OKLAHOMA EMPLOYEE INJURY BENEFIT PLAN

OFFICIAL PLAN DOCUMENT

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The Company (and any Participating Employer identified on the Benefits Schedule) establishes or updates this Oklahoma Employee Injury Benefit Plan which is intended to conform to the requirements for an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Employer has elected to be exempt from the Oklahoma Administrative Workers' Compensation Act and establishes a separate employee injury benefit plan to provide non-fringe disability and medical benefits to injured employees by signing the Benefits Schedule. The provisions of this Plan apply solely to a Participant who suffers a Bodily Injury in the Course and Scope of Employment on or after the Plan's Effective Date and any beneficiaries, spouse, heirs, legal Representatives and assigns of such Participant.

ARTICLE I
PARTICIPATION IN THE PLAN

Each Covered Employee shall become a Participant in this Plan as of the later of (A) 12:01 a.m. on the Effective Date specified in Item No. 8 of the Benefits Schedule or (B) the time and date of his or her employment as a Covered Employee. Except to the limited extent provided under Article III regarding the continuation of certain benefit payments, if a Participant ceases to be a Covered Employee, he or she shall thereupon cease to participate in this Plan; provided, however, that if such Participant is thereafter reemployed as a Covered Employee, he or she shall resume participating in the Plan as of the time and date of such reemployment. Compensation under this Plan to alien nonresidents of the United States or Canada shall be the same in amount as provided for residents.

ARTICLE II
MAKING A CLAIM FOR BENEFITS

2.1 Reporting A Bodily Injury. The Participant (or person acting on their behalf) must report every incident that the Participant believes results, or might reasonably be expected to result, in a Bodily Injury. The Participant must provide verbal notice immediately after being injured at work to his or her supervisor then on duty, no matter how minor the Bodily Injury appears to be. **For a Bodily Injury due to an Accident, or for a known exposure to an Occupational Disease, verbal notice must be provided immediately, but not more than 24 hours from the time of the incident. For an actual Bodily Injury due to Occupational Disease or Cumulative Trauma, verbal notice must be provided within the earlier of (1) 48 hours after being medically diagnosed as a work-related Bodily Injury, or (2) 30 days after the Participant should have known of the Bodily Injury. Any provision in the Plan to the contrary notwithstanding, no benefits are payable under this Plan unless notice of a Bodily Injury is provided by the Participant as described above not later than 35 months from the expiration date of an insurance policy referred to in section 8.2 or the date such policy is cancelled, whichever is earlier.**

No benefits will be payable under the Plan if notice is not provided as required above, unless the Claims Administrator determines that good cause exists for failure to give notice in a timely manner.

2.2 Providing Required Information. An injured Participant (or the Participant's Representative) must complete the incident reporting forms, medical authorization form, provide recorded statements (whether sworn or unsworn), and provide such proof and demonstrations (relating to the Bodily Injury and any prior or subsequent damage or harm suffered by the Participant,

in or out of the course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may from time-to-time direct. **The written First Report of Bodily Injury form must be provided within 48 hours after the Bodily Injury is reported** as required under Section 2.1 above. No benefits will be payable under the Plan if all information is not provided as required above, unless the Claims Administrator determines that a good cause exception exists for the failure to provide such information in a complete and timely manner.

ARTICLE III
BENEFITS

Participants shall be entitled to receive under this Plan the benefits described in this Article III with respect to any Bodily Injury incurred (i) in the Course and Scope of Employment by the Employer, and (ii) during his or her participation in this Plan. Any provision of this Plan to the contrary notwithstanding, this Plan shall be interpreted in compliance with the Oklahoma Employee Injury Benefit Act found in Sections 200 through 213 of Title 85A of the Oklahoma Statutes, as in effect on February 1, 2014

3.1 Medical Benefits. Subject to the medical management and other provisions of this Plan:

(a) the Plan shall pay Medical Benefits to, or with respect to, a Participant for a Bodily Injury in an amount equal to all Medical Expenses; provided, however, that Medical Benefits shall cease as otherwise provided under Article VII;

(b) unless recommended by an Approved Provider at the time the Participant reaches Maximum Medical Improvement, Continuing Medical Maintenance and pain management outside the parameters of the Official Disability Guidelines shall not be provided by the Plan;

(c) the Plan Administrator may terminate, modify, or reduce a previously approved treatment plan prior to the Participant's completion of the approved treatment.

3.2 Disability Benefits.

(a) **Temporary Total Disability.** If a Participant is determined to be Temporarily Totally Disabled by the Approved Provider as a result of a Bodily Injury for the number of consecutive working days specified in Item No. 10(a) of the Benefits Schedule, the Plan shall pay Temporary Total Disability Benefits equal to the percentage specified in Item No. 10(b) of the Benefits Schedule of the Participant's Average Weekly Wage, but not to exceed 70% of the Maximum Weekly Indemnity amount identified in Item No. 10(c) of the Benefits Schedule, for up to 104 weeks.

(1) If the Plan Administrator finds that a consequential Bodily Injury has occurred and that additional time is needed to reach Maximum Medical Improvement, Temporary Disability Benefits may continue for a period of not more than an additional 52 weeks. Such finding shall be based upon a showing of medical necessity by clear and convincing evidence.

(2) Subject to (a) above, if the Participant suffers a non-surgical soft tissue Bodily Injury, Temporary Total Disability will not exceed eight (8) weeks, regardless of the number of body parts injured.

(3) Temporary Total Disability benefits shall cease upon the earliest of:

(A) release from active medical treatment by the Approved Provider;

(B) the date the Participant is certified by the treating Approved Provider to no longer be Temporarily Totally Disabled, without regard to whether the Participant returns to regular or Modified Duty Work on that date;

(C) voluntary termination of the Participant's status as a Covered Employee;

(D) involuntary termination of the Participant's status as a Covered Employee for Misconduct;

(E) the date the Participant is placed in jail, is deported or detained by or at the request of any government agency or foreign government; provided, however, that this paragraph (E) shall operate to cease Temporary Partial Disability benefits only for such period of time that such Participant is unavailable for work; or

(F) as otherwise provided for under Section 7.1.

(4) Temporary Total Disability benefits for a Bodily Injury resulting in hernia, soft tissue injury or mental Bodily Injury are subject to the following restrictions:

(A) Hernia. Benefits shall not exceed six weeks, unless the Participant refuses to permit an Approved Provider-recommended hernia operation, in which case he or she will be entitled to receive seven additional weeks of Temporary total Disability benefits.

(B) Soft Tissue Injury- Non-Surgical. Benefits shall not exceed eight weeks, unless the Participant is treated with an injection(s), in which case he or she shall be entitled to receive an additional eight weeks of Temporary Total Disability benefits.

(C) Soft Tissue-Surgical. Benefits shall not exceed 24 weeks, unless the surgery is not performed within 30 days of approval due to the Participant acting in bad faith, in which case benefits will only be available for a total of eight weeks. Any benefits already provided beyond the eight weeks must be reimbursed by the Participant. Surgery does not include the performance of an epidural steroid injection, or any similar procedure.

(D) Mental Injury or Illness. Benefits shall not exceed 26 weeks, unless it is determined by a competent medical doctor's review, supported by objective findings and shown by clear and convincing evidence that benefits should continue for a set period of time for the Participant to reach Maximum Medical Improvement, in which case the Participant shall be entitled to receive up to an additional 26 weeks of Temporary Total Disability benefits.

(b) **Temporary Partial Disability.** If the Participant becomes partially disabled as the result of a Bodily Injury, the Plan shall pay Temporary Disability Benefits equal to the difference between the percentage identified in Item No. 10(b) of the Benefits Schedule of the Participant's pre-Bodily Injury Average Weekly Wage and the weekly wage while performing Modified Duty, for up to 52 weeks.

(1) If a Participant is released to Modified Duty, but (i) the Employer has no Modified Duty position available, and (ii) an Approved Provider has not assigned permanent restrictions and released the Participant to any other gainful employment, then the Participant shall be considered to be Temporarily Totally Disabled and Temporary Total Disability benefits shall be payable in the manner specified under subsection (a) above.

(2) If a Participant with a Temporary Partial Disability has made a good faith effort to comply with the treating Approved Provider's instructions and carry out the Participant's responsibilities in the Modified Duty position, but is either:

(A) again determined by an Approved Provider to be Temporarily Totally Disabled, or

(B) the Modified Duty position ceases to be available (for example, the position reaches its maximum duration) and an Approved Provider has not assigned permanent restrictions and released the Participant to any other gainful employment;

then the Participant will be considered to be Temporarily Totally Disabled and Temporary Total Disability benefits shall be payable in the manner specified under subsection (a) above.

(3) If the Participant refuses to perform the Modified Duty work offered by the Employer, he or she shall not be entitled to Temporary Partial Disability benefits or Temporary Total Disability benefits.

(4) Temporary Partial Disability shall cease upon the earliest of:

(A) the date the Participant is certified by the treating Approved Provider to no longer be Temporarily Partially Disabled, without regard to whether the Participant returns to regular or Modified Duty Work on that date;

(B) voluntary termination of the Participant's status as a Covered Employee;

(C) involuntary termination of the Participant's status as a Covered Employee for Misconduct;

(D) the date the Participant is placed in jail, is deported or detained by or at the request of any government agency or foreign government; provided, however, that this paragraph (E) shall operate to cease Temporary Partial Disability benefits only for such period of time that such Participant is unavailable for work; or

(E) as otherwise provided under Section 7.1

(c) **Permanent Partial Disability**.

(1) **Unscheduled Benefits.** Any claim by a Participant for compensation for Permanent Partial Disability must be supported by competent medical testimony of an Approved Provider, and shall be supported by objective medical findings. The opinion of the Approved Provider shall include the Participant's percentage of Permanent Partial Disability and whether or not the Disability is job-related and caused by the Bodily Injury. An Approved Provider's opinion of the nature and extent of Permanent Partial Disability to parts of the body other than scheduled members (as described in Subsection (2) below) must be based solely on criteria established by the current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" in effect at the time of the impairment rating. A Permanent Partial Disability award or combination of awards granted a Participant shall not exceed a Permanent Partial Disability rating of 100% to any body part or to the body as a whole. A copy of any written evaluation shall be sent to the Employer and Participant within 7 days of issuance.

(A) **Percentage and Duration.** In cases of Permanent Partial Disability, the compensation shall be the percentage of the Participant's Average Weekly Wage as specified in Item No. 10(b) of the Benefits Schedule, not to exceed $323, for the number of weeks which the Permanent Partial Disability of the employee bears to 350 weeks.

(B) **Deferral and Reduction.** Except pursuant to settlement agreements entered into by the Employer and Participant, payment of a Permanent Partial Disability award shall be deferred and held in reserve by the Employer if the Participant has reached Maximum Medical Improvement and has been released to return to work by his or her treating Approved Provider, and then returns to his pre-Bodily Injury or equivalent job for a term of weeks determined by dividing the total dollar value of the award by the percentage specified in Item No. 10(b) of the Benefits Schedule of the Participant's Average Weekly Wage.

(i) The amount of the Permanent Partial Disability award shall be reduced by the percentage identified in Item No. 10(b) of the Benefits Schedule of the Participant's Average Weekly Wage for each week he or she works in his or her pre-Bodily Injury or equivalent job.

(ii) If, for any reason other than Misconduct, the Employer terminates the Participant, or the position offered is not the pre-Bodily Injury or equivalent job, the remaining Permanent Partial Disability award shall be paid in a lump sum. If the Participant is discharged for Misconduct, the Employer shall have the burden to prove that the Participant is engaged in Misconduct.

(iii) If the employee refuses an offer to return to his pre-Bodily Injury or equivalent job, the Permanent Partial Disability award shall continue to be deferred and shall be reduced by the percentage identified in Item No. 10(b) of the Benefits Schedule of the Participant's Average Weekly Wage for each week he refuses to return to his pre-Bodily Injury or equivalent job.

(C) **Previous Disability.** The fact that a Participant has suffered previous Disability or received compensation therefore shall not preclude the Participant from compensation for a later Bodily Injury or Occupational Disease. In the event there exists a previous Permanent Partial Disability, including a previous non-work-related injury or condition which produced Permanent Partial Disability and the same is aggravated or accelerated by a Bodily Injury or Occupational Disease, compensation for Permanent Partial Disability shall be only for such amount as was caused by such Bodily Injury or Occupational Disease and no additional compensation shall be allowed for the preexisting Disability or impairment.

(i) If workers' compensation benefits have previously been awarded through settlement or judicial or administrative determination in Oklahoma, the percentage basis of the prior settlement or award shall conclusively establish the amount of Permanent Partial Disability determined to be preexisting. If workers' compensation benefits have not previously been awarded through settlement or judicial or administrative determination in Oklahoma, the amount of preexisting Permanent Partial Disability shall be established by competent evidence.

(ii) In all cases, the applicable reduction shall be calculated as follows: (a) if the preexisting impairment is the result of a Bodily Injury sustained while working for the Employer against whom Plan benefits are currently being sought, any award of compensation shall be reduced by the current dollar value attributable to the percentage of Permanent Partial Disability determined to be preexisting. The current dollar value shall be calculated by multiplying the percentage of preexisting Permanent Partial Disability by the compensation rate in effect on the date of the Accident or Bodily Injury against which the reduction will be applied, and (b) in all other cases, the Employer against whom benefits are currently being sought shall be entitled to a credit for the percentage of preexisting Permanent Partial Disability.

(D) No payments on any Permanent Partial Disability order shall begin until payments on any preexisting Permanent Partial Disability orders have been completed.

(E) The whole body shall represent a maximum of 350 weeks.

(2) **Scheduled Benefits.** The Permanent Partial Disability rate of compensation for amputation or permanent total loss of use of a scheduled member specified in the Schedule of Losses below shall be the percentage identified in Item No. 10(b) of the Benefits Schedule of the Participant's Average Weekly Wage, not to exceed the amount identified in Item No. 10(c) of the Benefits Schedule, multiplied by the number of weeks set forth for the member in the Schedule of Losses below, regardless of whether the injured Participant is able to return to his or her pre-Bodily Injury or equivalent job.

SCHEDULE OF LOSSES

Loss of:	**Benefit Amount:**
Arm amputated at elbow or between elbow and shoulder	275 weeks
Arm amputated between elbow and wrist	220 weeks
Leg amputated at knee or between knee and hip	275 weeks
Leg amputated between knee and ankle	220 weeks
Hand amputated	220 weeks
Thumb amputated	66 weeks
First finger amputated	39 weeks
Second finger amputated	33 weeks
Third finger amputated	22 weeks
Fourth finger amputated	17 weeks
Foot amputated	220 weeks
Great toe amputated	33 weeks
Toe other than great toe amputated	11 weeks
Eye enucleated, in which there is useful vision	275 weeks
Loss of hearing in one ear	110 weeks
Loss of hearing in both ears	330 weeks
Loss of one testicle	53 weeks
Loss of both testicles	158 weeks

(1) Compensation for amputation of the first phalange of a digit shall be 1/2 of the compensation for the amputation of the entire digit.

(2) Compensation for amputation of more than one phalange of a digit shall be the same as for amputation of the entire digit.

(3) Compensation for the permanent loss of 80% or more of the vision of an eye shall be the same as for the loss of an eye.

(4) In all cases of permanent loss of vision, the use of corrective lenses may be taken into consideration in evaluating the extent of loss of vision.

(5) Compensation for amputation or loss of use of two or more digits or one or more phalanges of two or more digits of a hand or a foot may be proportioned to the total loss of use of the hand or the foot occasioned thereby, but shall not exceed the compensation for total loss of a hand or a foot.

(6) Compensation for permanent total loss of use of a member shall be the same as for amputation of the member. Prior to payment of the benefit, loss of use must be certified, following the care of an Approved Physician, for 12 straight months from the date the loss of use began. At the end of this time it must be medically determined by an Approved Physician that the loss of use is total and not reversible.

(7) The sum of all Permanent Partial Disability awards shall not exceed 350 weeks.

(d) **Permanent Total Disability.**

(1) If a Participant is determined to be Permanently Totally Disabled, the Plan shall pay the Participant the percentage specified in Item No. 10(b) of the Benefits Schedule of his or her Average Weekly Wages, not to exceed the Maximum Weekly Indemnity amount identified in Item No. 10(c) of the Benefits Schedule.

(2) The Plan shall pay Permanent Total Disability to the Participant until:

(A) the time the Participant reaches the age of maximum Social Security retirement benefits; or a period of fifteen (15) years, whichever is longer; or

(B) the date of the Participant's death of causes unrelated to the Bodily Injury or illness;

Provided, however, if the Participant has been determined to be Permanently Totally Disabled prior to death, and death results from causes other than the Participant's covered Bodily Injury that caused such Permanent Total Disability, then the award of Permanent Total Disability Benefits may be revived by the Surviving Spouse, Child or Children, who shall receive a one-time lump-sum payment equal to 26 weeks of weekly benefits for Permanent Total Disability awarded the Participant. If more than one person is entitled to revive the claim, the lump-sum payment shall be evenly divided between or among such persons. In the event the Plan awards both Permanent Partial Disability and Permanent Total Disability benefits, the Permanent Total Disability award shall not be due until the Permanent Partial Disability award is paid in full. If otherwise qualified according to the provisions of this Plan, Permanent Total Disability benefits may be awarded to a Participant who has exhausted the 104 week maximum period of Temporary Total Disability even though the Participant has not reached Maximum Medical Improvement.

Payments shall be subject to affidavit requirements related to gainful employment.

(e) **Vocational Rehabilitation.** A Participant who is eligible for Permanent Partial Disability or is otherwise unable to return to his or her pre-Bodily Injury or equivalent position due to permanent restrictions can request vocational rehabilitation services within 60 days from the date of receiving such permanent restrictions. The claims administrator may order vocational rehabilitation before the Participant reaches Maximum Medical Improvement, if the treating Approved Physician believes that it is likely that the Participant's Bodily Injury will prevent the Participant from returning to his or her former employment. In granting early benefits for vocational rehabilitation, the claims administrator shall consider temporary restrictions and the likelihood that such rehabilitation will return the Participant to gainful employment earlier than if such benefits are granted after an award of Permanent Partial Disability benefits. Vocational rehabilitation services may be provided by a technology center or public secondary school offering vocational-technical education courses, or a member institution of The Oklahoma State System of Higher Education, which shall include retraining and job placement to restore the employee to gainful employment. Vocational rehabilitation services or training shall not extend for a period of more than 52 weeks.

If the injured Participant is unable to return to his or her pre-Bodily Injury or equivalent position due to permanent restrictions as determined by the treating Approved Provider, upon the request of either party, the Approved Provider shall determine if it is appropriate for a Participant to receive vocational rehabilitation training or services, and will oversee such training. A vocational rehabilitation evaluation must be ordered for any injured Participant unable to work for at least 90 days. A Participant may be assigned to vocational rehabilitation counselors for coordination of recommended services. The cost of the services shall be paid by the Employer; provided, however, that the cost for an evaluation of rehabilitation services may be deducted from Disability Benefits payable to the Participant if he or she refuses the services or training offered.

During the period when a Participant is actively and in good faith being evaluated or participating in a retraining or job placement program for purposes of evaluating Permanent Total Disability status, the Participant shall be entitled to receive Temporary Total Disability Benefits for up to an additional 52 weeks.

3.3 Disfigurement Benefits. If a Participant incurs serious and permanent disfigurement to any part of the body, the Plan shall pay compensation to the Participant in an amount not to exceed $50,000. For this purpose, the Claims Administrator may consider specific guidelines and measures for an award for disfigurement, such as a percentage of the body affected and part of the body affected. No benefits shall be paid for disfigurement until 12 months after the Bodily Injury. A Participant shall not be entitled to compensation due to Disfigurement Benefits if he or she receives an award for Permanent Partial Disability to the same part of the body, or if payment for cosmetic or reconstructive surgery has been approved by the Plan and the Participant refuses such surgery.

3.4 Occupational Death Benefits. In the event that a Participant dies as the direct and sole result of, a Bodily Injury, then the Plan shall pay Occupational Death Benefits.

(a) The Participant's death must occur within one year from the date of the Bodily Injury, or within the first 3 years of the period for compensation payments fixed by the Claims Administrator. If death does not occur within these time frames, then a rebuttable presumption shall arise that the death did not result from the Bodily Injury. Death directly or

indirectly related to mental injury or illness occurring one year or more from the date of the accident resulting in the mental injury or illness shall not be a compensable Bodily Injury.

(b) Occupational Death Benefits shall be paid as follows:

(1) If there is a Surviving Spouse, a lump-sum payment of $100,000 and 70% of the lesser of the deceased Participant's Average Weekly Wage and the Maximum Weekly Indemnity amount identified in Item No. 10(c) of the Benefits Schedule shall be paid to such Surviving Spouse. In no event shall this spousal weekly income benefit be diminished by the award to other Beneficiaries. In addition to the benefits theretofore paid or due, 2 years' indemnity benefit in one lump sum shall be payable to a Surviving Spouse upon remarriage;

(2) If there is a Surviving Spouse and a Child or Children, a lump-sum payment of $25,000 and 15% of the lesser of the deceased Participant's Average Weekly Wage and the Maximum Weekly Indemnity amount identified in Item No. 10(c) of the Benefits Schedule shall be paid to each Child; provided, however, that if there are more than two Children, each Child shall receive a pro rata share of $50,000 and 30% of the deceased Participant's Average Weekly Wage;

(3) If there is a Child or Children and no Surviving Spouse, a lump-sum payment of $25,000 and 50% of the lesser of the deceased Participant's Average Weekly Wage and the Maximum Weekly Indemnity amount identified in Item No. 10(c) of the Benefits Schedule shall be paid to each Child; provided, however, that if there are more than two Children, each Child shall receive a pro rata share of 100% of the lesser of the deceased Participant's Average Weekly Wage and the Maximum Weekly Indemnity amount identified in Item No. 10(c) of the Benefits Schedule. With respect to the lump-sum payment, if there are more than six Children, each child shall receive a pro rata share of $150,000;

(4) If there is no Surviving Spouse or Children, each legal guardian, if financially dependent on the Participant at the time of death, shall receive 25% of the lesser of the deceased Participant's Average Weekly Wage and the amount identified in Item No. 10(c) of the Benefits Schedule until the earlier of:

(A) death;

(B) becoming eligible for social security;

(C) obtaining full-time employment; or

(D) 5 years from the date Occupational Death Benefits begin.

(5) If any member of the class of beneficiaries who receive a pro rata share of weekly income benefits becomes ineligible to continue to receive benefits the remaining members of the class shall receive adjusted weekly income benefits equal to the new class size.

(6) If there is no Surviving Spouse, Child, or legal guardian that is financially dependent on the Participant at the time of death, then no Occupational Death Benefit shall be payable.

(c) Weekly income benefits shall terminate:

(1) Upon remarriage of the Surviving Spouse; or

(2) Upon the earlier of death, marriage, or reaching the age of 18 of any Child. However, if the Child turns 18 and is:

(A) Enrolled as a full-time student in high school or is being schooled by other means pursuant to the Oklahoma Constitution;

(B) Enrolled as a full-time student in any accredited institution of higher education or vocational or technology education; or

(C) Physically or mentally incapable of self-support;

then he or she may continue to receive weekly income benefits under this section until the earlier of reaching the age of 23 or, with respect to (A) and (B) above, no longer being enrolled as a student, and with respect to (C) above, becoming capable of self-support.

(d) Payments of Occupational Death Benefits shall be paid within 15 days of the determination of the proper Beneficiaries.

(e) In addition to the Occupational Death Benefits set forth above, the Plan shall reimburse reasonable funeral expenses to any person who incurs liability therefore, up to $10,000.

3.5 Non-Occupational Death Benefit. In the event that a Participant suffers an accidental death as the direct and sole result of a Non-Occupational Injury, then the Plan shall pay a death benefit equal to $1,000.

(a) The Participant's death must occur within one year from the date of the Accident. If death does not occur within one year from the date of the Accident, then a rebuttable presumption shall arise that the death did not result from the Non-Occupational Injury.

(b) Non-Occupational death benefits shall be paid as follows:

(1) If there is a Surviving Spouse, a single, lump sum payment shall be made to such Surviving Spouse.

(2) If there is a Child or Children and no Surviving Spouse, payment shall be made to such Child or Children in equal shares.

(3) If there is a legal guardian that is financially dependent on the Participant at the time of death and no Surviving Spouse or Child, a single, lump sum payment shall be made to such legal guardian.

(4) If any member of the class of beneficiaries who receive a pro rata share of weekly income benefits becomes ineligible to continue to receive benefits the remaining members of the class shall receive adjusted weekly income benefits equal to the new class size.

(5) If there is no Surviving Spouse, Child, or legal guardian that is financially dependent on the Participant at the time of death, then no Non-Occupational death benefit shall be payable.

ARTICLE IV
MEDICAL MANAGEMENT

4.1 Utilization of Approved Providers and Pre-Authorization Requirements. The cost of a service or supply shall be a Medical Expense (as described in Section 12.24) only if:

(a) treatment is pre-approved by the Claims Administrator and furnished by or under the direction of an Approved Provider, acting within the scope of the Approved Provider's license. Such pre-approval may include authorization for multiple visits to an Approved Provider, and may be verbal, in writing, or by electronic notice. The Claims Administrator will not deny a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the Participant; provided; however that this exception to the pre-approval requirement does not change the requirement that care be provided by or under the direction of an Approved Provider; or

(b) (1) treatment is provided as Emergency Care; and

(2) An Approved Provider is not available or is not within a reasonable distance from the location of the Participant at the time of Bodily Injury (taking into account available transportation and the nature of the Bodily Injury); and

(3) the Claims Administrator receives notification of such Emergency Care within 48 hours of the Participant's receipt of such care; and

(4) after receiving primary Emergency Care, subsequent treatments are provided by, or at the directions of, an Approved Provider, in accordance with paragraph (a) above.

4.2 First and Continuing Treatment.

(a) The first Medical Expense must be received from an Approved Provider and incurred within 30 days following the date of the Bodily Injury; and

(b) No further amount shall be considered a Medical Expense if the Participant does not receive medical treatment from an Approved Provider for a period of more than 90 days.

4.3 Medical Determinations and Treatment. All determinations relating to the physical condition of a Participant, upon which the continued payment of benefits is based (for example, inability to return to work or results of a prior Bodily Injury), must be made by an Approved Provider. The Participant must follow fully and completely the advice of, and the course of medical treatment prescribed by, the treating Approved Provider, and must keep all scheduled appointments to fulfill the prescribed medical treatment plan. The Claims Administrator may require that the Participant present an authorization and report form to the treating Approved Provider or Emergency Care provider at the time of primary medical treatment. The Employer may also require that the Participant submit to any form of drug and/or alcohol testing in accordance with the Employer's substance abuse policy. The Claims Administrator shall have the right to require the Participant to be examined or reexamined by an Approved Provider (including, but not limited to an autopsy, where not prohibited by law) as often as the Claims Administrator determines to be reasonably necessary or appropriate during the pendency of a claim for benefits under the Plan.

(a) **Initial Treatment and Denial.** Any provision of this Plan to the contrary notwithstanding, the Employer may render First Aid, or the Plan may pay for Emergency Care, pay Disability Benefits or pay for a medical evaluation or treatment of a Participant, and the Plan can still make a subsequent determination that the Participant has not suffered a covered Bodily Injury or otherwise deny any or all further benefits under the provisions of this Plan.

(b) **Medical Provider Referrals.** If the treating Approved Provider finds it necessary to refer a Participant to another health care provider, the treating Approved Provider must notify such Participant and the Claims Administrator of his or her desire to make the referral and the objectives of such referral. The Claims Administrator will provide advance approval or disapproval of all referrals (and may rescind any such approval at any time) based upon such criteria as the Claims Administrator may determine for the effective administration of the Plan. It is the Participant's responsibility to determine the status of any such approval or disapproval, and the expense of services or supplies relating to any disapproved referral shall be solely the responsibility of the Participant.

4.4 No Interference with Patient-Provider Relationship. Although benefits under this Plan are conditioned on a Participant's use of only Approved Providers and Approved Facilities, a Participant remains entitled to seek any medical care he or she deems appropriate from any provider of his or her choice at his or her expense. However, expenses for such medical care shall not be payable under the Plan and the Participant's use of a non-approved provider or facility may result in a complete denial or termination of Plan benefits. The Employer, Claims Administrator, and Appeals Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other health care services provided by any Approved Provider or other designated health care service provider. Health care providers are not agents of the Plan, Employer, Claims Administrator, or Appeals Committee. The Plan, Employer, Claims Administrator, or Appeals Committee is not liable or responsible for the acts or omissions of any health care provider. The actual medical treatment or rehabilitation of any Bodily Injury remains the sole prerogative and responsibility of the attending

Approved Provider and other health care providers based on their independent judgment for the provision of health care.

4.5 Professional Medical Review and Quality/Efficiency Features. The Claims Administrator shall have the discretion to assign Approved Providers and other health care providers or firms to a Participant's case in order to (i) coordinate and expedite medical treatment of the Participant, in consultation with the treating Approved Provider, (ii) facilitate such case management, quality, and efficiency measures and procedures as the Claims Administrator deems appropriate, based upon particular facts and circumstances, and (iii) review the propriety of any and all treatment, services, and supplies, including charges for such treatment, services, and supplies.

4.6 Second Medical Opinions. The Plan reserves the right to require a second medical opinion from an Approved Provider selected by the Claims Administrator for purposes of obtaining an Independent Medical Evaluation (IME) or for any other reason relating to the payment of Medical Benefits, Disability Benefits, or any other benefits under this Plan. If a Participant refuses to be examined by an Approved Provider selected by the Claims Administrator for the second opinion, all benefits under the Plan shall be suspended.

(1) The Claims Administrator will weigh the findings of the treating Approved Provider and the Approved Provider providing the second opinion and make a benefit determination under the Plan. However, if the Participant is in disagreement with the diagnosis or treatment recommended by the Approved Provider whose opinion is accepted by the Claims Administrator ("Provider A"), then the Participant may request a second medical opinion. The Participant must notify the Claims Administrator in advance of receiving any second medical opinion in order for this opinion to be considered by the Plan. If the Participant provides advance notice to the Claims Administrator, then the Participant shall have the right to a one-time examination at his or her own expense by another provider ("Provider B"). This examination by Provider B shall be solely for the purpose of evaluating the Participant's condition and making a treatment recommendation.

(2) If the diagnosis and treatment recommended by Provider B is contrary to that of Provider A, then the Claims Administrator shall designate a peer review provider who will evaluate the medical records and advise the Claims Administrator, and who may designate another Approved Provider for a further medical examination. If the Participant refuses to be so examined, all benefits under the Plan shall be suspended. The diagnosis and/or recommended treatment of the peer review provider or this last Approved Provider will be controlling. The fees and related expenses of the peer review provider and this last Approved Provider will be paid by the Plan (although the Participant shall have the option of paying up to one-half of such fees and expenses).

ARTICLE V
COVERED AND NON-COVERED BODILY INJURIES AND BODILY INJURY CIRCUMSTANCES

5.1 Covered Bodily Injuries. "Covered Bodily Injuries" shall mean a Bodily Injury that occurs (the "Occurrence") on or after the Effective Date specified in Item No. 8 of the Benefits Schedule. The Participant's Bodily Injury must have resulted directly and solely from an Occurrence in the Course and Scope of Employment. All Injuries sustained by a Participant that relate to (a) an

Accident, or related series of Accidents, (b) exposure to an environmental or physical hazard that causes an Occupational Disease, or (c) repetitious, physically traumatic activities that result in Cumulative Trauma shall be considered a single Bodily Injury for purposes of the Plan.

5.2 Non-Covered Bodily Injuries. Any provision of this Plan to the contrary notwithstanding, the term Bodily Injury shall not include any damage or harm arising out of:

(a) a cardiovascular, coronary, pulmonary, respiratory, or cerebrovascular accident or myocardial infarction, unless it caused a covered Bodily Injury and, in relation to other factors contributing to the physical harm, the Course and Scope of Employment was the major cause. For this purpose, it must be shown that the exertion of the work necessary to precipitate the Disability or death was extraordinary and unusual in comparison to the Participant's usual work in the Course and Scope of Employment. Physical or mental stress shall not be considered;

(b) a hernia, , unless -

(1) the occurrence of the hernia followed as the result of sudden effort, severe strain, or the application of force directly to the abdominal wall;

(2) there was severe pain in the hernial region;

(3) the pain caused your work to be substantially affected;

(4) notice of the occurrence was given to the Employer within five (5) days thereafter;

(5) the physical distress following the occurrence of the hernia was such as to require the attendance of an Approved Provider; and

(6) the hernia was caused solely as the result of an Accident in the Course and Scope of Employment.

(c) any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure or other body part resulting from the natural results of aging, osteoarthritis, arthritis, or degenerative process including, but not limited to, degenerative joint disease, degenerative disc disease, degenerative spondylosis/spondylolisthesis and spinal stenosis;

(d) any Preexisting Condition**,** except when the treating Approved Provider clearly confirms an identifiable and significant aggravation incurred in the Course and Scope of Employment, in which case:

(1) coverage for such aggravation will be provided only if and to the extent that an approved Physician –

(A) confirms that the preexisting condition has been previously repaired or rehabilitated, and

(B) prescribes services or supplies that are Medically Necessary to treat such aggravation and likely to return the Participant to pre-Injury status; and

(2) no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury.

5.3 Non-Covered Bodily Injury Circumstances. Furthermore, no benefits will be paid under the Plan for a Bodily Injury if:

(a) the Bodily Injury was an intentionally self-inflicted Bodily Injury, while either sane or insane, or Bodily Injury intentionally caused or intentionally aggravated by the Employer;

(b) the Bodily Injury was a result of a Participant's participation in:

(1) an assault or a felony, except an assault committed in defense of the Employer's business or property;

(2) any illegal act; or

(3) service in the military of any country or any civilian non-combatant unit serving with such forces;

(c) the Bodily Injury was directly or indirectly, contributed to, caused by, resulting from, or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss:

(1) war or acts of war (whether war be declared or not); or

(2) riots, strikes, or civil disturbance.

This exclusion also excludes from coverage all actual or alleged losses, liabilities, damages, injuries, defense costs, costs or expenses directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, retaliating against, or responding to (1) or (2) above.

(d) an Accident was caused by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician's orders. If, within 24 hours of being injured or reporting a Bodily Injury, a Participant tests positive for intoxication, an illegal controlled substance, or a legal controlled substance used in contravention to a treating physician's orders, or refuses to undergo the drug and alcohol testing, there shall be a rebuttable presumption that the Bodily Injury was caused by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician's orders. This presumption may only be overcome if the Participant proves by a preponderance of the evidence that his or her state of intoxication was not the major cause of the Bodily Injury;

(e) the Injury occurred while employed in violation of law with the Employer's actual knowledge or the actual knowledge of any of the Employer's executive officers;

(f) damage or harm was caused by exposure to the following:

(1) asbestos, asbestos fibers or asbestos containing products;

(2) silicon or silica; and

(3) mold, microbes or fungus;

(g) the Bodily Injury arose out of a Participant's participation in any recreational, social or athletic activity not constituting part of the Participant's Course and Scope of Employment, whether or not such participation occurs on the Employer's premises or during your normal business hours;

(h) the Bodily Injury arose out of the use of nuclear, chemical or biological weapons of mass destruction meaning the use, release, emission, discharge, and/or dispersal of materials that may cause death and/or incapacitating disablement to people or animals. This includes but is not limited to nuclear, radioactive, pathogenic materials; toxins; gaseous, liquid, and solid compounds; synthesized chemicals; microbiological toxins; and/or liquid compounds;

(i) the Participant receives benefits under any workers' compensation law, unemployment compensation law, disabilities benefits law or other similar law (other than the Oklahoma Employee Injury Benefit Act). For this purpose, any Bodily Injury for which a Participant has filed a claim under any state workers' compensation law, occupational disease law, unemployment compensation disability benefits law or other similar law, will not be resolved under this Plan until such claim or filing is approved or denied. If such claim is denied and not appealed, this Plan will pay benefits in accordance with its terms. If such claim is denied, and the Covered Person appeals the denial, no benefits will be paid under this Plan until a final disposition of the appeal is issued. If the final disposition is an approval of the claim, the Plan reserves the right to recover, from the Participant, any benefits paid under this Plan which are subsequently paid for under any workers' compensation law, occupational disease law, unemployment compensation disability benefits law or other similar law. If the final disposition is a denial of the claim, this Plan will pay benefits in accordance with its terms;

(j) the claim is a statutory cause of action, including, without limitation, Title VII of the U.S. Civil Rights Act of 1964, the U.S. Civil Rights Act of 1991, the U.S. Civil Rights Act of 1866, the U.S. Age Discrimination in Employment Act, the Employee Retirement Income Security Act, the U.S. Fair Labor Standards Act, the U.S. Bankruptcy Code, the Oklahoma Anti-Discrimination Act, the Oklahoma Administrative Workers' Compensation Act (or any successor law), the U.S. Railway Labor Act and the U.S. National Labor Relations Act. This exclusion does not apply to payments the Employer is obligated to make under the Oklahoma Employee Injury Benefit Plan which is specifically insured under the insurance policy;

(k) the Bodily Injury arose or was alleged to have resulted from the following common law causes of action:

(1) breach of any contract of employment, whether written, oral or implied;

(2) breach of duty of good faith and fair dealing;

(3) breach of any non-competition agreement;

(4) tortious interference with contractual relations;

(5) negligent or intentional infliction of emotional distress;

(6) negligent hiring, negligent promotion, or negligent retention (unless resulting in a Bodily Injury); or

(7) assault and battery by the Participant or at the Participant's direction, defamation, invasion of privacy, false light publicity, negligent invasion of privacy, misrepresentation, fraud, false imprisonment, false arrest, malicious prosecution, unreasonable search or retaliatory discharge; or

(l) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Participant is:

(1) boarding, alighting from, riding in or being struck by any aircraft owned, operated or leased by the Employer, a Participant, or a member of a Participant's household;

(2) riding as a pilot, operator or crew member in any aircraft;

(3) flying in any aircraft which is rocket propelled;

(4) flying in any aircraft being used for aerobatics, racing or endurance test;

(5) crop dusting, seeding, fertilizing, or spraying, fighting a fire, any exploration or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting or any test or experimental cause;

(6) flying when a special permit or waiver from the proper authority has to be issued.

ARTICLE VI
ELIGIBILITY AND NATURE OF PAYMENTS

6.1 Nature of Payments.

(a) **No Admission of Liability.** The Plan has been established and is maintained by the Employer to protect themselves from certain liabilities. Payments made under this Plan by the Employer shall not in any way constitute an admission of liability or responsibility by the Employer for a Bodily Injury and any such liability or responsibility is specifically denied.

(b) **No Collateral Source.** Benefit payments under the Plan shall be considered to be made by the Employer of a Participant and shall not be considered payment from a "collateral source" as that term has been defined under any applicable rule, statute, judicial decision, or directive. All benefits paid under this Plan shall be offset against any alleged liability of the Employer, its officers, directors, or agents to a Participant or Participant's Beneficiaries, heirs, or assigns due to a Bodily Injury.

ARTICLE VII
CONTINUING BENEFITS

7.1 Suspension Or Termination of Benefits. The Claims Administrator may deny a claim for, or suspend or terminate the payment of, Plan benefits otherwise due a Participant if:

(a) the Participant refuses to submit to drug and/or alcohol testing in accordance with the Employer's substance abuse policy or refuses to provide the Company and its designated representatives with (or access to) drug and/or alcohol testing information related to a Bodily Injury;

(b) the Participant does not receive prior approval for all medical care other than Emergency Care;

(c) the Participant utilizes a non-approved provider or facility other than for Emergency Care;

(d) the Participant refuses to submit to examination by an Approved Provider selected by the Claims Administrator (other than the treating Approved Provider) as required by the Claims Administrator with respect to any surgical procedure or other diagnosis or treatment opinion rendered by the treating Approved Provider for which the Claims Administrator considers a second medical opinion advisable;

(e) the Participant is persistently nonresponsive to treatment, including, but not limited to, nonresponsiveness due to the need for Participant behavioral modification recommended by the treating Approved Provider;

(f) the Participant fails to provide accurate information to, or fails to follow the directions of, a treating Approved Provider. Following the directions of a treating Approved Provider includes, but is not limited to, any recommended treatment, therapy, course of action, abstinence, or rehabilitation program;

(g) the Participant fails to keep, or is late for, a scheduled appointment with a health care provider. Except in extraordinary circumstances as determined by the Claims Administrator, a first missed appointment shall result in a verbal warning, the second missed appointment shall result in a written warning, and the third missed appointment shall result in a termination of benefits;

(h) the Participant engages in conduct following a Bodily Injury which is determined by the treating Approved Provider to be an injurious practice that is hindering the Participant's recovery from the Bodily Injury;

(i) the Participant fails to immediately inform the Participant's supervisor that he or she has been released by an Approved Provider to return to full or Modified Duty, or fails to timely report to work in accordance with such work release;

(j) the Participant receives benefits with respect to the Bodily Injury from any workers' compensation law (whether or not any coverage for benefits is actually in force under such law);

(k) the Participant has been untruthful or demonstrates bad faith in connection with administration of the Plan, including, but not limited to, any aspect of the required information supplied as part of the Bodily Injury reporting or employment process;

(l) the Participant fails to fully cooperate with the Claims Administrator (including, but not limited to, failure to comply with the provisions of Section 2.2) in connection with the administration of the Plan, including, but not limited to, subrogation or coordination of benefits procedures; or

(m) the Participant fails or refuses to comply with any of the provisions of the Plan or the rules and procedures adopted by the Claims Administrator for the administration of the Plan.

7.2 Mandatory Final Compromise And Settlement. At any time following the date of Bodily Injury, the Claims Administrator may notify the Participant of the Plan's intention to be released from any further known and unknown benefit and all other Bodily Injury-related claims by such Participant and pay a final claim settlement to, or with respect to, such Participant in exchange for the Participant's agreement to a release of liability in favor of the Plan, Employer, Claims Administrator, Appeals Committee, and other interested parties with respect to such claims. In that event, the Claims Administrator may appoint an actuary, appraiser, and/or Approved Provider to investigate, determine, and capitalize such claims, or use such other valuation method as the Claims Administrator may specify. The payment by the Plan and/or Employer of the value of such claims (as finally determined by the Claims Administrator) shall be made in such manner as the Claims Administrator may determine. No additional claims will be subsequently accepted with respect to such Bodily Injury. Any actuary or appraiser shall apply such rules, standards, and assumptions (present value discount, inflation, and mortality rates, etc.) as the Claims Administrator may determine. The Participant must cooperate and provide all information, sign such forms and agreements, and submit to all medical examinations as may be requested by the Claims Administrator to arrive at a valuation and settlement of the Participant's claims. No further benefits will be payable to, or with respect to, a Participant who fails or refuses to accept the Claims

Administrator's claim valuation, sign the release agreement presented by the Claims Administrator, or otherwise comply with the requirements of this Section or other provisions of the Plan. Prior or subsequent to the Claims Administrator's evaluation and determination of the value of a Participant's claims, the Claims Administrator may determine to not capitalize and satisfy any such claim as described above and to instead continue eligibility for benefit payments and defer the above valuation and settlement. Any such deferral shall not waive the right of the Claims Administrator to proceed with valuation and settlement as outlined in this Section, at any future date, without limitation.

ARTICLE VIII
ADMINISTRATION

8.1

Plan Administrator.

(a) **Administrator.** The Company shall be the Plan Administrator and named fiduciary of the Plan. The Plan shall be administered on behalf of the Company and Employer by the Claims Administrator and Appeals Committee. The Claims Administrator or Appeals Committee so appointed shall serve in such office until his or her death, resignation, or removal by the Company. The Company may change the Claims Administrator or Appeals Committee with or without cause at any time, and may modify the membership of the Claims Administrator or Appeals Committee positions at any time and from time to time. The Claims Administrator and Appeals Committee shall keep such records of their proceedings and acts as they deem to be necessary or appropriate for the purposes of the Plan. The Claims Administrator and Appeals Committee shall cause such information, documents or reports to be prepared, provided and/or filed as may be necessary to comply with the provisions of ERISA, or any other applicable law. The Appeals Committee shall receive no remuneration from the Plan for his or her services as the Appeals Committee. The Plan shall operate and keep its records on the basis of the Plan Year.

(b) **Administrative Authority.** Subject to the Plan claims procedures, the Claims Administrator and Appeals Committee shall have discretionary and final authority to interpret and implement the provisions of the Plan, including, but not limited to, making all factual and legal determinations, correcting any defect, reconciling any inconsistency and supplying any omission, and making any and all determinations that may impact a claim for benefits hereunder. The Claims Administrator and Appeals Committee shall perform all of the duties and may exercise all of the powers and discretion that the Claims Administrator and Appeals Committee deem necessary or appropriate for the proper administration of the Plan, and shall do so in a uniform, nondiscriminatory manner. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter. Every interpretation, choice, determination or other exercise by the Claims Administrator or Appeals Committee of any power or discretion given either expressly or by implication to it shall be conclusive and binding upon all parties having or claiming to have an interest under the Plan or otherwise directly or indirectly affected by such action, without restriction, however, on the right of the Claims Administrator or Appeals Committee to reconsider and redetermine such action. There shall be no de novo review by

any arbitrator or court of any decision rendered by the Appeals Committee and any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion. The Claims Administrator and/or Appeals Committee may adopt such rules and procedures for the administration of the Plan as are consistent with the terms hereof.

(c) **Delegation of Responsibilities.** The Claims Administrator's and Appeals Committee's authority shall include, but not be limited to, the power to allocate or delegate fiduciary and non-fiduciary responsibilities or duties to Employees or third persons, including any insurer or contract administrator, and, except as is otherwise provided by applicable law, those persons to whom such responsibilities and duties have not been allocated or delegated shall not be liable for any act or omission of those persons to whom such responsibilities and duties have been allocated or delegated. Except as otherwise provided under ERISA, neither the Employer, the directors, officers, partners, managers, or supervisors of the Employer, the Plan Administrator, the Claims Administrator or the Appeals Committee nor any person designated to carry out fiduciary responsibilities pursuant to this Plan shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of the Plan.

8.2 Funding Policy And Method. All benefits payable to or with respect to a Participant under this Plan shall be paid or provided for by the Employer who was the Employer of such Participant at the time of his or her Bodily Injury. Unless provided by a trust established pursuant to the Plan, said benefits shall be paid by such Employer at the direction of the Claims Administrator or Appeals Committee or its designated representative solely out of the general assets of such Employer. The Employer shall have no obligation to establish any fund or trust for the payment of benefits under this Plan. The Employers shall obtain an insurance contract from Great American Insurance Company that may (depending upon the terms of such policy) provide funds to reimburse or pay on behalf of an Employer for a benefit payable under this Plan. Benefits under this Plan shall not be payable or shall immediately cease in the event that such insurance coverage is not available (for reasons other than the need to satisfy a self-insured retention) or ceases under such policy for any reason. Any such insurance policy proceeds or other amounts payable by an employer shall not be considered "plan assets" for purposes of ERISA. Payments by an Employer shall be from its general assets. The Employer that applied for the insurance contract shall own such contract. As a condition to the receipt of benefits under this Plan, and unless otherwise prohibited by law, the Claims Administrator may require a Participant to sign a form prescribed by the Claims Administrator which will serve to assign all or a portion of any benefits payable under such an insurance contract to the Employer that applied for the contract. If, notwithstanding the provisions of this Section 8.2, any insurance benefits are paid directly by an insurance company to a Participant or Beneficiary with respect to a Bodily Injury covered under this Plan, such payments shall be deemed to be made under this Plan by the Employer or shall otherwise be subject to the coordination of benefits provisions of Article X, as determined by the Claims Administrator.

ARTICLE IX
CLAIMS PROCEDURES

9.1 Filing a Claim for Benefits. A claim for Medical Benefits or Disability Benefits under the Plan shall be initiated by a Participant (or his or her Representative) by (i) complying with the notice requirements of Section 2.1, and (ii) submitting to medical treatment in accordance with

Section 4.1. A claim for Medical Benefits can also be directly submitted on the behalf of a Participant to the Claims Administrator by a health care professional. A claim for Occupational Death Benefits under the Plan shall be initiated by a Beneficiary providing notice of entitlement thereto to the Claims Administrator within 90 days after the date of the Participant's death.

(a) **What is a Claim** - Each (i) medical service or supply for which payment is requested, (ii) Disability Benefit for a particular payroll period, or (iii) claim for Occupational Death Benefits or Disfigurement Benefits, shall be deemed a separate "claim" for benefits that is subject to a Determination under the Plan. The Plan's payment of a particular claim (for example, payment for an initial medical evaluation, even on a claim that may have been reported late) does not waive or otherwise prejudice the Claims Administrator's or Appeals Committee's right to deny another particular claim or all future claims for benefits under the Plan. As stated above, any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter.

(b) **Who is a Claimant** - References in this ARTICLE to "claimant" shall include a Participant, a medical provider seeking payment for a service or supply, a Beneficiary, or a claimant's Representative, as applicable. A claimant or a claimant's Representative may file a claim for benefits under the Plan, as well as an appeal of an Adverse Benefit Determination. The Plan shall have the right to establish reasonable procedures for determining whether and to what extent an individual has been authorized to act on behalf of a claimant. However, with respect to an Urgent Care Claim, a provider or other health care provider licensed, accredited and certified to perform specified health services consistent with state law and with knowledge of a claimant's medical condition shall be permitted to act as the authorized Representative of the claimant.

(c) **Information to Submit** - Claims must include the information required by Section 2.2 and such other reasonable information requested by the Claims Administrator, such as medical records or a written statement from an independent service provider evidencing the date, type of services rendered, and the total cost of such services. In addition, the Claims Administrator may require the claimant to provide a written and signed statement which provides that the Medical Expense has not been reimbursed, or is not reimbursable under any other plan or program. Further, the Claims Administrator may also request that the claimant file all appropriate claims and requests for payment from any other plan or program maintained by the claimant prior to making any payments under this Plan. See ARTICLE X on "Coordination of Benefits and Subrogation." The Claims Administrator may rely upon all such information furnished by the claimant, including the claimant's current mailing address, and shall have no obligation or duty to locate a claimant.

(d) **Submission of Medical Bills for Payment** - Approved Providers will be requested to invoice all health care-related charges directly to the Claims Administrator (or the Employer, which shall immediately transmit such invoice to the Claims Administrator).

However, in the event that a Participant receives such an invoice or pays such a charge, all requests for payment or reimbursement of Medical Expenses must be filed with the Claims Administrator within 30 days from the date such expenses are incurred or, if later,

the date such Participant receives an invoice from an Approved Provider or other health care provider (in the case of Emergency Care) for such expenses.

(e) **Incomplete Claim Submissions** - In the event that a claim, as originally submitted, is not complete, the Claims Administrator shall notify the claimant in the manner described below, and the claimant shall have the responsibility for providing the missing information. Notwithstanding the foregoing, the period of time within which a benefit Determination must be made shall begin at the time that a claim is filed in accordance with this Plan, without regard to whether all the information necessary to make a benefit Determination accompanies the claimant's filing. Subject to the applicable provisions of this Article IX, in the event that the period of time for a particular claim is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be suspended from the date on which the notification of the extension is sent to the claimant until the date on which the Claims Administrator receives the claimant's response to the request for additional information.

9.2 Claims Review.

(a) **Notice of Initial Benefit Determination** - The Claims Administrator shall provide notice to the claimant of its initial benefit Determination as follows:

(1) **Urgent Care, Pre-Service Medical Claims** - In the case of a Pre-Service Claim for Medical Benefits that is an Urgent Care Claim, the Claims Administrator shall notify the claimant of the Plan's initial benefit Determination (whether adverse or not) as soon as possible, taking into account the medical exigencies of the particular claim, but not later than 72 hours after receipt of the claim. A Determination that such claim will be covered can be communicated to the claimant verbally, in writing, or by electronic notice; but an Adverse Benefit Determination must be provided in writing or by electronic notice as described further below. If the claimant (i) fails to follow the Plan's procedures for filing an Urgent Care Claim, or (ii) otherwise fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan on an Urgent Care Claim, then:

(A) The Claims Administrator shall notify the claimant as soon as possible, but not later than 24 hours after its receipt of the claim, of the procedure to follow or the specific information necessary to complete the claim. Notification may be oral, unless the claimant requests a written notice. This notice requirement shall only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

(B) The claimant shall then be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to correct such failure.

(C) The Claims Administrator shall then notify the claimant of the Plan's initial benefit Determination as soon as possible, but not later than 48 hours after the earlier of (i) the Claims Administrator's receipt of the specified information necessary to complete the claim, or (ii) the end of the time period given the claimant to provide such information.

(2) **Concurrent Medical Care Decisions** - If the Claims Administrator has approved an ongoing course of medical treatment to be provided over a period of time or number of treatments:

(A) The Claims Administrator shall notify the claimant of any reduction or termination by the Plan of such course of treatment. Such reduction or termination shall be considered an Adverse Benefit Determination and the Claims Administrator shall notify the claimant sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a benefit Determination on review before the course of treatment is actually reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is an Urgent Care Claim shall be decided as soon as possible, taking into account the medical exigencies of the claim. The Claims Administrator shall make an initial benefit Determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If such claim is not made to the Plan within such 24-hour period, the request shall be treated as an Urgent Care Claim and be decided within the normal Urgent Care Claim timeframes (i.e., as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after receipt).

(C) Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is not an Urgent Care Claim shall be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (i.e., as a Pre-Service Claim or a Post-Service Claim).

Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, shall be made in accordance with the provisions of this Section.

(3) **Non-Urgent Care, Pre-Service Medical Claims** - In the case of a Pre-Service Claim for Medical Benefits that is not an Urgent Care Claim, the Claims Administrator shall notify the claimant of the Plan's initial benefit Determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after its receipt of the claim. A Determination that such claim will be covered can be communicated to the claimant

verbally, in writing, or by electronic notice; but an Adverse Benefit Determination must be provided in writing or by electronic notice as described further below.

(A) If the claimant fails to follow the Plan's procedures for filing a non-urgent care, Pre-Service Claim, then the Claims Administrator shall notify the claimant as soon as possible, but not later than 5 days after its receipt of the claim, of the procedures to follow. Notification may be oral, unless the claimant requests a written notice. This notice requirement shall only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

(B) The Claims Administrator may extend the 15-day benefit Determination period up to an additional 15 days if it determines that, due to matters beyond the control of the Plan, an initial benefit Determination cannot be made within the first 15-day period, and notifies the claimant of the special circumstances requiring the extension and the date by which the Plan expects to render a decision. If the extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the extension notice shall specifically describe the required information and the claimant shall then be given at least 45 days to provide the specified information. However, the Claims Administrator's timeframe for making a benefit Determination shall be suspended until the date upon which the claimant responds to the request for additional information.

(4) **Post-Service Medical Benefit, Disability Benefit, Occupational Death Benefit, and Disfigurement Benefit Claims** - In the case of a Post-Service Claim for Medical Benefits or a claim for Disability Benefits, Occupational Death Benefits or Disfigurement Benefits, the Claims Administrator shall notify the claimant of an Adverse Benefit Determination within 30 days after its receipt of the claim. The Claims Administrator may extend this period up to an additional 15 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan. Notice of such extension must be provided to the claimant prior to the expiration of the initial 30-day period and state (i) the special circumstances requiring the extension, and (ii) the date by which the Plan expects to render a decision. If the extension relates to a claim for Disability Benefits, such notice shall also state (i) the standards on which entitlement to benefits is based, and (ii) unresolved issues that prevent a benefit determination on the claim and what additional information is needed to resolve those issues. If additional information is requested with the extension notice, the claimant shall have 45 days from the date of the notice of extension in order to provide the specified information. However, the Claims Administrator's timeframe for making a benefit Determination shall be suspended until the date upon which the claimant responds to the request for additional information.

(b) **Manner and Content of Adverse Benefit Determinations** - If the initial benefit Determination is an Adverse Benefit Determination, the Claims Administrator shall provide a written or electronic notice to the claimant that satisfies the following requirements:

(1) Any electronic notice shall satisfy ERISA regulations that specify the standards for electronic disclosure of benefit plan information;

(2) The notice shall be written in a manner calculated to be understood by the claimant;

(3) The notice shall set forth the specific reason or reasons for the Adverse Benefit Determination, making reference to the specific Plan provisions on which the Adverse Benefit Determination is based;

(4) If an internal rule, guideline, protocol or other similar criterion was relied upon in making an Adverse Benefit Determination on a claim for Medical Benefits or Disability Benefits, the notice shall state that such rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy thereof shall be provided free of charge to the claimant upon request;

(5) If the Adverse Benefit Determination of a Medical or Disability Benefits claim is based upon medical necessity, an experimental treatment or similar exclusion or limit, the notice shall provide either an explanation of the scientific or clinical judgment for the Adverse Benefit Determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(6) The notice shall include a statement that in the case of an Adverse Benefit Determination on review by the Appeals Committee, the Plan offers no further voluntary levels of appeal and that the claimant can pursue his or her right to bring a legal action under ERISA section 502(a);

(7) If the initial Adverse Benefit Determination involves an Urgent Care Claim, the notice shall provide a description of the expedited review process applicable to such claims. Notification of an Adverse Benefit Determination that involves an Urgent Care Claim may be provided to the claimant orally within the time frames specified above, provided that the oral notification satisfies the requirements of this subsection and that a written or electronic notice satisfying the requirements of this subsection is furnished to the claimant not later than 3 days after the oral notification;

(8) The notice shall describe any additional materials or information necessary for the claimant to perfect the claim and explain why such material or information is necessary; and

(9) The notice shall provide a description of the Plan's review procedures (including the time limits applicable to these review procedures).

(c) **Appeal of Adverse Benefit Determinations** - The claimant may appeal in writing an initial Adverse Benefit Determination to the Appeals Committee within the

following number of days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator:

(1) 180 days for a Medical Benefits or Disability Benefits claim; or

(2) 60 days for an Occupational Death Benefit or Disfigurement Benefit claim.

If the Adverse Benefit Determination involves an Urgent Care Claim for Medical Benefits, the claimant may request orally, or in writing, an expedited review of the Adverse Benefit Determination and all necessary information, including the Plan's benefit Determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available expeditious method.

(d) **Appeals Committee Consideration** - When reviewing the appeal of an Adverse Benefit Determination, the Appeals Committee shall comply with the following requirements:

(1) The claimant may submit written comments, documents, records, and other information relating to the claim for benefits, and the Appeals Committee shall take all of such information into account when reviewing such claim, without regard to whether such information was submitted or considered in the initial benefit Determination;

(2) The claimant may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information that is Relevant to the claimant's claim for benefits (as determined by the Appeals Committee);

(3) The Appeals Committee review of an Adverse Benefit Determination on a claim for Medical Benefits or Disability Benefits shall not give any deference to the initial Adverse Benefit Determination.

(4) If the appeal request on a Medical Benefits or Disability Benefits claim is based in whole or in part on a medical judgment, including Determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Appeals Committee shall consult with an Approved Provider who has appropriate training and experience in the field of medicine involved in the medical judgment. This Approved Provider shall not be an individual who was consulted in connection with the initial Adverse Benefit Determination or a subordinate of such individual.

(5) Upon request of a claimant, the Appeals Committee shall identify the individual names of any medical or vocational experts whose advice was obtained in connection with an initial Adverse Benefit Determination, without regard to whether the advice of such experts was relied upon in making the benefit Determination.

(e) **Timing of Notice of Benefit Determination on Review** - The Appeals Committee shall provide notice to the claimant, as described in subsection (f) below, of the Plan's benefit Determination on review in accordance with the following timeframes:

(1) **Urgent Care, Pre-Service Medical Claims** - In the case of a Pre-Service Claim for Medical Benefits that is an Urgent Care Claim, the Appeals Committee shall notify the claimant of the Plan's benefit Determination on review as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after its receipt of the claimant's appeal request. No extension of time is available for Appeals Committee Determinations on the review of claims for Medical Benefits.

(2) **Non-Urgent Care, Pre-Service Medical Claims** - In the case of a Pre-Service Claim for Medical Benefits that is not an Urgent Care Claim, the Appeals Committee shall notify the claimant of the Plan's benefit Determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after its receipt of the appeal request. No extension of time is available for Appeals Committee Determinations on the review of claims for Medical Benefits.

(3) **Post-Service Medical Benefit, Disability Benefit, Occupational Death Benefit, and Disfigurement Benefit Claims** - In the case of a Post-Service Claim for Medical Benefits or a claim for Disability Benefits, Occupational Death Benefits or Disfigurement Benefits, the Appeals Committee shall notify the claimant of the Plan's benefit Determination on review within 45 days after its receipt of the appeal request. The Appeals Committee may extend this period up to an additional 45 days on a claim for Disability Benefits, Occupational Death Benefits, or Disfigurement Benefits if the Appeals Committee determines that an extension is necessary due to matters beyond the control of the Plan. Written or electronic notification of an extension must be provided to the claimant prior to the expiration of the initial 45-day period and indicate the special circumstances requiring the extension and the date by which the Plan expects to render a decision.

(f) **Manner and Content of Benefit Determination on Review** - The Appeals Committee shall provide a claimant with written or electronic notification of the Plan's benefit Determination on review. If the decision on review is an Adverse Benefit Determination, the notice must satisfy all the requirements set forth in subsection (b)(1) through (6) above, and also state 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 Plan benefits.

(g) **Extension of Time Frames Allowed by Law or Agreement** - In the event that ERISA rules and regulations permit additional time for decisions or actions by the Claims Administrator or Appeals Committee, the Claims Administrator or Appeals Committee may exercise their discretion to utilize (but not exceed) those extended time frames; provided, however, that this discretion shall only be exercised when necessary to provide a full and fair review of a claimant's right to benefits in accordance with the terms of this Plan (e.g., additional time needed to obtain an appointment and results of a medical examination). Upon request by the Plan, a claimant may also voluntarily agree to an extension or further extension of any time period within which the Plan must decide a claim.

(h) **Exhaustion of Administrative Remedies** - No legal action can be brought by or with respect to a Participant to recover benefits under the Plan before the foregoing claim

procedures have been exhausted. Every ERISA right of action by any Participant, former Participant, a Participant's Representative, Beneficiary, or the Participant's estate against the Plan, or any Plan fiduciary, must be brought no later than one (1) year from the date that the foregoing claim procedures have been exhausted (due to claimant inaction, claimant receipt of a final Adverse Benefit Determination on appeal, or otherwise).

ARTICLE X
COORDINATION OF BENEFITS, SUBROGATION AND WITHHOLDINGS

10.1 Coordination Of Benefits. The Disability Benefits and Medical Benefits payable under the Plan shall be reduced by any amount paid or available with respect to the Participant's Bodily Injury under the Social Security Act, the Railroad Retirement Act, any workers' compensation, unemployment compensation, occupational disease, or other law, or any other benefit plans, including, but not limited to, a policy or policies of automobile (including, but not limited to medical payment coverage, personal injury protection coverage, uninsured motorists coverage and under-insured motorist coverage), disability, or health insurance purchased by the Participant or an Employer; provided, however, the fact that a Participant is eligible for or is provided medical assistance under a state plan will not be taken into account in making payment under this Plan. If a Participant is covered under one or more such benefit plans, then (unless otherwise subject to Section 10.2) the benefits payable under this Plan will be either regular benefits or reduced benefits that, when added to the benefits of the other plan(s), will not exceed 100% of the amount described herein. The Participant must cooperate with the Employer in furnishing to such Employer copies of other policies, coverages or plans which may be applicable to the Injury and in completing and returning to such Employer any questionnaire or forms inquiring about, or assigning rights to recover under, other policies, coverages or plans which may cover or be applicable to such Participant.

10.2 Recovery From Third Parties And Excess Payments. For purposes of this Plan, the term "Payee" means a Participant or Beneficiary or their family members, heirs, estate, or other representative (in their individual or representative capacity), singularly or collectively as the context may require to give the Plan the broadest possible rights of recovery. If a Payee becomes entitled to or directly or indirectly receives Plan benefits for any Bodily Injury caused by the negligence or other act or omission of any person or organization (including, but not limited to, the Employer), and is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Bodily Injury (including, but not limited to, damages for negligence, survival, wrongful death or other legal or equitable action), whether by insurance, litigation, settlement or other proceeding, the Payee shall automatically be required to (i) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation to the extent of the Plan benefits paid to, or with respect to, the Payee, and (ii) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation for all medical management, investigation, attorneys' fees, costs of recovery, and other expenses related to the claim for benefits (including any subrogation proceeding). The subrogation rights of this Plan even apply with respect to a Payee who is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Bodily Injury but has not and will not receive any Plan benefits if such person's claim for damages or other compensation is dependent on whether the Participant had or has a valid claim against a third party. Upon request of the Plan, the Payee shall provide the Plan written confirmation of this subrogation right, including execution of any assignment, lien form or other document requested by the Claims Administrator to enable the Plan to recover such Plan benefits and related

expenses. Any failure of a Payee to give written confirmation of the Plan's subrogation rights does not adversely affect its rights of subrogation because the Plan's right of subrogation arises automatically once payment under this Plan is made to or on behalf of the Payee. If (i) a Payee fails, refuses or neglects to reimburse the Plan or otherwise comply with the provisions of this Section, or (ii) payments are made under the Plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the Plan, then the Plan shall still have all remedies and rights of recovery specified herein. The Plan shall also have the right to terminate or suspend benefit payments and/or recover the reimbursement of all amounts above due to the Plan by withholding, offsetting and recovering such amounts out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such Payee. The Plan shall have the first lien recovery against any benefits paid or to be paid by the Plan on behalf of a Participant. The Plan shall also have the right to bring a lawsuit and assert a constructive trust or other interest against any and all persons that have assets to which the Plan may claim a right. The Plan has the right of first recovery from any judgment, settlement or other payment, regardless of whether the Payee has been "made whole." The Plan's subrogation rights and first lien will not be reduced by attorneys' fees or expenses incurred by any party in pursuing recovery against a third party and the "common fund" doctrine shall not apply. Any attorneys' fees and/or expenses incurred by or at the request of the Payee or his, her or its attorneys in a third party or other action shall be the sole responsibility of such party.

10.3 Notice Of Legal Proceedings. A Payee shall provide the Claims Administrator with prior written notice of the involvement of such party in any lawsuit, settlement discussion or other proceeding, one of the principal purposes of which is recovering, from any person or organization, damages or other compensation in any way related to any Bodily Injury for which such Payee has received (or may in the future file a claim to receive) Plan benefits. The Plan shall have the right to intervene for itself and on behalf of a Payee in any such lawsuit, settlement discussion or other proceeding. If a Payee neglects, fails or refuses to seek a recovery from any person or organization for any Bodily Injury caused by the negligence or other act or omission of such person or organization, the Plan shall have the right to institute a lawsuit or other proceeding or do any other act that in the opinion of the Claims Administrator may be necessary or desirable to recover the Plan benefits paid (and to be paid in the future) to the Payee, plus any costs and expenses incurred by the Plan in pursuing such recovery.

10.4 Assignment Of Rights. By participating in this Plan, a Participant obligates himself or herself, as well as all other Payees (in both their individual and representative capacities), to the provisions of this Plan, including, without limitation, Sections 10.1, 10.2, and 10.3 hereof. Upon the request of the Claims Administrator, a Payee shall assign to the Plan the right to intervene in or institute any lawsuit, settlement discussion, or other proceeding described in Section 10.1 and/or 10.2, and to use the name of such party for such purpose. The Plan shall have the right to select legal counsel of its own choice and such counsel shall have complete control over the conduct of any such lawsuit, settlement discussion, or other proceeding without the consent or participation of any such Payee. Whenever the Plan shall intervene in or institute any lawsuit or other proceeding as permitted by the provisions of this Section, the Plan may pursue same to a final determination and the Plan expressly reserves the right to appeal from any adverse judgment or decision. The Payee shall give the Plan all reasonable aid in any such lawsuit, settlement discussion, or other proceeding in effecting settlement, in securing evidence, in obtaining witnesses, or as may otherwise be requested by the Claims Administrator. The Payee shall release the Plan, the Employer, the Plan Administrator, the Claims Administrator, the Appeals Committee, and their respective directors, officers, agents, attorneys, and employees from all claims,

causes of action, damages and liabilities of whatever kind or character that may directly or indirectly arise out of the pursuit or handling by the Plan of any such lawsuit, settlement discussion or other proceeding.

10.5 Taxes, Garnishments and Payroll Deferrals. Benefit payments under this Plan shall be reduced by the amount of any applicable federal or state income, employment, or other taxes that are required by law to be withheld. Disability Benefit payments under this Plan shall also be reduced by the Participant's earnings from any employer after the Disability begins, amounts legally garnished, and amounts that are contributed by an Employer, at the Participant's election, to a 401(k) plan, cafeteria plan, or other pre-tax salary deferral employee benefit plan. In the event that (a) the Plan withholds or otherwise pays federal or state income, employment, or other taxes on Plan benefit payments, and (b) the Claims Administrator subsequently determines that such benefit payments are not subject to such taxes, then the Claims Administrator shall seek a refund of such taxes, return to the Payee any excess amounts withheld from the Payee that are recovered by the Claims Administrator (subject to the Claims Administrator's right of recovery below), and provide information to the Covered Employee as needed to support his or her pursuit of any further tax refund. To the extent that any such benefit payments have been computed at a percentage in excess of the minimum percentage required for such form of benefit under the Oklahoma Employee Injury Benefit Act and such payments are subsequently determined to be non-taxable, such excess amount shall be recoverable by the Plan as an over-payment pursuant to the other provisions of this Article X, including, but not limited to, the Plan withholding, offsetting and recovering such amounts out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such Payee. Upon the Claims Administrator's determination that any form of benefit set at a percentage in excess of the minimum percentage required under the Oklahoma Employee Injury Benefit Act is non-taxable, this Plan shall be automatically amended to reduce such percentage to be equal to the minimum percentage required for such form of benefit under the Oklahoma Employee Injury Benefit Act, and a summary of such Plan modification shall be promptly provided to all Plan Participants.

ARTICLE XI
TERMINATION AND AMENDMENT

The Company shall have the right and power at any time and from time to time to amend this Plan, in whole or in part, on behalf of the Employer, and at any time to terminate this Plan or any Employer participation hereunder; provided, however, that no such amendment or termination shall reduce the amount of any benefit payable to, or with respect to, a Participant under the Plan in connection with a Bodily Injury occurring prior to the date of such amendment or termination; and provided, further, that no such amendment shall be effective with respect to an Oklahoma occupational injury insurance policy issued to the Company by Great American Security Insurance Company unless accepted in writing by such insurance company. Any such amendment or termination shall be pursuant to formal written action of a representative authorized to act on behalf of the Company.

This Plan document shall also automatically cease to be effective for all purposes as of the date of the cancellation, final expiration, or non-renewal of an Oklahoma occupational injury insurance policy issued to the Company by Great American Security Insurance Company, except for purposes of the administration of any open claims occurring prior such date. Only the Company's proper adoption of another, successor benefit plan document can prevent such automatic termination of this Plan.

In the event the Oklahoma Employee Injury Benefit Act is found to be unconstitutional and/or for such other reasons the Plan is deemed to no longer have legal force or binding effect, the Plan shall terminate and any payments made to or on behalf of a Participant shall fully offset any award of benefits under the Oklahoma Administrative Workers' Compensation Act.

ARTICLE XII
DEFINITIONS

12.1 "Accident" means an event involving factors external to the Participant which:

(a) was unintended, unanticipated, unforeseen, unplanned, and unexpected;

(b) occurred at a specifically identifiable time and place;

(c) occurred by chance or from unknown causes; and

(d) was independent of sickness, mental incapacity, bodily infirmity or any other cause.

12.2 "Acknowledgement and Safety Pledge" means the form attached hereto.

12.3 "Adverse Benefit Determination" means a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. For example, this includes denial, reduction or termination of benefits based upon (a) a claimant's ineligibility to participate in the Plan, (b) application of any utilization review, (c) a medical service being experimental or investigational or not Medically Necessary or appropriate, or (d) the Participant no longer being Disabled.

12.4 "Appeals Committee" means one or more persons or an entity appointed by the Plan Administrator to make Determinations on appeal of benefit claims and to otherwise administer the Plan on behalf of the Plan Administrator and the Employer as described in this Plan. The Appeals Committee's fiduciary responsibility is limited to discretionary authority and ultimate decision-making authority with respect to any final appeals of denied claims. The Appeals Committee shall otherwise hold no further authority, responsibility or liability as related to the administration of the Plan.

The Appeals Committee shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues related to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a Covered Employee's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Appeals Committee as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested. Benefits under this Plan will be paid only if the Plan Administrator or the Appeals Committee decides, in its discretion, that the Covered Employee is entitled to them.

The Appeals Committee shall have the following duties with respect to the final appeals of denied claims: (1) To administer the Plan in accordance with its terms; (2) to determine all questions of eligibility, status and coverage under the Plan; (3) to interpret the Plan, including the authority to

construe possible ambiguities, inconsistencies, omissions, and disputed terms; (4) to make factual findings; (5) to decide disputes which may arise relative to a Covered Employee's rights; (6) to review referred appeals and to uphold or reverse any denials; and (7) to keep and maintain records pertaining to the referred appeals.

12.5 "Approved Provider" means a person duly licensed under applicable state law as a Medical Doctor or Doctor of Osteopathy and either expressly approved by the Claims Administrator, included on an approved list of providers adopted by the Claims Administrator, or otherwise approved in writing by the Claims Administrator upon the request of a Participant. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any list of Approved Providers at any time.

12.6 "Average Weekly Wage" means a Participant's average earnings from the Employer for the six consecutive weeks immediately preceding the date of the Occurrence that gave rise to the Bodily Injury; provided, however, that if a Participant has worked for the Company for at least one but fewer than six weeks immediately preceding the date of Injury, a weekly average will be based upon the earnings received over his or her period of employment; provided, further, that if such a participant has been employed for less than one week or if his or her earnings as of such date have not been fixed or cannot be reasonably determined (in the judgment of the Claims Administrator), such six-week average will be based upon the earnings received over such period by a similar employee of the Company.:

(a) for a salaried Participant, the hourly wage shall be the earnings paid to the Participant during the most recent six weeks period, or shorter period if employed less than six weeks, prior to the Occurrence, divided by the number of work hours applicable to that salary if known, or by forty (40) hours per week, if not known; and

(b) for a Participant paid on commission, the Participant's hourly wage shall be his or her gross earnings divided by the number of full weeks the Participant has been employed up to fifty two (52) weeks to arrive at an Average Weekly Wage.

Average Weekly Wage shall include overtime, tips, and commission as reported to the Internal Revenue Service. Overtime earnings shall be computed by dividing the overtime earnings by the number of weeks worked by the Participant in the same employment under the contract of hire in force at the time of the Bodily Injury, not to exceed a period of 52 weeks preceding the Bodily Injury.

The reasonable value of board, rent, housing, lodging, or similar advantage received from the Employer shall also be included, as well as the amount of tips required to be reported by the Employer under Section 6053 of the Internal Revenue Code and the regulations promulgated pursuant thereto or the amount of actual tips reported, whichever amount is greater.

12.7 "Beneficiary" means a Surviving Spouse and/or dependent Child or Children, or legal guardian.

12.8 "Benefits Schedule" means the page(s) attached to the front of this Plan, setting forth certain Company information and benefit limits, and signed by any participating employer adopting the Plan. The Benefits Schedule and the other terms of the Plan will be construed as a single document.

Each provision of the Benefits Schedule corresponds to the referencing provisions in this official Plan document and the related Summary Plan Description booklet.

12.9 "Bodily Injury" means damage or harm to the physical structure of the body, or Prosthetic appliances, including eyeglasses, contact lenses, or hearing aids, caused solely as the result of either an Accident, Cumulative Trauma or Occupational Disease arising in the Course and Scope of Employment.

(a) Date of Bodily Injury. Any provision of this Plan to the contrary notwithstanding, in order to be subject to this plan document, the date of such Bodily Injury must be on or after the Effective Date specified in Item No. 8 of the Benefits Schedule. For all purposes of this Plan, the date of Bodily Injury shall be either (i) the date of the Accident resulting in the Bodily Injury, (ii) the date that the damage or harm, or symptoms thereof, were first known to (or should have been known to) the Participant or diagnosed by any provider as Cumulative Trauma, or (iii) the date that the damage or harm, or symptoms thereof, were first known to (or should have been known to) the Participant or diagnosed by any provider as an Occupational Disease. All Injuries sustained by a Participant that relate to (i) an Accident, or related series of Accidents, (ii) exposure to an environmental or physical hazard that causes an Occupational Disease, or (iii) rapid, repetitious, physically traumatic activities that result in Cumulative Trauma shall be considered a single Bodily Injury for purposes of the Plan.

(b) A mental injury or illness is not a Bodily Injury unless caused by a physical injury to the Participant, and shall not be considered a Bodily Injury arising out of and in the Course and Scope of Employment or compensable unless demonstrated by a preponderance of the evidence; provided, however, that this physical injury limitation shall not apply to any victim of a crime of violence.

(c) No mental injury or illness shall be compensable as a Bodily Injury unless it is also diagnosed by a licensed psychiatrist and unless the diagnosis of the condition meets the criteria established in the most current issue of the Diagnostic and Statistical Manual of Mental Disorders.

12.10 "Child" or "Children" means:

(a) a natural or adopted son or daughter of the Participant under 18 years of age;

(b) a natural or adopted son or daughter of a Participant 18 years of age or over who is physically or mentally incapable of self-support;

(c) any natural or adopted son or daughter of a Participant 18 years of age or over who is actually dependent; or

(d) any natural or adopted son or daughter of a Participant between 18 and 23 years of age who is enrolled as a full-time student in any accredited educational institution.

The term Child or Children includes a posthumous child, a child legally adopted or one for whom adoption proceedings are pending at the time of death, an actually dependent stepchild or an actually dependent acknowledged child born out of wedlock.

12.11 "Claims Administrator" means the individual, individuals or entity appointed by the Company to make initial Determinations of benefit claims under this Plan on behalf of the Company and the Employer.

12.12 "Company" means the entity named in Item No. 1 of the Benefits Schedule or any successor thereto.

12.13 "Continuing Medical Maintenance" means medical treatment that is reasonable and necessary to maintain the Participant's condition resulting from the compensable Bodily Injury after reaching Maximum Medical Improvement. Continuing medical maintenance shall not include diagnostic tests, surgery, injections, counseling, physical therapy, or pain management devices or equipment.

12.14 "Course and Scope of Employment" means an activity of any kind or character for which the Participant was hired and that relates to and derives from the work, business, trade or profession of the Employer, and that is performed by a Participant in the furtherance of the affairs or business of the Employer. The term includes activities conducted on the premises of the Employer or at other locations designated by the Employer and travel by a Covered Employee in furtherance of the affairs of the Employer that is specifically directed by the Employer. This term does not include:

(a) a Participant's transportation to and from his or her place of employment,

(b) travel by a Covered Employee in furtherance of the affairs of the Employer if the travel is also in furtherance of personal or private affairs of the Employee,

(c) any Bodily Injury occurring in the parking lot or other common area adjacent to the Employer's place of business before the Covered Employee clocks in or otherwise begins work for the Employer or after the Covered Employee clocks out or otherwise stops work for the Employer, or

(d) any Bodily Injury occurring while a Covered Employee is on a work break, unless the Bodily Injury occurs while the Covered Employee is on a work break inside the Employer's facility and the work break is authorized by the Employee's supervisor.

12.15 "Covered Employee" means any person, including a minor, in an Employer's service under any contract of hire or apprenticeship, written or oral, expressed or implied, but excluding one whose employment is casual and not in the course of an Employer's trade, business, profession, or occupation. Such person must be principally employed at one of an Employer's covered locations in the State of Oklahoma, or at a location outside of Oklahoma for a period of less than 90 consecutive days during the policy period of an insurance policy referred to in section 8.2, under an Employer's direction and control, and receiving pay by means of a salary, wage, or commission directly from an Employer and for whom an Employer files a Form W-2 with the Internal Revenue Service. A Covered Employee must be acting within his or her Course and Scope of Employment at the time and place of the Occurrence causing the Bodily Injury. Provided, however, the term Covered Employee specifically excludes sole proprietors, partners, members of a LLC and executive officers, unless included by endorsement to an insurance policy referred to in section 8.2. Provided further that under no circumstances shall the term Covered Employee include a leased employee, a temporary employee hired through a temporary services company, an independent contractor, or a third-party agent.

12.16 "Cumulative Trauma" means a Bodily Injury that is caused by the combined effect of repetitive physical activities extending over a period of time in the Course and Scope of Employment. Cumulative trauma shall not mean fatigue, soreness, or general aches and pain that may have been caused, aggravated, exacerbated or accelerated by the Participant's Course and Scope of Employment. Cumulative trauma shall have resulted directly and independently of all other causes and the Participant shall have completed at least one hundred eighty (180) days of continuous active employment with the Employer. Any provision of this Plan to the contrary notwithstanding, if the Employer has purchased an insurance policy, the purpose of which (in whole or in part) is to pay Plan benefits to Participants or indemnify the Employer for Plan benefits, then the Participant's last injurious exposure to the repetitive physical activities must have been in the Course and Scope of Employment and taken place during the policy period.

12.17 "Determination" means a decision of the Claims Administrator or Appeals Committee on whether benefits are payable to, or with respect to, a claimant under the Plan.

12.18 "Disability" or "Disabled" means Bodily Injury resulting from an Occurrence which, based upon objective medical findings, causes:

(a) **Temporary total disability** – Incapacity to earn, in the same or any other employment, substantially the same amount of wages the Participant was receiving at the time of the compensable Bodily Injury. The Participant must be under the continuous care of a physician during the period of temporary total disability.

(b) **Temporary partial disability** – Temporary inability to perform the Participant's normal job, but the Participant may perform alternative work offered by the Employer. The Participant must be under the continuous care of an Approved Physician during the period of temporary partial disability.

(c) **Permanent disability** – Expressed as a percentage, the loss of a portion of total physiological capabilities of the human body, established by Objective Findings.

(d) **Permanent partial disability** – An amputation or permanent loss of use of a scheduled member identified in Section 3.2(c); or permanent disability or loss of use after Maximum Medical Improvement has been reached which prevents the Participant from returning to his or her pre-Bodily Injury or equivalent job. For this purpose, "pre-Bodily Injury or equivalent job" means the job the Participant was working at the time of the Bodily Injury or other employment offered by the Employer that pays at least 100% of the Participant's Average Weekly Wage.

(e) **Permanent total disability** – Incapacity to earn wages in any employment for which the Participant may become physically suited and reasonably fitted by education, training, experience and vocational rehabilitation. Loss of both hands, both feet, both legs or both eyes, or any two thereof, shall be deemed to constitute permanent total disability.

The Claims Administrator may require a Participant to submit proof of continued Disability and of continuous care of a Participant. This may be done as often as the Employer

considers necessary and reasonable. Failure to submit the requested proof will cause the Employer to suspend indemnification until such proof is received.

12.19 "Disability Benefits" means any benefit payable under Section 3.2.

12.20 "Disfigurement Benefits" means any benefit payable under Section 3.3.

12.21 "Emergency Care" means a service or supply provided with respect to a medical condition manifesting itself by a sudden and unexpected onset of acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably be expected to (i) result in death, disfigurement, or permanent disability, or (ii) result in substantial impairment of any bodily organ, part, or function. **This Emergency Care determination solely relates to satisfaction of the Plan's approved medical provider requirements, and the consideration of an exception for Emergency Care. Urgent Care Claims may not arise to the level of involving Emergency Care. A Participant's decision to seek treatment from an urgent care clinic or hospital emergency room does not necessarily result in an Urgent Care Claim or involve Emergency Care. That determination shall be made within the sole administrative discretion of the Claims Administrator or Appeals Committee, with such advice and consultation from an Approved Provider as the Claims Administrator or Appeals Committee deems appropriate.**

12.22 "Employer" means the Company and any incorporated or unincorporated trade or business that (1) is a member of a control group (with the meaning of Section 3(40) of ERISA) with respect to which the Company is also a member, and (2) maintains Employees whose employment with the Employer is principally located within the State of Oklahoma. The Employer includes a person, partnership, association, limited liability company, corporation, and the legal representatives of a deceased employer, or the receiver or trustee of a person, partnership, association, corporation, or limited liability company, department, instrumentality or institution of Oklahoma and divisions thereof, counties and divisions thereof and other political subdivisions of Oklahoma and public trusts employing a person included within the term Covered Employee as defined in this Plan.

12.23 "Formulary" - the Plan Administrator may develop a formulary for purposes of this Plan. In the event a formulary is adopted and a Participant is prescribed a drug outside the formulary, the Participant may request written consent of the Plan Administrator for use of the non-formulary drug. A denial by the Plan Administrator of a request for use of a non-formulary drug shall be subject to appeal as set forth in Section 9.2(c).

12.24 "**Major Cause"** means more than fifty percent (50%) of the resulting injury, disease or illness. A finding of major cause shall be established by a preponderance of the evidence. A finding that the workplace was not a major cause of the injury, disease or illness shall not adversely affect the exclusive remedy provisions under the Employe Injury Benefit Act and shall not create a separate cause of action for a Participant or Beneficiary.

12.25 "Maximum Medical Improvement" means no further material improvement would reasonably be expected from medical treatment or the passage of time.

12.26 "Medical Benefits" means any benefit payable under Section 3.1.

12.27 "Medical Expense" means a Participant's expense for medical or dental services, procedures or supplies, provided the expense is Medically Necessary, Usual and Customary and prescribed by an Approved Provider.

(a) The term Medical Expense includes:

(1) Confinement within a hospital or Skilled Nursing Facility and the cost of Medically Necessary supplies and ambulance hire and those expenses incurred for rehabilitation; and

(2) Reimbursement for the actual mileage in excess of twenty (20) miles round-trip to and from the Participant's home to the location of a medical service provider for all reasonable and necessary treatment, for an evaluation of an independent medical examiner, and for any evaluation made at the request of the Employer. The rate of reimbursement for such travel expense shall be the official reimbursement rate as established by the State Travel Reimbursement Act. In no event shall the reimbursement of travel for medical treatment or evaluation exceed six hundred (600) miles round trip.

(b) The term Medical Expense does not include:

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

(2) Any part of a Medical Expense that is in excess of the Usual and Customary charge for that good, product or service;

(3) Charges for:

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

(B) Hypnosis, acupuncture, or chiropractic treatment, unless referred by an Approved Provider and pre-authorized in writing by the Claims Administrator;

(C) The purchase, rental or repair of environmental control devices, including but not limited to, air conditioners, humidifiers or air purifiers; or

(D) Services performed by a person who normally lives with an injured Participant, the spouse of an injured Participant, a parent of an injured Participant or the injured Participant**'s** spouse, a child of the injured Participant or the injured Participant's spouse or a brother or sister of the injured Participant or of the injured Participant's spouse; and

(E) any Preexisting Condition;

12.28 "Medically Necessary" means the services, procedures or supplies, which are:

(a) required, recognized, and professionally accepted nationally by providers as the usual, customary and effective means of diagnosing or treating the condition;

(b) the most economical supplies or levels of service that are appropriate and available for the safe and effective treatment of the Participant; and

(c) not primarily for the convenience of a Participant, the Participant's family, a provider, or a facility.

Even though an Approved Provider may have prescribed a particular treatment, such treatment may not be considered Medically Necessary within this definition or may otherwise be excluded from coverage under the terms of this Plan.

12.29 "Misconduct" shall include the following:

(a) unexplained absenteeism or tardiness;
(b) willful or wanton indifference to or neglect of the duties required;
(c) willful or wanton breach of any duty required by the employer;
(d) the mismanagement of a position of employment by action or inaction;
(e) actions or omissions that place in jeopardy the health, life, or property of self or others;
(f) dishonesty;
(g) wrongdoing;
(h) violation of a law; or
(g) a violation of a policy or rule adopted to ensure orderly work or the safety of self or others.

12.30 "Modified Duty" means work which is either --

(a) a temporary accommodation that allows a Covered Employee to perform his or her regular job; or

(b) an alternate, temporary job that complies with the Employee's work restrictions and Employer needs.

12.31 "Non-Occupational" means, with respect to an activity, Accident, incident, circumstance or condition involving a Participant that it does not occur or arise out of the Participant performing occupational services or in the Course and Scope of Employment for the Employer.

12.32 "Non-Occupational Injury" means Bodily Injury caused by a non-occupational accident occurring while this Plan is in force as to the Covered Employee whose injury is the basis of the claim and resulting directly and independent of all other causes in a covered loss.

12.33 "Objective Findings" means those findings which cannot come under the voluntary control of the patient.

(a) (1) When determining permanent Disability, an Approved Provider, any other medical provider, the Commission or the courts shall not consider complaints of pain.

(2) For the purpose of making permanent Disability ratings to the spine, the Approved Provider shall use criteria established by the most current edition of the American Medical Association "Guides to the Evaluation of Permanent Impairment".

(b) (1) Objective evidence necessary to prove permanent Disability in occupational hearing loss cases may be established by medically recognized and accepted clinical diagnostic methodologies, including, but not limited to, audiological tests that measure air and bone conduction thresholds and speech discrimination ability.

(2) Any difference in the baseline hearing levels shall be confirmed by subsequent testing; provided, however, such test shall be given within four (4) weeks of the initial baseline hearing level test but not before five (5) days after being adjusted for presbycusis.

(c) Medical opinions addressing compensability and permanent disability shall be stated within a reasonable degree of medical certainty.

12.34 "Occupational Death Benefits" means any benefit payable under Section 3.4.

12.35 "Occupational Disease" means a condition marked by a pronounced deviation from the normal healthy state or normal pregnancy of a Participant that results in Disability or death and arises out of and in the Course and Scope of Employment of the Participant or naturally follows or unavoidably results from a Bodily Injury. A causal connection between the occupation or employment and the Occupational Disease shall be established by a preponderance of the evidence. No benefit shall be payable for any contagious or infectious disease unless contracted in the Course and Scope of Employment. No benefit shall be payable for any ordinary disease of life to which the general public is exposed outside of a Participant's assigned duties in the Course and Scope of Employment or a disease resulting directly from an Accident. The disease must be due to the nature of an employment in which the hazards of the disease actually exist and are characteristic thereof and peculiar to the trade, occupation, process, or employment and is actually incurred in the Course and Scope of Employment. This includes any disease due to or attributable to exposure to or contact with any radioactive material by a Participant in the Course and Scope of Employment. Disablement or death must result within three years in case of silicosis or asbestosis, or one year in case of any other Occupational Disease. Any provision of this Plan to the contrary notwithstanding, if the Employer has purchased an insurance policy, the purpose of which (in whole or in part) is to pay Plan benefits to Participants or indemnify the Employer for Plan benefits, then the Participant's last injurious exposure to the hazards of the disease must have been in the Course and Scope of Employment and taken place during the policy period.

12.36 "Occurrence" means an Accident, or related series of Accidents, resulting in Bodily Injury to a Participant that arises out of the Participant’s Course and Scope of Employment and takes place during the policy period. As respects Occupational Disease or Cumulative Trauma, “Occurrence” means the Participant’s last day of last exposure to the conditions causing or aggravating such Occupational Disease or Cumulative Trauma.

12.37 "Official Disability Guidelines" means the current edition of the Official Disability Guidelines and the ODG Treatment in Workers' Comp as published by the Work Loss Data Institute.

12.38 "Participant" means a Covered Employee who satisfies the eligibility requirements of Article I.

12.39 "Plan" means the employee injury benefit plan established or continued by the Employer in the form of this document, including the Benefits Schedule. The name of the Plan is the Oklahoma Employee Injury Benefit Plan. The Plan created by each adopting Employer is a separate Plan, independent from the plan of any other employer adopting this document, unless the adopting Employer is adopting the same Plan sponsored by a related member of a control group (within the meaning of Section 3(40) of ERISA), as provided in Section 13.6.

12.40 "Plan Administrator" means the Company.

12.41 "Plan Year" means a 12 calendar month period beginning on the Effective Date in Item No. 8 of the Benefits Schedule and each anniversary thereafter, provided, however, that the Company may specify a different Plan Year for past, current, or future years by formal written action of a representative authorized to act on behalf of the Company and communicated to Participants in writing.

12.42 "Post-Service Claim" means any claim for a Medical Benefit that is not a Pre-Service Claim.

12.43 "Preexisting Condition" means any illness, injury, disease, or other physical or mental condition, whether or not work-related, for which medical advice, diagnosis, care or treatment was recommended or received preceding the date of Bodily Injury, or where a Participant manifested such symptoms such that the Bodily Injury, Occupational Disease or condition was reasonably capable of diagnosis by a health care practitioner or in the opinion of the health care practitioner the Participant could reasonably have been expected to be aware of its existence.

12.44 "Pre-Service Claim" means any claim for Medical Benefits with respect to which this Plan requires Claims Administrator approval in advance of obtaining medical care.

12.45 "Prosthetic" means an artificial device used to replace a part or joint of the body that is lost or injured in a covered Accident or illness.

12.46 "Relevant" shall mean, with respect to the relation of a document, record or other information to a claimant's claim, that such document, record or other information:

(a) was relied upon in making a benefit determination on the claimant's claim;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the actual benefit determination;

(c) demonstrates compliance with the Plan's administrative processes and safeguards required for making the benefit determination; or

(d) 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 the benefit determination.

The individual records or information specific to the resolution of one claimant's claim shall not be considered relevant to another claimant's claim.

12.47 "Representative" means a person that a Participant authorizes in writing to act on his/her behalf. The Plan will also recognize a legally valid power of attorney or a court or administrative agency order giving a person authority to take an act on a Participant's behalf. In the case of an Urgent Care Claim, a provider with knowledge of the Participant's condition may act as the Participant's Representative.

12.48 "Skilled Nursing Facility" means a section, ward, or wing of a hospital, or a free-standing health care facility, which:

(a) provides room and board;

(b) provides nursing care by or under the supervision of a nurse;

(c) provides physical, occupational, and speech therapy furnished by the facility or by others under arrangements made by the facility;

(d) provides medical social services;

(e) provides drugs, biologicals, supplies, appliances and equipment ordinarily furnished for use in such a facility;

(f) provides medical services by staff Approved Providers;

(g) has an agreement with a hospital for diagnostic and therapeutic services, the transfer of patients, and exchange of clinical records;

(h) provides other services necessary to the health and care of patients that are generally provided by such facilities; and

(i) is licensed or registered in accordance with local and state laws and regulations.

12.49 "Surviving Spouse" means a spouse by reason of legal marriage recognized by the State of Oklahoma or under the requirements of a common law marriage in Oklahoma.

12.50 "Urgent Care Claim" shall mean any claim for medical care or treatment with respect to which application of the time periods for making non-urgent Pre-Service Claim Determinations (i.e., generally, 15 days after the Claims Administrator's receipt of the claim):

(a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(b) in the opinion of a 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.

The determination of whether a claim is an Urgent Care Claim within the meaning of subsection (a) above shall be made by the Claims Administrator applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. However, if a provider with knowledge of the claimant's medical condition determines that a claim is an Urgent Care Claim and clearly communicates such determination to the Claims Administrator, such claim shall be treated as an Urgent Care Claim for purposes of this Plan. **The characterization of a claim as an Urgent Care Claim solely impacts the timeframes and other procedures for claims processing under ARTICLE IX, and in no way changes this Plan's approved medical provider, pre-authorization, or other medical management requirements. These requirements generally provide that (1) except in the case of Emergency Care, no amount shall be considered a Medical Expense unless treatment is pre-approved by the Claims Administrator and furnished by or under the direction of an Approved Provider, and (2) all determinations relating to the physical condition of a Participant, upon which the payment of benefits is based, must be made by an Approved Provider. Urgent Care Claims may not arise to the level of involving Emergency Care. A Participant's decision to seek treatment from an urgent care clinic or hospital emergency room does not necessarily result in an Urgent Care Claim or involve Emergency Care. The determination of whether a claim involves Emergency Care shall be made within the sole administrative discretion of the Claims Administrator or Appeals Committee, with such advice and consultation from an Approved Provider as the Claims Administrator or Appeals Committee deems appropriate.**

12.51 "Usual and Customary" the expense is usual when it is the fee regularly charged that the patient is responsible to pay, in the absence of insurance or other third party reimbursement, to a health care provider or physician for a given treatment, service or supply; and customary in relation to what other physicians and health care providers in the same geographic area charge for the same and similar treatment, service or supply.

The Plan Administrator shall not be bound by any fee schedule adopted by the Oklahoma Administrative Workers' Compensation Act or any amendment or successor thereto when determining Usual and Customary.

ARTICLE XIII
GENERAL PROVISIONS

13.1 Inability to Make Payment. In the event an individual becomes entitled to a payment under this Plan and such payment cannot be made (i) because the address provided by the individual is incorrect, (ii) because the individual fails to respond to a notice sent to the address provided by the individual, (iii) because of conflicting claims to such payment, or (iv) because of any other reason, the amount of such payment, if and when made, shall be the amount determined under the provisions of ARTICLE III without interest thereon. If, within two years after any amount becomes payable hereunder to an individual, the same shall not have been claimed, provided the Claims Administrator has exercised reasonable diligence in attempting to make such payment, the amount thereof shall be forfeited and shall cease to be a liability of this Plan.

13.2 Claims Administrator and Appeals Committee Indemnity. The Employer shall indemnify and hold harmless any employee designated as the Claims Administrator or the Appeals Committee, and any other employee of the Employer to whom the Claims Administrator or Appeals Committee has delegated administrative authority with respect to the Plan, against any claim, cost, expense (including reasonable attorneys' fees), judgment or liability (including any sum paid in settlement of a claim with the approval of the Company) arising out of any act or omission to act of the Claims Administrator or Appeals Committee under this Plan, except in the case of willful misconduct. The Employer shall be jointly and severally liable for any amounts owed pursuant to this Section.

13.3 Spendthrift Provision. Except as expressly provided for in this Plan, no right or interest of any Participant or Beneficiary under this Plan may be assigned, transferred or alienated, in whole or in part, either directly or by operation of law, and no such right or interest shall be liable for or subject to any debt, obligation or liability of such Participant or Beneficiary.

13.4 Employment Noncontractual. The establishment of this Plan shall not enlarge or otherwise affect an Employee's "at will" employment by the Employer, and the Employer may terminate the employment of any Employee at any time and/or modify the Employee's working relationship as desired, at-will for any or no reason (with or without cause), as freely and with the same effect as if this Plan had not been established.

13.5 Discharge for Benefit Payments. If the Claims Administrator determines that a Participant is unable to apply a benefit payment under this Plan in furtherance of his or her own interest and advantage, the Claims Administrator may direct all or any portion of such payment to be made (i) to the guardian of the person, managing conservator or guardian of the estate of the Participant, (ii) to a relative or friend of the Participant, to be expended for the Participant's benefit, (iii) to a custodian for the Participant under any Uniform Gifts to Minors Act, or (iv) to a trust established for the Participant. The Claims Administrator shall not be obligated to see to the proper application or expenditure of any payment so made. Any payment made pursuant to the power herein conferred upon the Claims Administrator or Appeals Committee shall operate as a complete discharge of all obligations of the Plan and the Claims Administrator and Appeals Committee, to the extent of the payments so made.

13.6 Participation By Affiliates. Any incorporated or unincorporated trade or business who is a member of a control group (within the meaning of Section 3(40) of ERISA), with respect to which the Company is also a member, shall automatically be considered the Employer under this Plan as of the date that such Employer maintains Employees who employment with the Employer is principally located within the State of Oklahoma. Such entity shall automatically cease to be considered the Employer under this Plan as of the date that such Employer no longer maintains Employees whose employment with the Employer is principally located within the State of Oklahoma.

13.7 Plan Documents Control. This written Plan document constitutes the entire Plan, and no oral or written representation or promise concerning the Plan which is inconsistent with the provisions of this Plan document shall have any effect. The provisions of this Plan document shall be the sole source of all legally enforceable rights with respect to the benefits herein provided.

13.8 Construction. The titles to the Articles and the headings of the Sections in this Plan are placed herein for convenience of reference only and in case of any conflict the text of this

instrument, rather than such titles or headings, shall control. Whenever a noun or pronoun is used in this Plan in plural form and there be only one person or entity within the scope of the word so used, or in singular form and there be more than one person or entity within the scope of the word so used, such word or pronoun shall have a plural or singular meaning as appropriate under the circumstance.

13.9 Separability. If for any reason any provision of this Plan is determined to be invalid or contrary to applicable law, such invalidity shall not impair the operation of or otherwise affect the remaining provisions of this Plan.

13.10 Applicable Law. This Plan shall be governed and construed in accordance with the provisions of ERISA and, except where superseded by federal law, the laws of the State of Oklahoma.

13.11 Application of Health Insurance Portability and Accountability Act. This Plan is exempt from the group health plan requirements of Part 7 of ERISA by operation of one or a combination of the excepted benefits listed in ERISA Section 733(c)(1) and is therefore exempt from the standards, rules, regulations and other requirements of the Health Insurance Portability and Accountability Act.

13.12 Application of Patient Protection and Affordable Care Act. This Plan is exempt from the group health plan requirements of the Public Health Service Act by operation of one or a combination of the excepted benefits listed in Title 42 of the United States Code Section 300gg-91(c)(1) and is therefore exempt from the standards, rules, regulations and other requirements of the Patient Protection and Affordable Care Act.

13.13 Application of Other Group Health Plan Requirements. This Plan is exempt from the group health plan requirements of any other standards, rules, regulations or other requirements that utilize or reference the excepted benefits definition listed in ERISA Section 733(c)(1).

APPENDIX A

ACKNOWLEDGEMENT AND SAFETY PLEDGE

RECEIPT OF MATERIALS. By my signature below, I acknowledge that I have received and read (or had the opportunity to read) the Benefits Schedule and Summary Plan Description (the "SPD") for the Oklahoma Employee Injury Benefit Plan effective on the Effective Date specified in Item No. 8 of the Benefits Schedule. Furthermore, I understand that it is my responsibility to read the SPD. Should I have any questions regarding the provisions or requirements of the SPD, I should direct those questions to the person identified in Item 5 on the Benefits Schedule.

BODILY INJURY NOTICE AND MEDICAL PROVIDERS. I understand and agree that if I am injured on the job, I must notify my supervisor within 24 hours of the time of the incident and receive any medical care from a Plan-Approved Provider within 30 days of my Bodily Injury in order to receive benefits under the Plan.

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

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

OKLAHOMA INJURY BENEFIT PLAN

Benefits Schedule

Company Information	
1. Company Name	Brookhaven Hospital, Inc.
2. Address	201 South Garnett Road, Tulsa, OK 74128
3. Telephone Number	415-209-9802
4. Federal Tax I.D. Number	74-2362662
5. Name and Telephone Number of Contact Person for Employee Questions	Anne Shaheen 415-209-9802
6. Name and Address of Agent for Service of Legal Process	Anne Shaheen 201 South Garnett Road, Tulsa, OK 74128
7. Plan Number	501

Benefits Limits	
8. Effective for Injury Occurrence On or After	6/15/2014
9. Medical Benefits	100% of Covered Charges
10. Disability Benefits * Participants may receive a higher percentage of pay or be subject to a shorter waiting period or higher maximum weekly amount pursuant to a payroll practice adopted by the Company and any Participating Employers. Contact the person in Item 5 above regarding availability (if any).	a. Waiting Period: 3 **days**
	b. Percentage of Average Weekly Wage: Temporary Total Disability **70%** — Permanent Partial Disability **70%** Temporary Partial Disability **70%** — Permanent Total Disability **70%**
	c. Maximum Weekly Indemnity: Temporary Total Disability **$561** — Permanent Partial Disability **$323** Occupational Death **$801** — Permanent Total Disability **$801**

Please see the attached Official Plan Document for other benefit limitations and exclusions.

The Company hereby adopts this Plan by signature of its authorized representative.

X _____ _____

(Signature and Title) Date

SCHEDULE OF PARTICIPATING EMPLOYERS

The following Employer(s) hereby adopt(s) this Plan by signature of their authorized representative(s):

(Additional insured 1)

X _____ _____

(Signature and Title) Date

(Additional insured 2)

X _____ _____

(Signature and Title) Date

(Additional insured 3)

X _____ _____

(Signature and Title) Date

(Additional insured 4)

X _____ _____

(Signature and Title) Date