SUMMARY PLAN DESCRIPTION
LANDMARK INDUSTRIES
EMPLOYEE OCCUPATIONAL INJURY BENEFIT PLAN

Effective August 1, 2009, Landmark Industries (the "Employer") has established the Landmark Industries Occupational Injury Plan (the "Plan") governed by the Employee Retirement Income Security Act of 1974 ("ERISA") to provide certain limited benefits for Participants who sustain certain Occupational Injuries.

I. GENERAL INFORMATION

I.1 This Summary Plan Description is intended to briefly describe the more important terms and conditions of the Plan, and does not review all of the Plan provisions. If a question should arise between a statement in this Summary Plan Description and the Plan, the terms and conditions of the Plan control. If you have any questions concerning these terms and conditions, You should consult the Plan document, a copy of which can be obtained from the Employer.

I.2 The Plan shall supersede and render void any previous benefit plans covering occupational injuries, to the extent that such previous benefit plans provided benefits for occupational injuries. The terms and conditions of the Plan may be amended at any time by the Employer. The Employer expects the Plan to be permanent, but does reserve the right to terminate the Plan at any time. Such amendment or termination shall not deprive any Participant or Beneficiary of any of the benefits to which he/she is entitled under the Plan and which have become payable under the terms and conditions of the Plan.

I.3 Receipt of this Summary Plan Description does not constitute an employment contract nor do any benefits hereunder constitute an admission of liability on the part of the Employer.

I.4 All expenses for the administration of the Plan shall be paid by the Employer.

II. WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN?

II.1 Each Employee who was an Employee on the Effective Date shall be eligible to participate in the Plan on the Effective Date. Other Employees shall be eligible to participate in the Plan as of the day he/she becomes an Employee.

II.2 You become a Participant (herein after You, Your) in the Plan upon making a claim for benefits, or receipt or acceptance of any benefits under the Plan and shall be bound by the terms and conditions of the Plan.

II.3 You cease to be a Participant in the Plan as of the earlier of (a) the day the Plan is terminated, or (b) the day on which You are no longer an Employee.

III. WHAT ARE THE PLAN BENEFITS?

III.1 If You sustain an Occupational Injury, You may be eligible for the following benefits: (a) Medical Benefits, (b) in some cases, limited Wage Replacement Benefits for disability, and (c) in some cases, defined Accidental Dismemberment Benefits. In some cases, a defined Accidental Death Benefit may be paid to a qualified Beneficiary.

III.2 "Occupational Injury" means specifically identifiable damage or harm to the physical structure of Your body that is incurred solely as the direct result of an Occupational Accident, and which arose out of Your Scope of Employment with the Employer. All Occupational Injuries sustained by You in any one Occurrence, including all related conditions and recurrent symptoms of those Occupational Injuries are considered a single Occupational Injury.

III.3 The sum total maximum amount of all Medical, Wage Replacement, Accidental Dismemberment and Accidental Death Benefits payable to You or on Your behalf under the Plan for each Occupational Accident resulting in an Occupational Injury is $250,000 (the "Combined Single Limit per Participant per Occurrence").

III.4 Benefits otherwise available under the Plan are not payable to the extent such benefits exceed the Combined Single Limit per Participant per Occurrence of $250,000.

III.5 Medical Benefits. If You suffer an Occupational Injury, You may be eligible for Medical Benefits for Medical Care directly relating to the treatment of Your Occupational Injury. Medical Benefits begin on the day You sustain an Occupational Injury, and continue until the earliest of: (1) the day a Designated Provider determines Medical Care is no longer necessary with respect to that Occupational Injury, (2) the day a Designated Provider determines You have reached Maximum Rehabilitative Capacity with respect to that Occupational Injury, (3) 104 weeks after the day of the Occupational Accident, (4) when the sum total amount of benefits paid under the Plan equals the Combined Single Limit per Participant per Occurrence of $250,000, or (5) Your date of death. The first Eligible Charge for Medical Care must be incurred within 90 days of the day of the Occupational Accident causing the Occupational Injury.

III.6 Designated Provider. The Administrator (or its employed third party administrator ("TPA")) shall approve one or more healthcare providers to administer Medical Care to You, and the Administrator (or its employed TPA) may change Designated Providers at any time for any reason. A healthcare provider which has not been approved as a Designated Provider may be utilized to provide emergency Medical Care if an Occupational Injury occurs when You are not at Your regular workplace, or if an emergency vehicle takes You to a healthcare provider which has not been approved as a Designated Provider. Except as provided immediately above, Medical Benefits shall not be paid for Medical Care received from a healthcare provider that has not been approved as a Designated Provider.

III.7 Although Eligible Charges are conditioned on Your use of Designated Providers, You may seek any Medical Care You deem appropriate from any provider of Your choice and at Your own expense. Accordingly, if You elect not to use a Designated Provider, the Plan does not cover and will not pay for any of the medical expenses otherwise payable under the Plan.

III.8 You must fully and completely follow the course of Medical Care treatment prescribed by the Designated Provider. You must keep all scheduled Medical Care appointments. You must also submit to any type of medical examination the Administrator (or its employed TPA) considers appropriate.

III.9 You must obtain Pre-authorization from the Administrator (or its employed TPA) in advance of all non-emergency Medical Care being rendered. Non-emergency Medical Care not Pre-authorized shall not be paid under the Plan.

III.10 A Designated Provider may release You to return to work under one of the following:

(a) Full Duty: You may resume full range of duties routinely associated with Your job.

(b) Restricted Duty: You may resume some, but not all of the duties routinely associated with Your job, or may be restricted in the number of hours of work; or You may not resume any of the duties routinely associated with Your job, but may be allowed to perform some other duties for which Your have been trained or may be trained.

III.11 Wage Replacement Benefits. If You are Temporarily Disabled as the direct result of an Occupational Injury, You may be eligible to receive Wage Replacement Benefits under the Plan.

III.12 For any Wage Replacement Benefits to be payable, Temporary Disability must commence within 90 days of the day of the Occupational Accident causing the Occupational Injury, and must continue for 7 consecutive days (the "Benefit Waiting Period").

III.13 Following the Benefit Waiting Period, You are eligible for Wage Replacement Benefits for each work day of Temporary Disability. Wage Replacement Benefits begin on the first scheduled work day immediately following the Benefit Waiting Period and continue until the earliest of: (1) the day a Designated Provider releases You to Full Duty; (2) the day You fail to have satisfactory proof from a Designated Provider of continuing Partial or Temporary Disability; (3) 104 weeks after the day of the Occupational Accident; (4) when the sum total amount of benefits paid under the Plan equals the Combined Single Limit per Participant per Occurrence of $250,000; or (5) Your date of death.

III.14 Wage Replacement Benefits are calculated at 75% of Your Average Weekly Earnings but never more than $600 per week. For any period of Temporary Disability which is less than a full week, the Average Weekly Earnings shall be prorated by the number of days in Your scheduled work week. However, if You are released to Restricted Duty, Wage Replacement Benefits will be reduced by the amount of Your earnings.

III.15 No Wage Replacement Benefits will be paid if You refuse to receive any Medical Care that is prescribed by a Designated Provider that is of a form an ordinary person of the same or similar circumstances would undergo.

III.16 Accidental Dismemberment Benefit. In the event You suffer a loss as the direct result of an Occupational Injury, You may be eligible for an Accidental Dismemberment Benefit as set forth below in the Schedule of Losses. If You suffer more than one scheduled loss as a result of one Occupational Accident, the Accidental Dismemberment Benefit will only be paid for the scheduled loss with the larger benefit. The Administrator may, in its sole discretion, pay out the Accidental Dismemberment Benefit in equal monthly installments over a period of one year. Accidental Dismemberment Benefits shall not be paid if an Accidental Death Benefit is payable under the Plan. However, the sum total amount of benefits paid under the Plan shall not exceed the Combined Single Limit per Participant per Occurrence of $250,000.

SCHEDULE OF LOSSES

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

III.17 Accidental Death Benefit. In the event You die as a direct result of an Occupational Injury within 365 days of the day of an Occupational Accident, Your Beneficiary shall be entitled to receive an Accidental Death Benefit equal to 10 times Your Base Annual Earnings but never more than $200,000. However, the sum total amount of benefits paid under the Plan shall not exceed the Combined Single Limit per Participant per Occurrence of $250,000. The Administrator may, in its sole discretion, pay out the Accidental Death Benefit in equal monthly installments over a period of one year.

Your Beneficiary shall be determined in the following order: 1) Your surviving Spouse; 2) Your surviving child(ren) under 18 years of age (or under 25 years of age if enrolled as a full-time student in an accredited educational institution); or 3) Your surviving child, parent, sibling or grandparent who at the time of Your death is Your dependent because of a physical or mental handicap. Payment of any Accidental Death Benefit will be made in equal shares if more than one Beneficiary is eligible to receive payment. If no Beneficiaries survive you, no Accident Death Benefit is payable.

IV. WHAT ARE THE REQUIREMENTS FOR RECEIPT OF BENEFITS?

IV.1 Reporting. If You believe an incident occurred resulting in an Occupational Injury, You must report the incident to Your supervisor, manager or other person in charge at the time (altogether “Supervisor”) before the end of Your work shift. No benefits will be paid under the Plan if such reporting is not timely given.

IV.2 Once reported, Your Supervisor shall assist You in obtaining the necessary initial Medical Care from a Designated Provider. At the time of initial Medical Care, You must also submit to drug and/or alcohol testing by a Designated Provider. After the initial Medical Care, and after each subsequent medical appointment with a Designated Provider, You must immediately inform Your Supervisor of Your ability (as determined by the Designated Provider) to perform the duties routinely associated with Your job.

IV.3 At the time of the Occupational Accident, You must also complete the required incident reporting forms. No benefits will be paid until all required information (including other written or sworn statements of proof as the Administrator (or its employed TPA) may require) is provided, and the Administrator may suspend or terminate benefits if additional information is subsequently required by but not provided to the Administrator (or its employed TPA).

IV.4 Benefit Exclusions. The Plan does not cover, and therefore benefits will be denied or terminated for any of the following:

(a) You tested positive for alcohol or drugs on the day of the Occupational Injury;

(b) You refuse to submit to drug and/or alcohol testing;

(c) to the extent You utilize a non-approved medical provider or facility (other than for emergency Medical Care);

(d) You fail to follow the advice and instructions, or cease to be under the care of any Designated Provider;

(e) You fail to keep, or do not cooperate during a scheduled appointment with a Designated Provider, or fail or refuse to allow an authorized representative of the Plan to accompany You to a medical appointment;

(f) You engage in conduct following an Occupational Injury which is determined by a Designated Provider to be an injurious practice that is hindering Your timely recovery from the Occupational Injury;

(g) to the extent You receive Medical Care that is not Medically Necessary;

(h) to the extent any billed charges for Medical Care are in excess of a Fair and Reasonable Reimbursement;

(i) Medical Care rendered by a member of Your Immediate Family or household;

(j) You refuse to be examined by a Designated Provider as often as the Administrator (or its employed TPA) in its sole discretion considers appropriate;

(k) You refuse to submit to an Occupational Assessment or Functional Capacity Examination;

(l) You participate in any activity not specifically within Your Scope of Employment;

(m) You take any voluntary aggressive action toward anyone which places you, other employers, or customers in a potentially dangerous situation. Landmark Industries strictly endorses a NO HEROES POLICY as relates to any form of theft or violence. You are to co-operate fully and make no attempt to restrain or subdue anyone.

(n) an alleged injury caused by Your involvement in horseplay, scuffling, fighting or similar inappropriate behavior;

(o) an alleged injury caused by an act of Your voluntary participation in any social, recreational or athletic activity not constituting part of Your Scope of Employment with the Employer;

(p) an alleged injury caused by an act of a third person intended to injure You because of personal reasons and not directed at You as an Employee of or because of Your employment by the Employer;

(q) an alleged injury caused by Your involvement in: 1) a riot or act of civil disturbance; 2) a felony or an assault, except an assault committed in defense of an Employer's business or property; 3) a war, declared or undeclared; or 4) service in the military of any country or any civilian non-combatant unit serving with such forces;

(r) injury or other damage arising out of, directly or indirectly, contributed by, caused by, resulting from, or in connection with any of the following, regardless of any other cause or event, including any action taken in controlling, preventing, suppressing, retaliating against or responding to: (1) war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war is declared or not), civil war, mutiny, revolution, rebellion, insurrection, uprising, military or usurped power, confiscation by order of any public authority or government de jure or de facto, martial law; (2) riots, strikes or civil commotion; or (3) any terrorist activity which shall mean any deliberate, unlawful act as further stated in the Plan.

(s) an alleged injury that is due to suicide or an attempt to commit suicide or intentionally self-inflict an injury or attempt to intentionally self-inflict an injury, feigned or an attempt to defraud the Employer or the Plan, or intentionally cause or aggravate an Occupational Injury;

(t) the alleged injury is not an Occupational Injury as defined in the Plan;

(u) there is any claim for benefits while You were not a Participant in the Plan;

(v) You fail or refuse to comply with any of the terms and conditions of the Plan or the policies, rules and procedures adopted by the Administrator;

(w) exclusions written elsewhere in the Plan;

(x) You were untruthful in regard to any aspect of the information provided as part of the employment process, including information as to physical or mental abilities to perform the duties routinely associated with the duties of Your job;

(y) You are untruthful or otherwise fail to fully cooperate with the Administrator (or its employed TPA) or demonstrate bad faith relating to a claim for benefits under the Plan, including, but not limited to, subrogation or coordination of benefits procedures;

(z) any Pre-existing Condition;

(aa) Your injury is due to a Pre-existing Condition which is aggravated or re-injured by an Occupational Accident;

(bb) You are diagnosed with osteoarthritis, arthritis or any other degenerative process of the joints, bones, tendons or ligaments;

(cc) Your have a stroke or cardiovascular event, myocardial infarction or heart attack, coronary thrombosis or aneurysm;

(dd) You sustain any claim or loss caused by Disease, Occupational Disease or Cumulative Trauma;

(ee) You fail to personally contact the Administrator (or its employed TPA) at least weekly to update Your present medical status and return to work expectations;

(ff) You fail to immediately report to Your Supervisor for work upon being released for Full or Restricted Duty by a Designated Provider;

(gg) You are diagnosed with any bacterial infections (except pyogenic infection occurring with and through an Occupational Injury) or Diseases of any kind not related to an Occupational Injury, regardless of how contracted;

(hh) there is any claim which would not have occurred, in whole or in part, but for the actual, alleged or threatened inhalation of, ingestion of, contact with, exposure to, existence of or presence of any Fungi on or within a building or structure, including its contents, regardless of whether any other cause, event, material or product contributed concurrently or in any sequence to such Occupational Injury;

(ii) any mental trauma, emotional distress or similar injury to the mental or emotional state, and which is not identifiable as damage or harm to the physical structure of Your body, including, without limitation, any mental or emotional damage or harm that arises from a personnel action, including a transfer, promotion, demotion or termination of employment;

(jj) an intentionally self-inflicted injury or other damage or injury while either sane or insane, or an injury or other damage intentionally caused or intentionally aggravated by any employer or its owners, directors, officers, superintendents, or Supervisors;

(kk) injury or other damage resulting from, relating to or connected in any way with asbestos or nuclear materials;

(ll) injury, damages, assessments, penalties or fines resulting from, relating to or connected in any way with but not limited to any of the following: (1) claims against the Employer for liability

assumed under any contract or agreement; (2) claims arising from Your employment relationship with the Employer, including without limitation, claims for any type of employment discrimination, wrongful discharge, retaliatory discharge, coercion, sexual harassment, Americans with Disabilities Act claims, claims arising under the Texas Labor Code, and all other claims affecting or arising from the employment relationship; or (3) claims or causes of action against the Employer under, or alleged or actual violations by the Employer of laws or act as further stated in the Plan document.

(mm) the injury is a result of You traveling on an airplane, helicopter, or any other type of aircraft; other than traveling as a passenger on a commercial aircraft;

(nn) any obligations imposed by a workers' compensation, occupational disease, unemployment compensation, disability benefits or similar law and any expenses or fees incurred by the Employer defending such obligations;

(oo) a claim for benefits arises from an Occupational Injury to You while employed in violation of any law or performing work-related duties in violation of any law;

(pp) You become covered, eligible for benefits, or seek benefits under any state's workers' compensation laws or any policy of workers' compensation insurance. You shall thereafter be reinstated as a Participant only at such time and under such conditions as may be specified by the Administrator;

(qq) an alleged injury caused by an act of God, unless Your employment with the Employer exposes You to a greater risk of injury from an act of God than ordinarily applies to the general public;

(rr) any claim otherwise covered by the Plan, whether known or unknown, that is not properly or timely reported in accordance with Plan terms and conditions, or if You fail to provide a complete statement, affidavit or deposition upon request by the Administrator (or its employed TPA) concerning the Occurrence which You believe resulted in an Occupational Injury.

IV.5 Subrogation. If an Occupational Injury is caused by a third party's alleged or actual wrongful act or negligence, in order to receive any Plan benefits relating to that Occupational Injury, You or your Beneficiary must agree that the Plan and Employer will be subrogated to any recovery from the third party.

IV.6 Other Coverage and Coordination of Benefits. If You are covered under one or more other plans, programs or insurance policies, the benefits payable under the Plan shall apply only in excess of the other plan, program or insurance policy.

V. WHAT TO DO IF BENEFITS ARE DENIED?

V.1 Review Procedures Pursuant to ERISA

(a) *Timing of notification of benefit determination*:

(i) Claims for Medical Benefits. The Plan's claims review procedures for medical benefits are set out as follows:

(1) Concurrent Care Claim. A concurrent care claim is a claim for an extension of the duration or number of medical treatments provided through a previously approved benefit claim.

In the event the Administrator determines to reduce or terminate a course of medical treatment or a series of medical treatments before the course of medical treatment or series of medical treatments ends (other than by Plan amendment or termination), the Administrator must notify the affected Participant of the intended termination or reduction (the adverse benefit determination) sufficiently in advance of the reduction or termination so that the Participant may appeal the adverse benefit determination and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. The

adverse benefit determination on a Concurrent Care Claim will include the information included in Section 5.6 (b) of the Plan.

If the Administrator receives a request to extend care that is an Urgent Care Claim, the Administrator must render a decision, whether adverse or not, within 24 hours of receipt of the claim, provided the claim is received at least 24 hours before care is scheduled to expire. The adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, will include the information included in Section 5.6 (b) of the Plan.

(2) Post-service Claim. A post-service claim is any claim for medical benefits under the Plan that is not a Pre-service Claim.

The Administrator will notify the Participant within a reasonable period of time and no later than 30 days after receipt of the claim of the adverse benefit determination on the Post-service claim. The claim denial must include the information included in Section 5.6 (b) of the Plan. This period may be extended one time by the Administrator for up to 15 days provided the Administrator both determines that an extension is necessary due to matters beyond the control of the Plan, and notifies the Participant prior to the expiration of the initial 30 day period of the circumstances requiring the extension and the expected date by which the Plan expects to render a decision. If such extension is necessary due to the need for additional information, the notice to the Participant must specifically describe the additional information needed and provide the Participant with at least 45 days in which the Participant may respond. In the event a Participant is notified of the need for additional information, the time period for processing the claim will not begin to run again until the additional information is received from the Participant or his authorized representative.

(3) Pre-service Claim. A pre-service claim is any claim for Medical Benefits under the Plan which by the terms and conditions of the Plan conditions the receipt of the benefit, in whole or in part, on obtaining approval or Pre-authorization prior to obtaining Medical Care.

The Administrator will render a decision and notify the Participant of the Plan's adverse benefit determination on a Pre-service Claim no later than 15 days after such claim is filed and within a reasonable period of time considering the medical circumstances. Such decision may be provided in writing or electronically. In the event circumstances outside of the Administrator's control require an extension of the period for rendering a decision and provided the Administrator notifies the Participant of the need for the extension prior to the expiration of the initial 15 day period, the period for determining the Pre-service Claim may be extended one time for up to 15 days. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. In the event a Participant is notified of the need for additional information, the time period for processing the claim will not begin to run again until the additional information is received from the Participant or his authorized representative. In the event the Pre-service Claim is denied, the claim denial must include the information included in Section 5.6 (b) of the Plan.

(4) Urgent Care Claim. An urgent care claim is any claim for Medical Care with respect to which the application of the time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or (ii) in the opinion of a Designated Provider with knowledge of the Participant's condition, would subject the Participant to severe pain that cannot be adequately managed without Medical Care that is the subject of the claim. The person acting on behalf of the Plan will apply the judgment of a prudent lay person who possesses an average knowledge of health and medicine to determine if a claim is an urgent care claim. Notwithstanding the above, any claim that a Designated Provider with knowledge of the Participant's medical condition determines in an "urgent care claim," as defined above, will be treated as an "urgent care claim."

The Administrator will render a decision and notify the Participant on the initial receipt of an Urgent Care Claim, whether adverse or not, as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the Urgent Care Claim if all information necessary is included with the initial claim.

If an Urgent Care Claim requires additional information in order for the Administrator to render a decision, the Administrator must notify the Participant of the specific information necessary to complete the claim within 24 hours of receipt of the Urgent Care Claim. The Administrator will permit the Participant at least 48 hours to provide the specific information. The Administrator must render a decision on an Urgent Care Claim that required additional information no later than 48 hours after the earlier of the Plan's receipt of the additional information or the end of the time period the Administrator gave the Participant to provide the additional information. In the event the Urgent Care Claim is denied, the claim denial must include the information included in Section 5.6 (b) of the Plan.

(ii) Claims for benefits other than Medical Benefits. The Plan's claims review procedures for claim benefits other than Medical Benefits are as follows:

In general, if any claim for benefits brought by a Participant under the Plan is (i) wholly or partially denied or (ii) the Administrator otherwise makes an adverse benefit determination as defined in the Department of Labor regulations regarding claims procedures (in either case, referred to herein as an "adverse benefit determination"), the Administrator will notify the Participant of its decision in writing. Such notification will be given within a reasonable period of time, but not later than 90 days (45 days in the case of a claim regarding wage replacement benefits) after the Administrator receives such claim, unless the Administrator determines that special circumstances require an extension of time for processing the claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Participant prior to the termination of the initial 90 day period. In no event shall such extension exceed a period of 90 days from the end of such 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.

In the case of a claim regarding wage replacement benefits, if the Administrator determines that an extension of time for processing the claim is necessary due to matters beyond its control, the Administrator may extend the initial 45 day period for up to 30 days provided it gives the Participant written notice of such extension within the initial 45 day period. If, prior to the end of the first 30 day extension period, the Administrator determines that, due to matters beyond its control, a decision cannot be rendered within that extension period, such determination period may be extended for a second period of up to an additional 30 days provided it gives the Participant written notice of such extension within the first 30 day extension period.

The extension notices for processing a claim for wage replacement benefits will contain (a) the special circumstances requiring an extension of time, (b) the date by which the Administrator expects to render a decision, (c) a specific explanation of the standards on which entitlement of a benefit is based (d) the unresolved issues that prevent a decision on the claim and (e) the additional information needed to resolve those issues. The Participant will be afforded at least 45 days within which to provide the additional specified information. In the event a Participant is notified of the need for additional information, the time period for processing the claim will not begin to run again until the additional information is received from the Participant or his authorized representative.

(b) *Manner and content of notification of adverse benefit determination*:

The written statement of an adverse benefit determination will be written in a manner calculated to be understood by the Participant, and will contain:

(i) specific reasons for the adverse benefit determination;

(ii) specific reference to the pertinent terms and conditions of the Plan on which the adverse benefit determination is based;

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

(iv) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement that the Participant has a right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal. However, instead of bringing any civil action in a court of trial, the Participant has agreed to finally resolve any issues following an adverse benefit determination on appeal pursuant to the Dispute Resolution Plan identified in Section 5.7.

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

The written statement of any adverse benefit determination regarding medical benefits (including urgent care, concurrent care, pre-service and post-service) or wage replacement benefits will also disclose:

(1) any policy, rule or procedure (or similar criterion) relied upon in making the adverse benefit determination (or state that such information will be provided free of charge to the Participant upon request); or

(2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse benefit determination, applying the terms and conditions of the Plan to the Participant's medical circumstances (or state that such explanation will be provided free of charge to the Participant upon request).

In the case of an adverse benefit determination concerning a claim involving urgent care, the information described in Section 5.6(b) of the Plan above may be provided to the Participant orally within the time frame prescribed in paragraph Section 5.6(a)(i)(4) of the Plan, provided that a written or electronic notification in accordance with Section 5.6(b) of the Plan above is furnished to the Participant no later than 3 days after the oral notification.

(c) *Appeal of adverse benefit determination*:

Within 60 days after the date on which a Participant receives a written notice of an adverse benefit determination (180 days in the case of an adverse benefit determination regarding medical benefits and wage replacement benefits), the Participant may submit written issues, comments, documents, records, and other information relating to the claim for benefits with the Administrator for a review of the adverse benefit determination.

The Administrator will give the Participant, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the Participant's claim for benefits.

The Administrator will provide a full and fair review of the claim taking into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In conducting its review of an adverse benefit determination regarding medical benefits or wage replacement benefits, the Administrator will not afford deference to the initial adverse benefit determination, and the review will not be conducted by the individual who made the initial adverse benefit determination or by the subordinate of such individual.

In reviewing an adverse benefit determination on a claim for medical benefits or wage replacement benefits that is based in whole or in part on a medical judgment, including determinations, if applicable, with regard to whether a particular treatment, drug, or other item is experimental, investigational or not Medically Necessary or appropriate, the Administrator will consult with a healthcare professional who has appropriate training and experience. Any such healthcare professional will not be the individual who was consulted in connection with the initial adverse benefit determination or the subordinate of such individual.

In reviewing an adverse benefit determination on a claim for medical benefits or wage replacement benefits, the Administrator will provide the Participant with the identification of medical or vocational experts whose advice was obtained on behalf of the Administrator in connection with the appeal of the Participant's adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination.

In reviewing an adverse benefit determination on an urgent care claim, the Administrator will provide the Participant with an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Participant and all necessary information, including the Plan's benefit determination on review shall be transmitted between the Plan and the Participant by telephone, facsimile, or other available similarly expeditious method.

(d) *Timing of Notification of benefit determination on review*:

The Administrator will notify the Participant of its decision on appeal in writing within a reasonable period, but not later than 60 days (45 days in the case of a claim for wage replacement benefits) after the request for review is received by the Administrator, unless the Administrator determines that special circumstances require an extension of time for processing the claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Participant prior to the termination of the initial 60 day period (45 days in the case of a claim for wage replacement benefits). In no event shall such extension exceed a period of 60 days from the end of the initial period (45 days in the case of a claim for wage replacement benefits). The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

If the Administrator holds regularly scheduled meetings at least quarterly, then, notwithstanding the foregoing, the Administrator will make a benefit determination on appeal no later than the date of the meeting of the Administrator that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review, or no later than the third meeting of the Administrator following the Plan's receipt of the request for review if special circumstances require a further extension of time for processing the request, such as a decision by the Administrator to hold a hearing, provided that written notice of such extension and circumstances is given to the Participant prior to the commencement of the extension. The Administrator will notify the Participant of the benefit determination as soon as possible, but no later than 5 days after the benefit determination is made. This Section also applies to benefit determination on review for wage replacement benefits and Post-service claims that involve a multiemployer Plan with a committee or board of trustees designated as the Administrator.

The Administrator will review the appeal of a denied Urgent Care Claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours of receipt of the appeal and render a decision on the appeal within such time period.

The Administrator will render a decision on the appeal of a Pre-service Claim within 30 days of receipt of the request for the appeal.

The Administrator will render a decision on the appeal of an adverse benefit determination of a Post-service Claim within sixty (60) days after receipt of the request for review.

The Administrator will render a decision on the appeal of a Concurrent Care Claim to extend care within the time period applicable to an appeal of an Urgent Care Claim, Pre-service Claim of Post-service Claim above, respectively dependent upon whether the claim is also defined as an Urgent Care Claim, a Pre-service Claim or a Post-service Claim. Any decision on the appeal of the adverse benefit determination on the reduction or termination of a Concurrent Care Claim must be rendered before the reduction or termination of Medical Care.

(e) *Manner and content of notification of benefit determination on review*:

The decision of the Administrator on appeal will be in writing, will be written in a manner calculated to be understood by the Participant, and will include:

i. specific reasons for denial of the appeal,

ii. specific reference to pertinent terms and conditions of the Plan on which the benefit determination is based,

iii. a statement that the Participant 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 Participant's claim for benefits, and

iv. a statement of the Participant's right to bring an action under Section 502(a) of ERISA. However, instead of bringing any civil action in a court of trial, the Participant has agreed to finally resolve any issues following an adverse benefit determination on appeal pursuant to the Dispute Resolution Plan identified in Section 5.7.

The written decision of the Administrator on denial of a claim for medical benefits (including urgent care, concurrent care, pre-service and post-service) or wage replacement benefits on appeal will also disclose:

any policy, rule or procedure (or similar criterion) relied upon in the denial of the appeal (or state that such information will be provided free of charge to the Participant upon request), or

if the denial of the appeal for Medical Benefits (including urgent care, concurrent care, pre-service and post-service) or wage replacement benefits is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial of the appeal, applying the terms and conditions of the Plan to the Participant's medical circumstances (or state that such information will be provided free of charge to the Participant upon request).

Subject to the foregoing, the Administrator may, in its discretion, hold a hearing to make a benefit determination.

V.2 Dispute Resolution Plan. All disputes relating to or arising from an Occupational Accident, Occupational Injury, or any claim for benefits under the Plan that are not resolved pursuant to the immediately foregoing procedures within this Section shall be finally resolved by the Dispute Resolution Plan for Texas Work Place Injuries (the "Dispute Resolution Plan") adopted (and as amended from time to time) by the Employer. The Dispute Resolution Plan is designed to fairly and efficiently resolve any and all disputes regarding Occupational Accidents, Occupational Injuries and claims for benefits under the Plan that may arise between an Employee or Participant and the Employer, Plan or Administrator.

VI. HOW ARE THE BENEFITS FUNDED?

VI.1 Payment of all benefits under the Plan shall be made by the Employer. The Employer has no obligation to establish any fund or trust for the payment of benefits under the Plan. However, the Employer may purchase an insurance policy to reimburse or indemnify it for benefits paid or losses incurred pursuant to the Plan. You do not have any interest in or right to any coverages under such insurance policy.

VII. ADMINISTRATOR

VII.1 "Administrator" means the Employer or such other person(s) as may be appointed from time to time by the Employer to administer the Plan according to its purpose, terms and conditions.

VII.2 The Administrator is authorized to take any and all action as it considers appropriate or necessary to carry out the purpose of the Plan. The Administrator's authority and power includes, but is not limited to: having the discretionary power to interpret the Plan; correcting any omissions; reconciling and correcting any errors or inconsistencies; and adjusting for any mistakes or errors made in administrating the Plan. The Administrator also has the authority and power to decide any question in the administration and application of the Plan, including but not limited to determining whether: (a) You are eligible to

participate; (b) Your injury constitutes an Occupational Injury; (c) whether You have compiled with all terms and conditions of the Plan; and (d) You are eligible for Benefits under the Plan.

VIII. WHAT ARE MY RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974?

VIII.1 This Plan is intended to be an employee welfare benefit plan as described in the Employee Retirement Income Security Act of 1974 ("ERISA"). This means the rights and obligations of the Employer and each Participant will be governed by ERISA. ERISA provides that all Participants in a plan covered by ERISA shall be entitled to: (a) examine, without charge, at the Administrator's office or at another designated location, all Plan documents filed by the Plan with the U.S. Department of Labor; and (b) obtain copies of the Plan document and other Participant information upon written request to the Administrator (the Administrator may make a reasonable charge for the copies).

In addition to creating right for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Participants and Beneficiaries. No one, including the Administrator, the Employer or any other person, may fire You or otherwise discriminate against You in any way to prevent you from obtaining a Benefit under the Plan or exercising Your rights under ERISA. If Your claim is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the Administrator review and reconsider Your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Administrator and do not receive them within 30 days, you may file an arbitration. In such a case, the court may require the Administrator to provide the material 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 which is denied or ignored, in whole or in part, you may file for arbitration. If the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file for arbitration. The arbitrator will decide who should pay costs and legal fees. If you are successful, the arbitrator may order the person you have sued to pay these costs and fees. If you lose, the arbitrator may order you to pay these costs and fees, for example, if it finds your claim to be frivolous.

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.