,000,000 (the "Annual Plan Aggregate Limit"). This amount is specified in Item 13(c) of the Schedule of Benefits. If, in the absence of the Annual Plan Aggregate Limit, the Plan would pay more than the Annual Plan Aggregate Limit for all Occupational Injuries occurring during the Plan Year, then the benefits payable to each Participant under the Plan will be reduced proportionately, so that the total amount of benefits paid under the Plan for all Occupational Injuries occurring during a Plan Year will not exceed the Annual Plan Aggregate Limit. The Annual Plan Aggregate Limit applies separately to each consecutive Plan Year. If the Plan terminates after a new annual Plan Year has begun, such that the Plan Year is for a period of less than twelve (12) months, then this period of time will be deemed part of and merged into the last prior Plan Year to determine benefits payable subject to the Annual Plan Aggregate Limit.

Benefits otherwise available under the Plan are not payable beyond the applicable Combined Limits for All Benefits specified in Items 13(a), 13(b), and 13(c), respectively, of the Schedule of Benefits.

B. Medical Benefits.

If you suffer an Occupational Injury, benefits for medical care and treatment of the Occupational Injury may be paid under the Plan directly to a Provider, or to you as a reimbursement if already paid by you. Medical benefits are payable only for expenses which are: Eligible Medical Expenses under the Plan; are Medically Necessary; are a Usual, Customary, and Reasonable Charge incurred for treatment by a Provider; and, are directly related to an Occupational Injury. Your first Eligible Medical Expense must be incurred within 14 days of the Occurrence causing your Occupational Injury, and if you thereafter reach Maximum Medical Improvement or go

without incurring Eligible Medical Expense related to that Occupational Injury for a period longer than 90 days, your Medical Expense benefits will cease for that Occurrence.

C. Pre-Certification

You must receive Pre-Certification for any charge other than an emergency service to be deemed an Eligible Medical Expense. Pre-Certification means you have obtained authorization from the Plan Administrator for non-emergency treatment or services, including referral to a specialist, prior to incurring an otherwise Eligible Medical Expense. The first Eligible Medical Expense must be incurred within fourteen (14) days after the date of the Occurrence which caused your Occupational Injury, in order for any medical expense to be deemed or paid as an Eligible Medical Expense for that Injury. No benefits will be paid for any portion of a charge incurred which, in the Administrator's sole and absolute discretion, is deemed to exceed a Usual, Customary and Reasonable Charge.

D. Provider Selection

Whether you are eligible for benefits for an Occupational Injury depends upon the health care provider you select:

(i) if you select a Provider (a TXFM-designated health care provider), the Plan pays the Eligible Medical Expenses within the specified Plan limits; or

(ii) if you select a health care provider who or which is not a Provider designated by TXFM, you must pay for all charges by that health care provider.

E. Duration of Benefits

The following general limits also apply to medical benefits for an Occupational Injury:

(i) Medical benefits will be payable to you with respect to an Occupational Injury only for medical care and treatment actually provided to you within 156 weeks after the Occurrence causing the Occupational Injury. The first Eligible Medical Expense must be incurred within fourteen (14) days after the date of the Occurrence causing the Occupational Injury.

(ii) Chiropractic Services are excluded under the Plan. Chiropractic Services, whether received exclusively or in conjuncture with another treatment or therapy, are not payable and not reimbursable. Physical therapy must be prescribed by a Doctor as part of a rehabilitation program, and cannot be provided by an affiliate of the prescribing Doctor. You are limited to twenty-four (24) physical therapy sessions per Occupational Injury, with an aggregate Plan Year limit of forty-eight (48) physical therapy sessions. At any point while undergoing physical therapy, you may be required to submit to one or more occupational assessments and or functional capacity examinations at the Administrator's discretion and expense.

F. Death Benefits.

(i) **Amount.** If you die as a direct and sole result from an Occupational Injury within three hundred sixty-five (365) days after the Occurrence causing the Occupational Injury, your Beneficiary or Beneficiaries designated in writing or determined by Section 2.9 of the Plan, will be entitled to receive a death benefit in an amount equal to the lesser of: (a) ten (10) times your Base Annual Earnings as defined by the Plan Document; or (b) the stipulated death benefit detailed in Item 11 of the Schedule of Benefits.

(ii) **Limits.** The total death benefit payable to your Beneficiary(s) as a direct result of an Occupational Injury to you, when combined with all other benefits payable under the Plan for an Occupational Injury, will not exceed the Combined Single Limit Per Participant Per Occurrence and are subject to the Aggregate Limit Per Occurrence, the Annual Plan Aggregate Limit, and other limits under the Plan. This death benefit, at the Administrator's discretion, may be paid out in equal monthly installments over a period of one year. The Administrator will provide you the TXFM Plan Beneficiary Designation Form you may use to designate your death benefit beneficiaries. You may also obtain the Plan Beneficiary Designation Form from your Supervisor.

G. Disability Benefits. If you are Temporarily Disabled as the result of an Occupational Injury, you may be eligible for disability benefits under the Plan:

(i) **Requirements for Eligibility.** "Temporary Disability," "Temporarily Disabled," "Disabled," or "Disability" means an objectively demonstrable physical, anatomical, or physiological abnormality or condition diagnosed by a Doctor resulting solely from an Occupational Injury occurring within thirty (30) days after the date of an Occurrence causing you to be unable to obtain and retain employment at wages equivalent to your Base Annual Earnings immediately prior to the Occurrence. For any benefit to be payable, such disability must commence within thirty (30) days after the date of the Occurrence causing the Occupational Injury and must continue for a period of seven (7) sequential days (the "Waiting Period"). Following the Waiting Period, you are eligible for disability benefits. You must cooperate with your Provider and follow your Provider's treatment plan to remain eligible for these benefits. You must also periodically report to and be examined by a Provider designated by TXFM, if TXFM requires. Drug and alcohol screening tests may be required, and are a condition to continued receipt of Plan benefits

(ii) **Disability Benefit Period.** Following the Waiting Period, you are eligible for disability benefits for each work day of Temporary Disability as specified in the Plan. Disability benefits will begin on your first scheduled work day immediately following the Waiting Period and continue during each succeeding week of Temporary Disability. Weekly disability benefits will continue until the earliest of: (a) the day the total benefits paid under the Plan equals the Combined Single Limit Per Participant Per Occurrence payable to you for a single Occurrence causing an Occupational Injury; (b) your date of death; (c) the day you are released for full-duty work by a Doctor; (d) the day which completes 157 weeks after the Occurrence causing your Occupational Injury; (e) the day you fail to submit satisfactory proof of continuing Temporary Disability; (f) the day you are released for restricted (limited or light) duty work and you refuse or fail to promptly resume restricted duty work, or (g), the day you are no longer Temporarily Disabled.

(iii) **Amount of Benefit**. Disability benefits shall be calculated and paid to you at 85% of your Average Weekly Earnings, up to a maximum weekly benefit paid of $800. For any period of incapacity which is less than a full week, your Average Weekly Earnings will be divided by the number of days in your scheduled work week, and you will be paid 1/7 of your Average Weekly Earnings for each day of Temporary Disability. Disability benefits incurred as a direct result of an Occupational Injury are payable subject to the Combined Single Limit Per Participant Per Occurrence, the Aggregate Limit Per Occurrence, the Annual Plan Aggregate Limit, and other limits under the Plan Document.

If you are able to return to work on a part-time basis, you will be deemed partially Temporarily Disabled and your covered Disability benefits will be reduced by the amount of your actual earnings.

No Disability benefits will be paid if you refuse to participate in any medically recommended occupational rehabilitation program, or if your Temporary Disability is treatable by medical care that is reasonable and of a form that an ordinary person in the same or similar circumstances would undergo, and you have not availed yourself of the treatment.

(iv) **Subsequent Disability**. If you recover from Temporary Disability and then become Temporarily Disabled again, the subsequent period of Temporary Disability will be deemed continuous with the first, if the separate periods of disability arise from the same or related causes and are separated by less than fourteen (14) consecutive days during which you are in Active Service. A period of disability is not continuous if separate periods of Temporary Disability result from unrelated causes, or the later Temporary Disability occurs after this Plan terminates. You will not receive disability benefits for successive periods of Temporary Disability which result from entirely different and unrelated causes, unless such periods of Temporary Disability are separated by at least one (1) full day during which you are not Temporarily Disabled and have returned to Active Service.

(v) **Release to Return to Work**. If you are injured and have been released only for restricted duty under paragraph (b) below, and you remain in Active Service of TXFM, you will only be entitled to Disability Benefits until the earlier of your release for full duty, or the end of your Disability Benefit Period. After initial medical treatment for an Occupational Injury, a Doctor may release you to return to work under one of the following options:

(a) **Full Duty**. You may resume the full range of duties routinely associated with performance of your job; or

(b) **Restricted (Limited or Light) Duty**. You may resume some, but not all of the duties routinely associated with your job; or, you may be restricted in your number of hours of work; or, you may not resume any of the duties routinely associated with your job, but may be required to perform some other duties for which you have been trained or may be trained; or, any combination of the foregoing. If you are released for, but refuse or fail to promptly undertake restricted duty, your Plan benefits will cease. Disability Benefits are governed generally by Sections 4.6 and 4.7 of the Plan Document.

(vi) **Your Employment Is At Will**. Nothing in this Summary Plan Description shall be construed as giving any Participant the right to be retained in the service of TXFM for any period of time, and all Participants shall remain subject to discipline and discharge to the same extent as if the Plan Document had never been adopted. Unless otherwise contracted or agreed in writing, your employment at TXFM is at will.

H. Dismemberment and Paralysis Benefits. If you suffer a loss described in the Schedule of Losses below, and your loss is the direct result of an Occupational Injury, and the loss

is incurred within three hundred sixty-five (365) days after the Occurrence causing the Occupational Injury, you will be entitled to receive the scheduled benefit in one lump sum amount, or at the discretion of the Administrator, in one initial payment equal to twenty percent (20%) of the scheduled Dismemberment or Paralysis benefit due, and the remainder of this scheduled benefit due will be paid in thirty-five (35) equal monthly payments thereafter. Dismemberment or Paralysis benefits will not be paid if a death benefit becomes payable under the Plan. If you suffer more than one scheduled loss as a result of one Occurrence, a benefit will only be paid for the scheduled loss providing the larger benefit. The total death and dismemberment or paralysis benefits paid, when combined with all other benefits payable under the Plan to you for an Occurrence causing an Occupational Injury, will not exceed the Combined Single Limit Per Participant Per Occurrence and will be subject to the Aggregate Limit Per Occurrence, the Annual Plan Aggregate Limit and other limits under the Plan Document.

SCHEDULE OF LOSSES

For loss of:	Portion of Death Benefit
Life	100%
Quadriplegia	100%
Two or More Members	100%
One Member	50%
Hemiplegia	50%
Paraplegia	50%
Thumb and Index Finger of the Same Hand	25%
Four Fingers of the Same Hand	25%

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

"Quadriplegia" means total Paralysis of both upper and both lower limbs. "Paraplegia" means total Paralysis of both lower limbs or both upper limbs. "Hemiplegia" means total paralysis of the upper and lower limbs on one side of the body. A designated Provider must determine Paralysis to be complete and not reversible when the request for benefits is made. Paralysis means complete loss of muscle function for one or more muscle groups

6. CONDITIONS TO RECEIPT OF PLAN BENEFITS

A. Compliance With These Conditions Is Necessary. In order to receive payment or continued payment of any benefits otherwise available under this SPD or the Plan Document, you must first comply with all requirements of this Section 6.

B. Reporting. You must report every incident which you believe resulted from an Accident. **Your incident report must be made as soon as possible, but no later than the end of the shift when you sustain an Occupational Injury. This initial incident report is made to your Supervisor, Manager, or other person in charge of your workplace at the time.** That person will then help you obtain necessary medical treatment and complete the required Occurrence report forms. You must notify the Company of your expected recovery date (i) immediately after primary medical treatment, and (ii) after each succeeding appointment with your treating Doctor.

C. Medical Treatment. You must fully and completely follow the advice of and/or the course of medical treatment prescribed by your treating Doctor, and keep all scheduled appointments with Providers, to fulfill your prescribed medical treatment plan. **You must submit to drug and/or alcohol testing by the treating Doctor or other Provider at the time of your first medical treatment, and thereafter as requested by the Administrator or a Provider; these tests are a condition of coverage and of receipt and continued receipt of benefits under this SPD and the Plan.** A positive alcohol or drug test result at any time when you are receiving benefits under the Plan will cause your Plan benefits to cease. You may be required to submit to examination by a Doctor of the Administrator's choice as often as is reasonably necessary. If you have a Temporary Disability, you may also be required to submit to an occupational assessment and functional capacity examination.

D. No-Adversarial-Proceeding Condition. If you seek to bring or bring a cause of action, or notice a claim under arbitration, or institute a state or federal administrative proceeding, of any kind against TXFM or an insurer of TXFM whether based on an Occupational Injury or otherwise, then all benefits otherwise payable under the Plan shall immediately cease and no benefits shall be payable thereafter for any Occupational Injury to you.

E. Work-At-Home Associate Condition. If the physical property or the activities at the "Work At Home Address" listed on the "Work At Home Agreement" are in violation of any provision within the Plan Document at the time of an Occurrence causing an Occupational Injury at the Work At Home Address, no benefits will be paid under the Plan.

F. General Conditions to Receipt or Continued Receipt of Plan Benefits:

(i) You must complete the required Occurrence reporting forms before the end of the shift when your Injury occurs, must provide any other required form or document related to the Occurrence to your Employer, and must fully cooperate with an investigation of the circumstances surrounding your Occupational Injury;

(ii) You must comply with all of the requirements and provisions of the Plan Document;

(iii) You must follow the directions and course of treatment provided by your treating Doctor;

(iv) You must contact the Administrator at least weekly after your initial medical treatment and update your present recovery status and proposed return-to-work date;

(v) You must immediately report to your Supervisor or Manager to begin work after being released by your treating Doctor, as specified in your work release papers;

(vi) You must submit to drug and alcohol testing at the time of the Occurrence and or the time of initial medical treatment, and from time to time thereafter while the you are receiving Plan benefits;

(viii) After your Occupational Injury, you must submit to examination by a Doctor of the Administrator's choice as often as deemed reasonably necessary by the Administrator;

(ix) You must submit to one or more occupational assessments and/or functional capacity examinations in event of Temporary Disability, as directed by the Plan Administrator;

(x) If you are terminated from employment with the Employer for cause, all benefits otherwise payable to you under this Plan Document shall terminate immediately and automatically, without any further action by Employer. In this regard, termination for cause includes not by way of limitation those "job-related actions subject to immediate discharge" as specified in the "Disciplinary Action" section of the Nebraska Furniture Mart Staff Handbook as it may be amended from time to time. At the Effective Date, the job-related actions subject to immediate discharge include, but are not limited to:

(a) theft or other criminal behaviors, including such behavior outside of work;

(b) making statements that are false, misleading, or dishonest;

(c) falsification of any Company document, record, or report;

(d) unauthorized disclosure, use, or copying of confidential Company information;

(e) failure to handle Company funds in accordance with established procedures;

(f) accepting or requesting kickbacks, bribes, or payoffs from customers or suppliers;

(g) willful abuse or unauthorized use of NFM property, equipment, or materials;

(h) intentionally clocking another staff member's time or allowing another staff member to intentionally clock Participant's time;

(i) misuse of staff pricing benefit;

(j) endangering another person's life;

(k) insubordination, such as refusal or failure to accept or complete job assignments;

(l) harassment or discrimination;

(m) immoral or indecent conduct; horseplay; fighting; use of profane, threatening, or abusive language; acting in a disorderly manner or gross discourtesy to customers, vendors, or staff;

(n) intoxication, use, or possession of alcoholic beverages or drugs on Company property or during working hours;

(o) failure to report an Accident as outlined in the safety policy;

(p) leaving Company property while on the time clock without authorization;

(q) giving unauthorized discounts; or

(r) positive drug screen result.

(xi) You must timely attend all appointments scheduled with a Provider, including without limitation medical check-ups, diagnostic tests, physical therapy as limited herein, functionality assessments, and any other scheduled treatments or evaluations. If you miss two consecutive appointments with a Provider, or three non-consecutive appointments with a Provider, then the Administrator may terminate Plan benefits for that Occupational Injury.

7. BENEFIT CLAIMS EXCLUDED UNDER THE PLAN

No benefits will be provided to you, and benefits will immediately terminate under the Plan, if the Administrator determines that your Injury or claim for Plan benefits results or arises from any of the following:

(a) Suicide or an attempt to commit suicide or intentionally self-inflict an Injury, or intentionally cause or aggravate an Injury;

(b) Participation in: (i) a riot or act of civil disturbance; (ii) an assault or a felony, except an assault committed in defense of TXFM 's business or property; (iii) war or act of war, whether declared or undeclared; (iv) service in the military of any country or any civilian non-combatant unit serving with such forces; (v) any loss or damage directly or indirectly occasioned by confiscation, nationalization, requisition, or destruction of, or damage to property by or under the order of any government or public or local authority; or (vi) riots, strikes, civil commotion, revolution, terrorism, or uprising.

(c) Terrorism, meaning an act or acts of any person or group of persons committed for political, religious, ideological or similar purposes with the intention to influence any government or put the public, or any section of the public, in fear. Terrorism can include, but is not limited to, the actual use of force or violence or the threat of such use. Perpetrators of terrorism can be acting alone, or on behalf of, or in connection with, any organization or government.

(d) Use of: (i) nuclear weapons of mass destruction, meaning use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death to people or animals; (ii) chemical weapons of mass destruction meaning the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound that, when suitably distributed, is capable of causing incapacitating disablement or death to people or animals; or (iii) biological weapons of mass destruction, meaning emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism or biological produced toxin including genetically modified organisms and chemically synthesized toxins capable of causing incapacitating disablement or death to people or animals;

(e) Claims for liability under any contract or agreement, including representations, warranties, or indemnities of any kind, except covered welfare benefit claims made under the Plan Document;

(f) Travel to or from work, except when (i) the transportation is furnished as a part of your contract of employment, or is paid for by TXFM, or the means of transportation are under TXFM's control; or (ii) you are directed in your Scope of Employment to proceed from one place to another place; travel by a Work At Home Associate to or from Employer's business premises for any reason is excluded from coverage under this Plan;

(g) 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 with TXFM, or liability to any third person due to an Occurrence;

(h) Voluntary participation in any recreational, social, or athletic activity not constituting part of your Scope of Employment, whether or not such participation occurs on TXFM premises or during TXFM normal business hours;

(i) Participation in any activity or hazard not specifically within your Scope of Employment;

(j) The loss arose from an act of God, unless employment with TXFM exposed you to a greater risk of Injury from an act of God than ordinarily applies to the general public;

(k) Actual or punitive damages for Injury to you while employed in violation of law or performing work-related duties in violation of the law;

(l) Claims arising out of employment relationships including, without limitation, claims for any type of employment discrimination, wrongful discharge, retaliatory discharge, coercion, sexual harassment, Americans with Disabilities Act claims, and claims arising under the Labor Code of any state, and all other claims affecting or arising from the employment relationship whether arising under state or federal statutes or regulations or the common law;

(m) Claims for liability under the Federal Employer's Liability Act, United States Longshore and Harbor Workers' Compensation Act, the Jones Act, or the Migrant Seasonal Agricultural Worker Protection Act;

(n) Fines, assessments, or penalties levied pursuant to federal, state, local or other statute;

(o) Charges incurred by you for which you may be entitled to receive benefits under any state workers' compensation law, occupational disease law, unemployment compensation, disability benefits law, or other similar law;

(p) Any diagnostic procedure, treatment, service, or supply that is not Medically Necessary;

(q) Any charge in excess of a Usual, Customary, and Reasonable Charge, or not Medically Necessary, or not Pre-Certified as required by the Plan;

(r) Any Injury occurring while you were legally intoxicated or presumed intoxicated under any civil or criminal code or statute, regardless of the cause of the Occurrence;

(s) You are under the influence of drugs or alcohol at the time of the Injury, unless ingested or administered under the advice of and as directed by a Doctor;

(t) Use of, or exposure to: (i) asbestos, asbestos fibers, or asbestos products; or (ii) the hazardous properties of nuclear material; or (iii) silicon, silicate dust, or silicosis;

(u) Any statutory cause of action including, but not limited to, Title VII of the Civil Rights Act of 1964; Civil Rights Act of 1991; Civil Rights Act of 1866; Age Discrimination In Employment Act; Employee Retirement Income Security Act (except for Plan benefits awarded under actions brought pursuant to 502(a)(1)(B) of ERISA); 29 U.S.C. §1132(a)(1)(B); Fair Labor Standards Act; Bankruptcy Code; Texas Commission on Human Rights Act; Texas Workers' Compensation Act; Railway Labor Act; and, National Labor Relations Act;

(v) Claims arising out of the following common law causes of action alleged against TXFM by you: (i) claims under any contract of employment whether written, oral, or implied; (ii) a breach of duty of good faith and fair dealing; (iii) breach of non-competition agreement; (iv) claims for tortuous interference with contractual relations; (v) intentional or negligent infliction of emotional distress; or (vi) claims based on assault and battery, defamation, invasion of privacy, false light publicity, negligent invasion of privacy, misrepresentation and fraud, false imprisonment, false arrest, malicious prosecution, unreasonable search and seizure, or retaliatory discharge;

(w) Failure of TXFM to comply with the statutory requirements to become and continue as a Non-Subscriber under the Texas Workers' Compensation Act;

(x) Infections of any kind regardless of how contracted, except bacterial infections directly caused by botulism, ptomaine poisoning or an accidental cut or wound occurring within your Scope of Employment, independent and in the absence of any underlying sickness, disease or condition including, but not limited to, diabetes;

(y) Travel or flight in or on (including getting into or out of, or onto or off of) an airplane, helicopter or any other device used for aerial navigation, if you are: (i) flying in an aircraft that is rocket propelled; (ii) flying in any aircraft used for aerobatics, racing or endurance test, crop dusting or seeding or fertilizing or spraying, fighting a fire, any exploration or pipe or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting or any test or experimental usage; (iii) flying when a special permit or waiver from the proper authority has to be issued; (iv) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; (v) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or (vi) riding as a passenger in an aircraft owned, leased or operated by TXFM;

(z) Any Pre-Existing Condition, Occupational Disease, or Cumulative Trauma unless expressly covered by the Plan Document;

(aa) Osgood-Schlatter's Disease; osteochondritis, osteoarthritis, arthritis, or any other degenerative process of the joints, bones, tendons or ligaments; appendicitis; osteomyelitis; pathological fractures; congenital weakness; or detached retina unless caused by an Occupational Injury;

(bb) Any mental trauma, mental condition or nervous disorder, or emotional, psychological or psychiatric care or treatment, all whether or not caused by a Covered Accident;

(cc) Loss from medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity, whether the loss results directly, or indirectly, from the treatment;

(dd) Stroke or cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm; stroke; cardiac disease or conditions, al whether or not caused by a Covered Accident;

(ee) Any alleged Injury which is not an Occupational Injury as defined in the Plan Document;

(ff) Any Injury arising from horseplay, scuffling, fighting, altercation, or other inappropriate workplace behavior by you;

(gg) Any claim otherwise covered by the Plan Document, but you tendered a forged, untrue, or materially misleading document, or you made a false, untrue or otherwise materially misleading representation to TXFM in the process of gaining your employment with TXFM; under any of these conditions, you are not deemed a Participant under the Plan Document and Plan benefits will not be paid;

(hh) Hypnosis, acupuncture, or Chiropractic Services;

(ii) Biofeedback and other forms of self-care or self-help training or any related diagnostic testing;

(jj) Medical services performed by a person who normally lives with you, your spouse, your parent or your spouse's parent, your child or your spouse's child, your brother or sister or your spouse's brother or sister, your cousin or your spouse's cousin, or your grandparent or your spouse's grandparent;

(kk) Lead or lead-based products;

(ll) Any Injury resulting from an Occurrence, for which a claim is made under the "Nebraska Furniture Mart, Inc. Employee Health Plan Omaha NE," dated and effective 01-01-2012, as hereafter amended, or under any other welfare benefit plan sponsored by Nebraska Furniture Mart, Inc. or its affiliates other than the Plan;

(mm) Any Injury resulting from an Occurrence which occurs while you are in violation of a TXFM written safety policy, safety regulation, or safety guideline.

(nn) Any Injury resulting from an Occurrence which occurs at a Work At Home Address while the Work At Home Associate is acting in violation of any TXFM written safety policy, safety regulation, or safety guideline.

8. SUBROGATION RIGHTS

If your Occupational Injury is allegedly caused by a third party's wrongful act or negligence, the following provisions will apply:

A. To receive any Plan benefits for that Occupational Injury, you or your legal representative [or in the case of your death, your Beneficiary(s)] **agree** as a condition to receiving or continuing receipt of any benefit under the Plan:

(i) that TXFM will be subrogated to any recovery (regardless whether there is recovery from the third party of the full amount of all claims) against the third party or right of recovery against that third party;

(ii) not to take any action which would prejudice TXFM's subrogation rights including seeking attorney's fees and costs;

(iii) to cooperate in doing what is reasonably necessary to assist TXFM or its designated Administrator in any recovery, including, but not limited to signing and delivering documents to evidence or secure the rights of subrogation and the right of recovery; and

(iv) to include in any liability claim against any third party, any benefits payable to you or on your behalf under the Plan Document.

B. TXFM will be subrogated only to the extent of the Plan benefits paid or reimbursed for the Occupational Injury.

C. Subrogation rights of TXFM under this Section 8 will not be jeopardized merely because TXFM fails to recognize its right of subrogation until after paying Plan benefits or if TXFM recognizes its right of subrogation but fails to obtain the necessary consent before paying Plan benefits. Any Plan benefits paid to you, your legal representative, or your Beneficiary must be returned to TXFM immediately if TXFM requests the subrogation agreement provided for herein and the recipient of such Plan benefits fails or refuses to execute or comply fully with such agreement.

D. You, by participation in the Plan, agree that your Beneficiary, and the legal representative of your Beneficiary, shall be obligated to agree that TXFM will be subrogated to any recovery or right of recovery the Beneficiary has against any third party with respect to your Occupational Injury, or with respect to any wrongful death claim or action.

E. If you are covered under one or more other plans, including, but not limited to, insurance, indemnity or reimbursement plans, the benefits otherwise payable for expenses under the Plan Document shall apply only over and in excess of the other contract of insurance, indemnity or reimbursement.

9. How Are Plan Benefits Funded?

You do not pay any part of the cost of the Plan. Plan benefits are funded solely by TXFM out of its general assets. There is no trust or other funding mechanism for Plan benefits other than the general assets of TXFM. At TXFM's election, TXFM may purchase an insurance policy at TXFM's sole expense, to reimburse TXFM for benefits paid under the Plan. No Employee or Participant or Beneficiary of a Participant shall have any interest in such insurance policy or any proceeds thereof.

10. Review Procedures for A Plan Benefit Claim.

10(i) General.

10(i)(a) Missing Claim Information. If a claim as originally submitted is not complete, the Claimant will be notified, and then Claimant will be responsible to provide the missing information within the timeframe stated in the notification.

10(i)(b) Inquiries. Casual or general inquiries regarding eligibility or particular Plan benefits are not claims. For an "inquiry" to constitute a claim for Plan benefits or an appeal of an Adverse Benefit Determination, a Participant must follow the claim procedures in this Section **10**.

10(i)(c) HIPAA and the Affordable Care Act. The substantive text of the Plan benefit claim procedures described in this Section **10** may be found at 29 CFR §2560.503-1 (Claims Procedure) adopted under ERISA during year 2000. However, Plan benefits are "excepted benefits" both under the Affordable Care Act (see 45 CFR §148.220) and under the HIPAA [see 26 CFR §54.9831-1(c)]. Plan benefits are not subject to the claims provisions of the Affordable Care Act, nor to the Protected Health Information provisions of the HIPAA, nor to the otherwise applicable Regulations adopted under those Acts.

10(ii) Definitions for this Section 10 (capitalized terms in this Section 10 which are not defined below have the definitions provided for them at Section 4, above).

"**Adverse Benefit Determination**" means any of the following: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan; (2) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, resulting from application of precertification procedures or other utilization review procedures; and (3) a failure to cover an item or service for which benefits under the Plan are otherwise provided because it is determined to be experimental and/or investigational, or not Medically Necessary, or because another Plan exclusion applies.

"**Adverse Benefit Determination on Review**" means upholding or affirmation of an initial Adverse Benefit Determination.

"**Benefit Determination**" means a determination by the Plan Administrator on a claim for Plan benefits, whether or not it is an Adverse Benefit Determination.

"**Benefit Determination on Review**" means a determination by the Plan Administrator on appeal of an initial Adverse Benefit Determination, whether or not it is an Adverse Benefit Determination.

"**Claimant**" means a Participant (or other payee, such as an Eligible Spouse in event of a death benefit claim), or his or her authorized representative or health care Provider designated by the Participant or payee, as applicable, to act on his or her behalf. For an Urgent Care Claim, a Health Care Professional with knowledge of the Participant's medical condition shall be permitted to act as an authorized representative of that Participant.

"**Concurrent Care Decision**" means, with respect to an ongoing course of treatment previously approved by the Plan Administrator which is to be provided over a period of time or number of treatments: (1) any reduction or termination by the Plan Administrator of such course of treatment (other than by Plan amendment or Plan termination) before the end of such period of time or number of treatments; or, (2) any request by a Claimant to extend the ongoing course of treatment beyond the approved period of time or number of treatments. A Concurrent Care Decision described in (1) above is an Adverse Benefit Determination.

"**Disability Claim**" means a claim for benefits conditioned on a showing of Disability by the Claimant.

"**Health Care Professional**" means a Doctor or other Provider who is licensed, accredited, or certified to perform specified health services consistent with state law.

"**Medical Care Claim**" means a Pre-Service Claim, a Post-Service Claim, a Concurrent Care Decision, or an Urgent Care Claim, as defined in this Section **10**.

"**Non-Health Claim**" means a claim other than a Disability Claim or Medical Care Claim, as defined in this Section **10**.

"**Pre-Service Claim**" means a claim for a medical benefit under this Plan, the receipt of which the Plan conditions, in whole or in part, on pre-approval of the requested benefit in advance of obtaining medical care.

"**Post-Service Claim**" means a post-facto claim for a medical benefit under this Plan for (1) reimbursement of, or (2) consideration of payment for, the cost of medical care that has already been delivered to a Participant. A Post-Service Claim is a medical benefit claim that is neither a Pre-Service Claim nor an Urgent Care Claim.

"**Urgent Care Claim**" means a claim for medical care or treatment that, if not received, (1) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to

regain maximum function; or (2) in the opinion of a health care Provider with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If a health care Provider with knowledge of the Claimant's medical condition deems the medical care or treatment urgent, then the claim is an Urgent Care Claim.

10(iii) Initial Claim Procedure and Time Limits.

10(iii)(a) Initial Claim Process. A claim and all required claim documentation must be filed in writing with the Plan Administrator, and decided within the applicable timeframe under federal law, regardless of whether all information required to perfect the claim is included. The timeframe for the Plan's decision begins on receipt by the Plan Administrator of a claim submitted by the Claimant in accordance with the Plan's claims procedures, and is contingent upon (1) the type of claim that is submitted, (2) whether the claim submitted is a complete claim or incomplete claim, (3) whether additional information is required, and (4) whether an extension is required to make a decision on the claim.

10(iii)(b) Urgent Care Claim.

10(iii)(b)(1) If an Urgent Care Claim is submitted, the Plan Administrator will render a Benefit Determination and provide notice to the Claimant of such Benefit Determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Urgent Care Claim is received, subject to subsection **10(iii)(b)(2)** below.

10(iii)(b)(2) If an Urgent Care Claim as submitted is incomplete, the Plan Administrator will notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receiving the incomplete claim. Such notice will request the additional information required to render a decision on the claim and explain why such information is necessary. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the requested information. Regardless of whether the Claimant provides the Plan Administrator with the requested information, the Plan Administrator will render a Benefit Determination on the claim and provide notice to the Claimant of such Benefit Determination as soon as possible, but not later than forty-eight (48) hours after the earlier of (A) receipt of the requested information, or (B) the end of the period afforded the Claimant to provide the requested information.

10(iii)(b)(3) If a Claimant fails to follow the Plan's procedures for filing an Urgent Care Claim, the Claimant shall be notified of such failure and of the proper procedures to be followed in filing such a claim. The notification shall be provided to the Claimant as soon as possible, but not later than twenty-four (24) hours following the failure. Notification may be oral, unless written notification is requested by the Claimant. For purposes of this subsection **10(iii)(b)(3)**, a failure to follow the Plan's procedures for filing shall mean only such a failure that is (A) a communication by Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under this Plan; and (B) a communication that names a specific Claimant,

a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

10(iii)(b)(4) Notification of any Adverse Benefit Determination with respect to an Urgent Care Claim shall be made in accordance with Section **10(iv)**.

10(iii)(c) Concurrent Care Decisions.

10(iii)(c)(1) As to a Concurrent Care Decision which is an Adverse Benefit Determination, the Plan Administrator shall notify the Claimant, in accordance with Section **10(iv)** below, of the Adverse Benefit Determination at a time sufficiently in advance of the benefit reduction or termination to allow the Claimant to appeal and obtain a Benefit Determination on Review of that Adverse Benefit Determination, before the benefit is actually reduced or terminated.

10(iii)(c)(2) If a Concurrent Care Decision is a request by a Claimant to extend the course of treatment beyond the period of time or number of treatments approved, and is an Urgent Care Claim, such Concurrent Care Decision shall be decided as soon as possible, taking into account the medical exigencies. The Plan Administrator shall notify the Claimant of the Benefit Determination, whether or not adverse, within twenty-four (24) hours after receipt of the Claim by the Plan, provided that any such Claim is made to the Plan at least twenty-four (24) hours prior to expiration of the approved period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether or not involving an Urgent Care Claim, shall be made in accordance with Section **10(iv)**, and appeal of the same shall be governed by Sections **10(vi)(a)(1), (2) or (3)**, as appropriate.

10(iii)(d) Other Medical Care Claims. If a Medical Care Claim is neither an Urgent Care Claim nor a claim involving a Concurrent Care Decision as described in subsection **10(iii)(c)** above, the Plan Administrator shall notify the Claimant of the Plan's Benefit Determination, as follows:

10(iii)(d)(1) *Pre-Service Claim.*

10(iii)(d)(1)(A) The Plan Administrator will render a Benefit Determination, and provide notice to the Claimant of such Benefit Determination (whether or not adverse), within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the Pre-Service Claim by the Plan Administrator. This period may be extended one time by the Plan Administrator for up to fifteen (15) additional days, provided the Plan Administrator both (1) determines such an extension is necessary due to matters beyond the control of the Plan, and (2) notifies the Claimant, prior to expiration of the initial fifteen (15) day period, of the circumstances requiring extension of time, and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to Claimant's failure to submit information necessary to decide the claim, the notice of extension shall specifically describe the required information, and Claimant shall be afforded at least forty-five (45) days from receipt of the notice, within which to provide the specified information.

10(iii)(d)(1)(B) If a Claimant fails to follow this Plan's procedures for filing a Pre-Service Claim, the Claimant shall be notified of such failure and of the proper procedures to be followed in filing such a claim. The notification shall be provided to the Claimant as soon as possible, but not later than five (5) days following Claimant's failure. Notification may be oral, unless written notification is requested by the Claimant. For purposes of this subsection **10(iii)(d)(1)(B)**, a failure to follow the Plan's procedures for filing shall mean only such a failure that is (i) a communication by Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under this Plan; and (ii) a communication that names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

10(iii)(d)(1)(C) Notification of an Adverse Benefit Determination made under this Section **10** shall be made in accordance with Section **10(iv)** below.

10(iii)(d)(2) *Post-Service Claim.*

10(iii)(d)(2)(A) The Plan Administrator shall render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the Post-Service Claim. This period may be extended one time by the Plan Administrator for up to fifteen (15) days, provided the Plan Administrator both (i) determines such an extension is necessary due to matters beyond the control of the Plan, and (ii) notifies the Claimant, prior to expiration of the initial thirty (30)-day period, of the circumstances requiring extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to a failure by Claimant to submit the information necessary to decide the Post-Service Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least forty-five (45) days from receipt of the notice, within which to provide the specified information.

10(iii)(d)(2)(B) Notification of an Adverse Benefit Determination made hereunder shall be made in accordance with Section **10(iv)** below.

10(iii)(e) Non-Health Claims.

10(iii)(e)(1) If a Non-Health Claim is submitted, the Plan Administrator will render a Benefit Determination and provide notice to the Claimant of any denial, in whole or in part, of such Non-Health Claim within a reasonable period of time, but not later than ninety (90) days after receipt of the Non-Health Claim, unless the Plan Administrator determines that special circumstances require an extension of time for processing the Non-Health Claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to termination of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial ninety (90) day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render a Benefit Determination.

10(iii)(e)(2) Notification of any Adverse Benefit Determination with respect to a Non-Health Claim shall be made in accordance with Section **10(iv)** (below).

10(iii)(f) Disability Claims.

10(iii)(f)(1) If a Disability Claim is submitted, the Plan Administrator will render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the Disability Claim (the "Initial Period"). The Initial Period may be extended by the Plan for up to thirty (30) days (the "First Extension"), provided the Plan Administrator both (A) determines that such an extension is necessary due to matters beyond the control of the Plan, and (B) notifies the Claimant, prior to expiration of the Initial Period, of the circumstances requiring the First Extension and the date by which the Plan expects to render a decision.

10(iii)(f)(2) If, prior to the end of the First Extension, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the First Extension, the period for making the determination may be extended for up to an additional thirty (30) days (the "Second Extension"), provided the Plan Administrator notifies the Claimant, prior to expiration of the First Extension, of the circumstances requiring the Second Extension and the date by which the Plan expects to render a decision. In the case of an extension under this subsection **10(iii)(f)**, the notice of extension shall specifically explain (A) the standards on which entitlement to a benefit is based, (B) the unresolved issues that prevent a decision on the claim, and (C) the additional information needed to resolve those issues. The Claimant shall be afforded at least forty-five (45) days to provide the specified information.

10(iii)(f)(3) Notification of any Adverse Benefit Determination with respect to a Disability Claim shall be made in accordance with Section **10(iv)** below.

10(iv) Notification of Benefit Determination.

10(iv)(a) Except as provided in Section **10(iv)(b)** below, the Plan Administrator shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. Any electronic notification shall comply with the standards imposed by 29 CFR §2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth in a manner calculated to be understood by the Claimant:

10(iv)(a)(1) the specific reason or reasons for the Adverse Benefit Determination;

10(iv)(a)(2) reference to the specific Plan provisions upon which the determination is based;

10(iv)(a)(3) a description of additional material or information necessary for the Claimant to perfect the claim, and an explanation of why such material or information is necessary;

10(iv)(a)(4) a description of the Plan's appeal procedures and the time limits applicable to such procedures, including, in the case of an Urgent Care Claim, a description of the expedited review

process applicable to those claims, along with a statement of the Claimant's right to bring a civil action under §502(a) of ERISA following an Adverse Benefit Determination on Review;

10(iv)(a)(5) in the case of an Adverse Benefit Determination regarding a Disability Claim or a Medical Care Claim, if the Adverse Benefit Determination is based upon:

10(iv)(a)(5)(A) an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

10(iv)(a)(5)(B) a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan terms to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

10(iv)(b) In the case of an Adverse Benefit Determination involving an Urgent Care Claim, the information described in Section **10(iv)(a)** (above) may be provided to the Claimant orally within the time frame prescribed in Section **10(iii)(b)** (above), provided that a written or electronic notification is furnished to the Claimant not later than three (3) days after the oral notification.

10(v) Appeal Procedures.

10(v)(a) Filing an Appeal.

10(v)(a)(1) Each Claimant shall have a reasonable opportunity to appeal an Adverse Benefit Determination to the Plan Administrator as set forth below.

10(v)(a)(2) The Claimant shall have one-hundred eighty (180) days (or sixty (60) days in the case of a Non-Health Claim) following receipt of notification of an Adverse Benefit Determination, within which to file an appeal of said Benefit Determination.

10(v)(a)(3) The Claimant shall be provided a reasonable opportunity for full and fair review of an Adverse Benefit Determination, in accordance with the provisions of Section **10(v)(b)** below.

10(v)(b) General Review Procedures.

10(v)(b)(1) Each Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim which is the subject of the appeal.

10(v)(b)(2) Each Claimant shall be provided, 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 under the Plan. Whether a document, record, or other information is "relevant" to a claim for benefits under the Plan shall be determined by reference to Section **10(viii)** below.

10(v)(b)(3) The appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

10(v)(b)(4) The Plan offers one level of review on appeal, consisting of the appeal of an initial Adverse Benefit Determination as described in this Section **10(v)**.

10(v)(c) Disability Claims and Medical Care Claims; Review Procedures. The following review procedures, in addition to those set forth in subsection **10(v)(b)** (above), shall apply to Disability Claims and Medical Care Claims:

10(v)(c)(1) The appeal shall not afford deference to the initial Adverse Benefit Determination and shall be conducted by a decision-maker who is neither the individual who made the Adverse Benefit Determination that is on appeal nor the subordinate of such decision-maker.

10(v)(c)(2) In deciding an appeal of an Adverse Benefit Determination based in whole or in part on a medical judgment, the decision-maker shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involving the medical judgment.

10(v)(c)(3) All medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination on appeal shall be identified, without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

10(v)(c)(4) All Health Care Professionals engaged for purposes of consultation under Section **(v)(c)(2)** (above) shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is on appeal, nor the subordinate of such individual.

10(v)(c)(5) In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Plan's Benefit Determination on Review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

10(vi) Benefit Determination on Review.

10(vi)(a) Timing of Notification.

10(vi)(a)(1) *Urgent Care Claim.* In the case of an Urgent Care Claim, the Plan Administrator shall notify the Claimant in accordance with Section **10(vi)(b)**, of the Plan's Benefit Determination on Review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claimant's appeal of an Adverse Benefit Determination by the Plan.

10(vi)(a)(2) *Pre-service Claims.* In the case of a Pre-Service Claim, the Plan Administrator shall notify the Claimant, in accordance with Section **10(vi)(b)**, of the Plan's Benefit Determination on Review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than fifteen (15) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination.

10(vi)(a)(3) *Post-Service Claims.* In the case of a Post-Service Claim, the Plan Administrator shall notify the Claimant in accordance with Section **10(vi)(b)**, of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than thirty (30) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination.

10(vi)(a)(4) *Disability Claims.* In the case of a Disability Claim, the Plan Administrator shall notify the Claimant in accordance with Section **10(vi)(b)**, of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than forty-five (45) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to termination of the initial forty-five (45) day period. In no event shall such extension exceed a period of forty-five (45) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on Review.

10(vi)(a)(5) *Non-Health Claims.* In the case of a Non-Health Claim, the Plan Administrator shall notify the Claimant in accordance with Section **10(vi)(b)**, of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial sixty (60) day period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on Review.

10(vi)(a)(6) In the case of an Adverse Benefit Determination on Review, the Plan Administrator shall provide access to, and copies of, documents, records, and other information described in Sections **10(vi)(b)(3)** and **(5)** as appropriate.

10(vi)(b) Manner and Content of Notification of Benefit Determination on Review. The Plan Administrator shall provide a Claimant with written or electronic notification of the Plan's Benefit Determination on Review. Any electronic notification shall comply with the standards imposed by 29 CFR §2520.104b-1(c)(1)(i), (iii), and(iv). In the case of an Adverse Benefit Determination on Review, the notification shall set forth in a manner calculated to be understood by the Claimant:

10(vi)(b)(1) The specific reason or reasons for the Adverse Benefit Determination on Review;

10(vi)(b)(2) Reference to the specific Plan Document provisions upon which the Adverse Benefit Determination on Review is based;

10(vi)(b)(3) 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 under the Plan (whether a document, record, or other information is relevant to a Claim for Benefits shall be determined by reference to Section **10(viii)**, below);

10(vi)(b)(4) A statement of the Claimant's right to bring an action under §502(a) of ERISA following an Adverse Benefit Determination on Review with respect to any appeal;

10(vi)(b)(5) In the case of an Adverse Benefit Determination on Review regarding a Disability Claim or a Medical Care Claim:

10(vi)(b)(5)(A) if the Adverse Benefit Determination on Review is based upon an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion will be provided, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on Review and that a copy of the rule, guideline, protocol, or other similar criterion will be provided, free of charge, to the Claimant upon request; or

10(vi)(b)(5)(B) if the Adverse Benefit Determination on Review is based upon a medical necessity or experimental and/or investigational 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 will be provided, or a statement that such explanation will be provided, free of charge, upon request; and

10(vi)(b)(5)(C) The following statement will be included: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

10(vii) Calculating Time Periods. For purposes of Sections **10(iii)** and **10(vi)(a)** (above), the period of time within which a Benefit Determination or a Benefit Determination on Review is required to be made shall begin at the time a claim or appeal, as the case may be, is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make a Benefit Determination or a Benefit Determination on Review, as the case may be, accompanies the filing. If a period of time is extended as permitted under Section **10(iii)** or **10(vi)(a)** due to a Claimant's failure to submit information necessary to decide a claim or the appeal, the period for making the Benefit Determination or the Benefit Determination on Review shall be tolled from the date on which the notification of the extension is sent to the Claimant, until the date on which the Claimant responds to the request for additional information.

10(viii) Relevance. For the purposes of this Section **10**, a document, record, or other information shall be considered "relevant" to a Claimant's claim if such document, record, or other information:

10(viii)(a) was relied upon in making a Benefit Determination;

10(viii)(b) was submitted, considered, or generated in the course of making a Benefit Determination, without regard to whether such document, record, or other information was relied upon in making the Benefit Determination;

10(viii)(c) demonstrates compliance with any administrative processes and safeguards in making a Benefit Determination; or

10(viii)(d) in the case of a Disability Claim or a Medical Care Claim, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making a Benefit Determination.

10(ix) Exhaustion of Administrative Remedies. No action at law or in equity may be brought to recover under this Plan until all administrative remedies, including the appeal procedure for an initial Adverse Benefit Determination, have been exhausted. If a Claimant fails to file a timely claim, or if the Claimant fails to request a review in accordance with the reasonable claim procedures outlined in this Plan Document, such Claimant shall have no right of review, and shall have no right to bring any action in any court, and denial of the claim shall become final and binding on all persons for all purposes.

10(x) Action for Recovery. No action at law or in equity may be brought for any recovery for any claim for any Plan benefit sooner than sixty (60) days, or later than one (1) year, after the time written proof of a claim is required to be furnished.

10(xi) Participant's Responsibilities. Each Participant is responsible to provide the Plan Administrator and/or his or her Employer with the Participant's current U.S. mailing address and any electronic address. Any notices required or permitted to be given under this Plan Document shall be deemed given if directed to any such address furnished by the Participant and mailed by regular United States mail, or by electronic means as specified in §2520.104b-l(c) of ERISA. Neither the Plan Administrator, nor the Plan Sponsor, nor the Employer shall have any obligation or duty to locate a Participant. If a Participant becomes entitled to a payment under this Plan Document and such payment is delayed or cannot be made:

10(xi)(a) because the current address according to the Plan Administrator's records is incorrect; or

10(xi)(b) because the Participant fails to respond to the notice sent to the current address according to the Plan Administrator's records; or

10(xi)(c) because of conflicting claims to such payment; or

10(xi)(d) for any other reason; then the amount of such payment, if and when made, shall be determined under this Plan Document without payment of any interest or earnings.

11. YOUR EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA") RIGHTS

A. As you are covered by the Plan, you have certain rights and protections under ERISA, which provides that all Plan Participants will be entitled to:

(i) Examine, without charge, at the Administrator's office or at another designated location, all Plan documents filed and a copy of the latest Annual Report (Form 5500 series), if required, by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;

(ii) Obtain copies of documents governing operation of the Plan and updated Summary Plan Description and a copy of the latest Annual Report (Form 5500 series), if required, upon written request to the Administrator (the Administrator may make a reasonable charge for the copies); and

(iii) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report if a Form 5500 is required to be filed.

B. Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. The people who operate your Plan are called "fiduciaries" of the Plan, and have a duty to do so prudently and in your interest and the interest of other Plan Participants. No one, including the Administrator 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 in whole or in part, you must receive a written explanation of the reason for the denial and how to obtain copies of documents relating to this decision without charge. You have the right to have the Administrator review and reconsider your claim. If you have any questions about your Plan, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

C. Enforcement. 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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, that cannot be settled through an internal review process or through

mediation, then you may file suit in a federal court to recover Plan benefits under §502(a)(1)(B) of ERISA. In addition, 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.

D. Assistance with Your Questions: If you have any questions about your Plan, you should contact the 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 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.