# DALLAS COUNTY HOSPITAL DISTRICT
# DISABILITY PLAN

Amended and Restated
Effective as of January 1, 2020

## TABLE OF CONTENTS

**Page**

## ARTICLE I.

## NAME AND PURPOSE OF THE PLAN

Section 1.01 Name. This Plan shall be known as the Dallas County Hospital District Disability Plan (hereinafter referred to as the ‘‘Plan”).

Section 1.02 Purpose. The purpose of the Plan is to provide Bi-Weekly Disability Benefits arising from occupational or non-occupational accident or sickness to those Eligible Employees who are Participants in the Plan and are Totally Disabled.

Section 1.03 Establishment and Effective Date. This Plan was originally established effective January 1, 1982 and was thereafter amended and restated effective February 1, 2003 and January 1, 2008. This Plan document amends and supersedes the most recent Plan document in its entirety and is effective January 1, 2020 and applies to all Eligible Employees, Plan Participants, Claimants and their Claims.

Section 1.04 Entire Plan. This Plan document constitutes the entire Plan established by the Employer. No other statement, writing or agreement shall vary or add to its terms unless in writing and signed by a person with authority to act on behalf of Employer and the Plan Participant.

Section 1.05 Plan Available. The Employer shall make a copy of this Plan available to Eligible Employees.

Section 1.06 Word Usage. Wherever appropriate, the masculine pronoun as used herein shall include the feminine, and the singular shall include the plural.

## ARTICLE II.

## DEFINITIONS

As used in the Plan, the following terms shall have the meanings described in Article II unless otherwise specifically provided.

Section 2.01 Actively At Work. An Eligible Employee will be considered actively at work on a day that is one of the Employer’s scheduled workdays if the Eligible Employee is performing in the usual way all the regular duties of the Eligible Employee’s job on that day. An Eligible Employee will be deemed to be actively at work on a day that is not one of the Employee’s scheduled workdays if the Eligible Employee was actively at work on the preceding scheduled workday.

Section 2.02 Basic Bi-Weekly Earnings. For Participants who are employed as full-time employees or House Staff employees, Basic Bi-Weekly Earnings shall be equal to 80 hours of work at the Participant’s basic hourly rate of pay on the Participant’s last day as a full-time employee or House Staff employee before the Participant’s Disability.

For Participants who are employed as part-time with benefits, Basic Bi-Weekly Earnings shall be equal to 40 hours of work at the Participant's basic hourly rate of pay on the Participant's last day as a benefits eligible part-time employee before the Participant's Disability.

For a Participant who is enrolled for continuation coverage under Article VI, Basic Bi-Weekly Earnings shall be determined using the Participant's rate of pay in effect on the last date of active employment.

In all events, Basic Bi-Weekly Earnings shall exclude bonuses, overtime, severance pay, differential pay and any contributions made by the Employer to or under any form of Eligible Employee benefit plan or program and shall be determined without regard to any reduction agreement between the Employer and the Eligible Employee pursuant to a plan described under Sections 125, 132, 403(b) and 457(b) of the Code.

Section 2.03 Bi-Weekly Disability Benefit(s). The benefit payments provided by the Plan after the completion of the Qualifying Period with respect to Total Disability, which shall be based on a specified percentage of the Eligible Employee's Basic Bi-Weekly Earnings.

Section 2.04 Board. The Board of Managers of the Employer, the Dallas County Hospital District d/b/a the Parkland Health & Hospital System

Section 2.05 Buy Down Option. The feature of this Plan that allows Participants to elect to decrease their Qualifying Period to 14 days by choosing to participate in the Buy Down Option in accordance with procedures prescribed by the Employer and timely paying the premium for such Buy Down Option in the amounts and manner specified by the Employer.

Section 2.06 Buy Up Option. The feature of this Plan that allows Participants to elect to increase their Bi-Weekly Disability Benefits to 60% of Basic Bi-Weekly Earnings by choosing to participate in the Buy Up Option in accordance with procedures prescribed by the Employer and timely paying the premium for such Buy Up Option in the amounts and manner specified by the Employer.

Section 2.07 Care and Treatment. Care and treatment are appropriate under the terms of this Plan if it meets all the following:

a. it is received from a Physician whose medical training and clinical experience are suitable for treating the specific condition;

b. it is necessary to meet basic health needs and demonstrated medical value;

c. it is consistent in type, frequency, and duration of treatment with relevant guidelines of nationally accepted, peer-reviewed research or healthcare coverage organizations (insurers and HMO's), and governmental organizations;

d. it is consistent with the diagnosis of the Participant's condition; and

e. it is for the purpose of maximizing medical improvement and return to work when medically possible and appropriate.

Section 2.08 Claimant. Claimant has the meaning specified in Section 7.06a.

Section 2.09 Code. The Internal Revenue Code of 1986, as now in effect and as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute or statutes of similar import. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provision of any legislation which amends, supplements or replaces such section or subsection.

Section 2.10 Committee. The Administrative Appeals Committee appointed by the Parkland CEO under authority delegated by the Board to serve as the decisionmaker for the Plan, which is vested with discretionary authority to decide appeals, determine questions of Eligibility and fact under the Plan, and interpret the Plan's provisions.

Section 2.11 Core Disability Option. The basic disability income protection plan provided by the Employer in which all Eligible Employees are enrolled, subject to Section 3.01, at no cost to the Eligible Employee. The Core Disability Option has a 42-day Qualifying Period and following the completion of the waiting period provides Bi-Weekly Disability Benefits in the amount of 50% of the Disabled Participant's Basic Bi-Weekly Earnings.

Section 2.12 Continuous Service. An Eligible Employee's uninterrupted period of service with the Employer to the extent such service is recognized as continuous service by the Employer in accordance with its policies as they may be modified from time to time.

Section 2.13 Disability means Total Disability.

Section 2.14 Disabled means Totally Disabled.

Section 2.15 Eligible Employee. All full-time, House Staff, and benefits eligible part-time employees of the Employer. The Employer's employment classification of an individual shall be binding and controlling for all purposes and shall apply irrespective of any contrary classification of such individual by a court of competent jurisdiction or other tribunal, a governmental agency or any other person or entity. If, for any period of time, an individual has not been treated as a common law employee on the Employer's books and records and a court or government agency subsequently makes a determination that the individual was in fact a common law employee during that period of time, such determination shall not entitle the individual to any retroactive rights under this Plan.

Section 2.16 Employer. The Dallas County Hospital District, a political subdivision of the State of Texas, and for purposes of this Plan its controlled affiliates, including by way of example the Parkland Foundation, the Parkland Community Health Plan, Inc., and the Parkland Center for Clinical Innovation.

Section 2.17 Employment. The service of an Eligible Employee with the Employer.

Section 2.18 House Staff. Medical physicians engaged in post-doctoral training programs who are employed by the Employer as W-2 employees.

Section 2.19 Mental Illness. Any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations or psychological, behavioral or emotional disorder, but excluding demonstrable structural brain damage. Such conditions may include by way of example a psychiatric or psychological condition, regardless of cause, such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Section 2.20 Participant. Any Eligible Employee who has become a "participant" in the Plan pursuant to Article III and whose participation in the Plan has not been terminated.

Section 2.21 Physician. A practitioner of a healing art who is properly and actively licensed and practicing within the scope of that license. For purposes of the Plan, no person who is a Physician shall be eligible to be a Physician with respect to himself, herself, his or her spouse or any family member of himself or herself or any person sharing living quarters with the Physician. For purposes of the Plan, the Physician must be qualified to treat the Participant's condition that results in a Disability. In addition, the Physician must prescribe a course of appropriate care and treatment for the Disabled Participant.

Section 2.22 Plan Year. The Plan Year shall be the period commencing each January 1 and ending the next following December 31.

Section 2.23 Preexisting Condition. Preexisting Condition means: (a) any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or (b) any manifestation, symptom, finding, or aggravation related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse, for which the Participant received "Medical Care" during the six (6) month period that ends on the day before the Participant's effective date of coverage; or the Participant's effective date of a change in coverage. For purposes of the foregoing, "Medical Care" is received when a Physician is consulted or medical advice is given; or treatment is recommended, prescribed by, or received from a Physician. Treatment includes but is not limited to medical examinations, tests, attendance or observations and use of drugs, medicines, medical services, supplies or equipment.

Section 2.24 Qualifying Period. A period of 42 consecutive days in the case of the Core Disability Option (or 14 days with the Buy Down Option) from the first day of absence for reason of Total Disability during which the Participant was eligible under the Plan.

Section 2.25 Regular and Customary Work. The Eligible Employee's usual assigned duties, including requirements, specifications, methods, job, work, hours of work, manner and level of performance prior to the onset of the Disability.

Section 2.26 Self-reported Symptom. The manifestation of a Participant's condition disclosed to the Participant's Physician that is not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of a Self-reported Symptom include, but are not limited to, headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

Section 2.27 Social Security Normal Retirement Age ("SSNRA") can be found at this link: https://www.ssa.gov/planners/retire/agereduction.html and may also be called "full" retirement age, which varies depending on the year of birth.

Section 2.28 Substance Abuse. The pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

a. impairments in social and/or occupational functioning;

b. debilitating physical condition;

c. inability to abstain from or reduce consumption of the substance; or

d. the need for daily substance use to maintain adequate functioning.

Section 2.29 Totally Disabled or Total Disability. The Participant is prevented by:

a. accidental bodily injury;

b. sickness;

c. Mental Illness;

d. Substance Abuse; or

e. pregnancy;

from engaging in any gainful occupation or profession for which he or she is reasonably fitted by education, experience, capability or training (except approved Rehabilitative Employment as determined by the Employer) on the basis of periodic medical examinations to which a Participant must submit in order to establish that a Participant is, or continues to be, Disabled and thus to be eligible to receive Bi-Weekly Disability Benefits under this Plan. A Participant who is employed by an employer other than the Employer will be conclusively presumed not to be Totally Disabled unless such other employment is approved in writing in advance by the Committee. The Committee reserves the right to require that a Participant undergo a medical examination provided by a Physician of the Committee's choosing and/or provide, at such times and in such

manner as the Committee may reasonably require, supporting medical records proving his or her continuing Total Disability and such other records as are relevant to the Participant's Claim. The failure of a Participant to cooperate with the Committee's request will result in termination of his or her benefits pursuant to Article V.

Section 2.30. Vendor. As used in this Plan, Vendor is that entity engaged by the Employer to provide defined services to the Plan, which may include by way of example, initial claims determination, contact with Participants, arranging Independent Medical Examinations and Eligibility Audits. Other than considering appeals, interpreting the terms of the Plan, resolving factual disputes relevant to a claim for Total Disability under the Plan, and making final determinations regarding Eligibility, the Committee may delegate its other duties set forth in this Plan to the Vendor.

## ARTICLE III.

## ELIGIBILITY AND PARTICIPATION

Section 3.01 Eligibility. Each Eligible Employee shall be eligible for participation in the Plan on the date he or she has completed three (3) months of Continuous Service. If an Eligible Employee terminates employment and is rehired at a later date, the Eligible Employee will be required to complete three (3) months of Continuous Service following his or her rehire date before recommencing participation in the Plan unless his or her temporary break in service is disregarded in accordance with the Employer's rehire policy as it may be amended from time to time.

Section 3.02 Participation. Each Eligible Employee shall become a Participant on the date he or she satisfies the eligibility requirements of Section 3.01, if he or she is then Actively At Work. An Eligible Employee otherwise eligible but not Actively At Work at the time of eligibility (for reasons other than injury or disease) will become eligible on the first day thereafter when he or she is Actively At Work. An Eligible Employee who is not Actively At Work for reasons of injury or disease at the time of eligibility will become eligible when he or she has performed the duties of his or her position for as long a period as he or she was absent from work, up to a maximum of 30 days.

Section 3.03 Termination of Participation. A Participant's participation in this Plan shall terminate at the earliest of the following dates:

a. the date the Participant's employment with the Employer terminates ( subject to Article VI); provided, however, that a Participant's employment shall not be considered to be terminated for purposes of the Plan during any period of time in which the Participant has reemployment rights that are protected by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA");

b. the date of the Participant's retirement from employment with the Employer;

c. the date a Participant becomes ineligible for continued participation in this Plan by reason of a change in employment status;

d. the date of the Participant's death; or

e. the date of the Plan's termination.

Section 3.04 Audit. The Employer or a Vendor acting on behalf of the Employer, reserves the right to conduct audits at reasonable times to confirm the Participant remains Totally Disabled, otherwise remains a Participant and to verify other information relevant to the Claim. The scope of the Audit will include active as well as former employees on "terminated with pay" status.

## ARTICLE IV.

## CONTRIBUTIONS

Section 4.01 Eligible Employee Contributions. No Eligible Employee contributions are required for the Core Disability Option. Contributions are required for Eligible Employees who enroll in the Buy Up Option and/or the Buy Down Option. Coverage under the Plan for Eligible Employees who enroll in either the Buy Up Option and/or the Buy Down Option but who do not make payment of the required contributions by the date specified by the Employer shall be determined without regard to the Eligible Employee's election for the Buy Up Option and/or the Buy Down Option, as applicable.

Participants may make or change an election for the Buy Up Option and/or the Buy Down Option during the Employer's annual enrollment period or within 31 days after a change in family status. An election or change during the Employer's annual enrollment period will be effective as of the January 1 following the annual enrollment period.

A change in family status occurs upon:

a. the Participant's marriage or divorce;

b. the birth or adoption of the Participant's child;

c. the death of the Participant's spouse or child;

d. the Participant initially becoming no longer responsible for providing the primary financial support of a child; or

e. an employment status change involving the Eligible Employee or the Eligible Employee's spouse (for example, a change in an Eligible Employee's status from part-time to part-time with benefits).

## ARTICLE V.

## BI-WEEKLY DISABILITY BENEFITS

Section 5.01 Commencement and Duration. If a Participant is Totally Disabled and under the care of a Physician pursuant to Section 5.10(a) at all times during and after

the Participant's Qualifying Period, the Participant shall be eligible to receive Bi-Weekly Disability Benefits for the period of the Participant's Total Disability commencing with the first day following completion of the Participant's Qualifying Period and continuing thereafter until the earliest of:

a. the date that the Participant is no longer Totally Disabled;

b. the date that the Participant fails or refuses to provide the Committee with medical records or other requested information in English in a timely manner, defined to mean within 30 days of the date the request was made, and otherwise reasonably acceptable to the Committee proving his or her continuing Total Disability or other information called for by the Plan as requested by the Committee (or its delegate), or fails or refuses to undergo an Independent Medical Exam as described in Sec. 5.09;

c. the date of the Participant's death; or

d. the Participant's attainment of Social Security Normal Retirement Age ("SSNRA") or the period shown in the table below, whichever time is later~~:~~

| **Age at Total Disability** | **Duration of Total Disability Benefits (assu all Plan terms and conditions are met** |
|---|---|
| Less than 62 | until SSNRA |
| 62 but less than 63 | 3 years 6 months |
| 63 but less than 64 | 3 years 0 months |
| 64 but less than 65 | 2 years 6 months |
| 65 but less than 66 | 2 years, 0 months |
| 66 but less than 67 | 1 year, 9 months |
| 67 but less than 68 | 1 year, 6 months |
| 68 but less than 69 | 1 year, 3 months |
| 69 and over | 1 year, 0 months |

Section 5.02 Providing Evidence of Total Disability and Other Requested Information. As a condition to eligibility to receive Bi-Weekly Disability Benefits under this Plan, a Participant must furnish medical records and other requested information in English in a timely manner, defined as 30 days from the date the request is made, which are reasonably acceptable to the Committee or the Vendor proving his or her continuing Total Disability or other information relevant to the Claim at such time or times as required by the Committee or the Vendor or undergo an Independent Medical Exam as described in Section 5.09; provided that the Committee may request such records from time to time as determined by the Committee or the Vendor in their sole discretion. In the event that the Participant fails to timely provide such medical records or other information that are acceptable to the Committee or the Vendor, no further benefit payments shall be made to the Participant under this Plan.

Section 5.03 Application for Social Security. A Participant who is Totally Disabled must provide written proof of the Participant's timely application for Social Security benefits to the Employer within six (6) months after the initial onset of the Participant's Disability. In addition, a Participant who has applied for Social Security benefits must notify the Employer within thirty (30) days after any action or decision by the Social Security Administration affecting the Participant with respect to Social Security benefits. A Participant who fails to provide documentation required by this section will no longer be eligible for any benefits under this Plan with respect to that Disability.

Section 5.04 Manner of Payment. Bi-Weekly Disability Benefits shall be paid on a bi-weekly basis, concurrent with the normal payroll schedule of the Employer during the period for which Bi-Weekly Disability Benefits are payable. Payments for a partial pay period shall be computed on a daily basis of one fourteen ($1/14^{th}$) of the Bi-Weekly Disability Benefit.

Section 5.05 Amount of Bi-Weekly Disability Benefits. The amount of Bi-Weekly Disability Benefits payable to a Participant who is Totally Disabled shall be equal to:

a. 50% of the Participant's Basic Bi-Weekly Earnings as defined in Section 2.02 (60% of the Participant's Basic Bi-Weekly Earnings if the Participant has elected the Buy Up Option), reduced (but not below zero) by

b. the aggregate of any "Other Bi-Weekly Income Benefits" as defined in Section 5.06.

Section 5.06 Other Bi-Weekly Income Benefits. The term "Other Bi-Weekly Income Benefits" shall mean the amount of any benefit for loss of income that is provided to a Participant, or to which the Participant is or may be entitled regardless of whether the Participant has actually applied for such amount, as a result of the period of Disability for which the Participant is claiming benefits under this Plan, regardless of whether paid on a bi-weekly basis or in some other manner. This includes the amount of any benefit for loss of income from:

a. any plan or arrangement of coverage, whether insured or not, as a result of employment by or association with the Employer, or as a result of membership in or association with any group, association, union or other organization;

b. the Veteran's Administration or any other foreign or domestic governmental agency for the same disability, including any amount paid by the United States government to, or on behalf of, any Participant who is injured in connection with his or her service in the "uniformed service" of the United States. The term "uniformed service" shall have the meaning specified in USERRA;

c. any governmental law or program that provides disability or unemployment benefits as a result of the Participant's job with the Employer;

d. any temporary or permanent disability benefits under a workers' compensation law, occupational disease law, or similar law, including any amount or benefit payable as a result of an occupational accident or injury by an employer that is a non-subscriber within the meaning of applicable workers' compensation laws, regardless of whether the sickness or injury resulting in the payment of the benefit for loss of income arose in connection with the Participant's employment with the Employer or any other employer;

e. any amounts paid under compulsory "no-fault" automobile insurance

f. the portion of a settlement or judgment of a lawsuit that represents or compensates for the Participant's loss of earnings;

g. any salary paid to the Participant under any salary continuance program or short-term accident and/or sickness programs sponsored by the Employer;

h. any Social Security benefit payable under the federal Social Security Act (other than benefits payable to a Participant's dependent(s) on account of the Participant's disability) and/or any benefits payable under any other national, state or municipal law or regulation providing similar benefits, whether or not the Participant has made application therefore; provided, however, that after a Participant becomes entitled to Bi-Weekly Disability Benefits under the Plan, the amount of his or her benefit will not be reduced by any increase in the benefits payable under the federal Social Security Act made effective after commencement of payment of benefits hereunder, so long as the Plan remains in force;

i. any other payments for disability or severance of employment (including, for example, payments in exchange for a release of employment-related claims in connection with severance of employment) toward which the Employer contributed, unless the Committee or a separate agreement signed by the Employer and Employee shall have expressly excluded them in whole or in part;

j. any retirement income benefit under an Employer-sponsored pension, savings or other retirement plan.

Any single sum payment and any payments received on a basis other than bi-weekly shall be allocated by the Committee in its sole discretion to bi-weekly periods.

A Participant must notify the Committee of all Other Bi-Weekly Income Benefits provided to the Participant or to which the Participant is or may be entitled on account of any disability within thirty (30) days after the Participant becomes aware of such amounts. If a Participant mistakenly receives greater benefits than he or she is eligible to receive under the Plan, then the Participant, upon written demand from the Committee, must repay to the Employer the amount of such overpayments. Without limiting the preceding sentence, the Committee may also make any adjustments that it deems necessary in the case of Other Bi-Weekly Income Benefits that have not previously been taken into

account in determining the amount of the Participant's Bi-Weekly Disability Benefits, including but not limited to a reduction or discontinuance of further benefits.

The Committee reserves the right to require that a Participant provide, at such times and in such manner as the Committee may reasonably require, supporting information concerning the application for or receipt of Other Bi-Weekly Income Benefits. The failure of a Participant to cooperate with the Committee's request will result in termination of his or her benefits.

Section 5.07 Return of Bi-Weekly Disability Benefits Paid After Death. The Estate of the Participant or any person who receives any payment under this Plan on behalf of a deceased Participant is obligated to return such amount to the Employer.

Section 5.08 Recurrent Disability. If, following a period of Total Disability after the Qualifying Period, a Participant resumes employment with the Employer for a continuous period of six (6) months or more, any subsequent Total Disability resulting from (i) the same cause or causes or (ii) any unrelated cause shall be considered a new period of Total Disability and shall be subject to a new Qualifying Period. If, however, following a period of Total Disability after the Qualifying Period, a Participant resumes employment with the Employer for a continuous period of less than six (6) months, any subsequent Total Disability resulting from the same cause or causes (but not an unrelated cause) will be considered a continuation of the original Total Disability and the Participant will not be required to complete a new Qualifying Period. Participants who are receiving Bi-Weekly Disability Benefits pursuant to this Plan and who are no longer employed by the Employer will only be eligible for benefits pursuant to the Plan for an illness or injury related to the original diagnosis of Disability.

Section 5.09 Independent Medical Examination. The Committee may from time to time require any Participant who is receiving Bi-Weekly Disability Benefits to undergo one or more independent medical examinations by a Physician designated by the Committee or the Plan's Vendor. If a Participant does not submit to a requested independent medical examination within 45 days of the date of the request, the Participant will no longer be eligible to receive Bi-Weekly Disability Benefits with respect to that injury or illness or any condition resulting from that injury or illness. If the Committee finds from such independent medical examination, or otherwise, that the Participant receiving Bi-Weekly Disability Benefits no longer is Disabled, the Participant will no longer be eligible for Bi-Weekly Disability Benefits under this Plan with respect to that injury or illness or any condition resulting from that injury or illness.

Section 5.10 Limitations.

a. Care Of A Physician. A Participant who is Totally Disabled must be under the ongoing care of a Physician for such Total Disability during the Qualifying Period and at all times thereafter during which the Participant believes that he or she may be entitled to Bi Weekly Disability Benefits from this Plan. No Bi-Weekly Disability Benefits will be paid for any period of Disability when the Participant is not under the ongoing care of a Physician. If a Participant who is Totally Disabled is not under the ongoing care of a

Physician for any period of 45 days, the Participant will no longer be eligible to receive Bi-Weekly Disability Benefits with respect to that injury or illness or any condition resulting from that injury or illness. In addition, during any period of Disability, a Participant must be receiving appropriate care and treatment. If a Participant who is Totally Disabled is not receiving appropriate care and treatment as determined by the Vendor, the Participant will no longer be eligible to receive Bi-Weekly Disability Benefits with respect to that injury or illness or any condition resulting from that injury or illness.

b. Mental Illness. Payment of Bi-Weekly Disability Benefits is limited to 24 months for each period of Total Disability caused or contributed to by a Mental Illness. However, if a Participant is confined in a hospital at the end of the 24 months, this limitation will not apply while the Participant is continuously confined. For this Section 5.10b, the term "hospital" means a legally operated and accredited facility providing full-time medical care and treatment, under the direction of a full-time staff of licensed physicians, for the condition causing the Participant's Total Disability. Rest homes, nursing homes, skilled nursing facilities, homes for the aged, and facilities primarily affording custodial, educational or rehabilitative care are not hospitals.

c. Alcohol Use, Alcoholism Or Drug Use. Payment of Bi-Weekly Disability Benefits is limited to 12 months during a Participant's entire lifetime for all disabilities caused or contributed to by the Participant's use of alcohol, alcoholism, use of any illegal drug including hallucinogens or drug addiction, or use of a legal drug in a manner that is not as prescribed or directed.

d. Rehabilitation. No Bi-Weekly Disability Benefits will be paid for any period of Disability when the Participant is not receiving appropriate treatment under the care of a Physician and is not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by the Employer unless the Disability prevents the Participant from participating.

e. Self-reported Symptom. Payment of Bi-Weekly Disability Benefits is limited to 24 months for each period of Total Disability caused or contributed to by a Self-reported Symptom. However, if a Participant is confined in a hospital at the end of the 24 months, this limitation will not apply while the Participant is continuously confined. For this Section 5.10(e), the term "hospital" has the meaning set forth in subsection b. above.

Section 5.11 Exclusions. Except as otherwise provided in this Plan, no Bi-Weekly Disability Benefits shall be payable to a Participant if it is determined by the Committee that the Participant's Total Disability is due to:

a. injury, sickness, Mental Illness, Substance Abuse or pregnancy not being treated on an ongoing, continuous basis by a Physician;

b. disability caused by or contributed to by war or act of war (declared or not) other than disability resulting to a Participant from acts of terrorism or disability incurred by a Participant who is injured in connection with his or her service in the "uniformed service" of the United States;

c. disability caused by the Participant's commission of or attempt to commit a criminal act, or to which a contributing cause was the Participant's being engaged in an illegal occupation;

d. disability caused or contributed to by an intentionally self-inflicted injury;

e. disability caused by any elective surgery or procedure, cosmetic surgery, services which are not medically necessary or which are not approved by the attending Physician, or services which are not generally accepted in the United States, or which are still considered experimental or investigational and not "generally accepted" by the medical profession. A necessary service is considered necessary only if it is broadly accepted professionally as essential to the treatment of an injury or illness. Notwithstanding anything in this subsection to the contrary, disability caused by gastric or lap-band surgery that is recommended to the Participant by a Physician is not excluded from the Plan; or

f. was caused or contributed to by a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the day the Participant became Disabled, the Participant has been continuously covered under the Plan for 12 months.

Section 5.12 Correction of Errors and Recovery of Payments. As a condition of participating in the Plan, each Participant acknowledges and agrees that if an incorrect amount is paid to or on behalf of the Participant or to the Participant's Estate or surviving heirs, any remaining payments may be adjusted to correct the error and the Estate or surviving heirs must refund the overpayments. Employer is also authorized to take such other action it deems necessary and equitable to correct any such error, including but not limited to offsetting wages or other amounts payable to the Participant to the extent permitted by applicable law.

## ARTICLE VI.

## CONTINUATION

Section 6.01 Purpose. The purpose of this Article VI is to permit individuals who have completed at least five (5) years of Continuous Service with the Employer and whose coverage would otherwise end pursuant to Section 3.03(a) or 3.03(c) (hereinafter referred to as "Former Participants") to voluntarily elect to continue their coverage.

Section 6.02 Election. Each Former Participant may elect to continue his or her coverage under the Plan by applying in writing for continued participation within thirty-one (31) days following his or her termination of employment or change in employment status to part-time without benefits.

Section 6.03 Duration of Coverage. Subject to timely payment of premiums by the Former Participant and other applicable requirements under the Plan, a Former Participant's coverage under this Article VI may continue for a period up to five (5) years following his or her timely enrollment for continuation coverage.

Section 6.04 Payment of Premiums. Former Participants will be required to pay a monthly premium to the Employer for the continuation coverage described in this Article VI. A former Participant's continuation coverage will be cancelled and cannot be reinstated if the Former Participant fails for any reason to make any such required payment in a timely manner. Monthly premiums for continuation coverage shall be due on the first day of the month to which such coverage relates. Coverage will terminate for all purposes retroactive to the first day of the month if the Former Participant does not pay the monthly premium by the last day of the month in which the payment is due. Payment for any initial partial month of coverage will be due within thirty-one (31) days after the date of the Former Participant's initial continuation coverage election; otherwise, continuation coverage will be retroactively terminated for all purposes.

Section 6.05 Qualifying Period. Notwithstanding any provision of the Plan to the contrary, no Buy Down Option is available for continuation coverage under this Article VI of the Plan.

Section 6.06 Commencement and Duration. Subject to Section 6.05, payment and duration of benefits shall be as provided in Section 5.01.

## ARTICLE VII.

## ADMINISTRATION OF THE PLAN

Section 7.01 Committee. The Board delegated its authority to appoint the Committee to Employer's CEO, who has appointed a Committee of individuals which are responsible for hearing appeals, deciding questions of Eligibility and fact and interpreting the terms of the Plan. The CEO may at any time remove an individual as a member of the Committee or substitute another individual therefore but shall not do so based in whole or in part on any decision rendered by the Committee or by the individual during service on the Committee.

Section 7.02 Powers and Duties of the Committee. The Committee is charged with and has delegated to it the exclusive power, duty, authority and discretion to interpret and construe the provisions of this Plan, to determine its meaning and intent and to make application thereof to the facts of any individual case; to resolve all issues of fact and Eligibility; to determine in its discretion the rights and benefits of Participants and Eligible Employees. All decisions of the Committee in matters properly coming before it according to the terms of this Plan, and all actions taken by the Committee in the proper exercise of its powers, duties and responsibilities, will be final and binding upon all Eligible Employees, Participants and upon any person having or claiming any rights or interest in this Plan; will be given deference in all courts of law or other tribunals, to the greatest extent allowed by applicable law. The Employer will make and receive any reports and information and retain any records necessary or appropriate to the administration of this Plan or to the performance of duties hereunder or to satisfy any requirements imposed by law. In the performance of its duties, the Committee will be entitled to rely on information duly furnished by any Eligible Employee, Participant, Claimant or their representatives, or by the Employer.

Section 7.03 Actions of the Committee. The Committee may adopt such rules as it deems necessary, desirable, or appropriate with respect to the conduct of its affairs and its decision making regarding the Plan. Whenever any action to be taken in accordance with the terms of the Plan requires the consent or approval of the Committee, or whenever an interpretation is to be made of the terms of the Plan, the Committee will act in a non-discriminatory manner, treating all Eligible Employees and Participants in similar circumstances in a like manner. The decisions of the Committee will be made by a majority vote. The Employer will have the authority to employ one or more persons or Vendors to render advice or services about the responsibilities of the Committee, including but not limited to attorneys, actuaries, and accountants., and may likewise discharge any engaged persons or entities.

Section 7.04 Reliance on Committee and Employer. Any persons employed to render advice or services will be fully protected in acting upon the written directions and instructions of the Employer made in accordance with the terms of this Plan.. Any persons employed to render advice or services may take cognizance of any rules established by the Employer or the Committee and rely upon them until notified to the contrary. Any persons employed to render advice or services will, to the extent permitted by law, be fully protected in taking any action upon any paper or document believed to be genuine and to have been properly signed and presented by the Employer or any agent of the Employer acting on its behalf..

Section 7.05 Expenses. The reasonable expenses incident to the operation of the Plan and the enrolled actuary, attorney, accountant, advisers, Vendors and such other technical clerical assistance as may be required may be paid from the Plan, but the Employer, in its discretion, may elect at any time to pay part or all of such expenses directly. The Employer shall advise the Committee as to the extent, if any, which it will pay expenses of the Plan. In the absence of such advice, or to the extent that expenses exceed those which the Employer has elected to pay, the Plan shall pay all expenses of the operation of the Plan. Any such election shall not bind the Employer as to its right to elect, with respect to the same or other expenses at any time, to have such expenses paid from the Plan.

Section 7.06 Benefit Claims Procedure.

a. Filing a Claim. All claims shall be submitted by a Participant or a duly authorized representative of such Participant (herein, a "Claimant") by following such procedures as the Committee shall require. Such procedures shall be reasonable and may include but are not limited to the completion of forms and the submission of documents and other information. Claimant must submit all required documentation including the Participant's claim form and appropriate medical records proving the Participant's Disability to the Committee (or the designated Vendor) within 45 days after the onset of the Participant's Disability. If the Participant's claim form and appropriate documentation is not filed with the Committee (or designated Vendor) within that period of time or at such other times as may be

requested by the Committee, the Claimant will not be eligible for a Biweekly Disability Benefits from the Plan with respect to that injury or illness or any condition resulting from that injury or illness. Neither the Employer nor the Committee shall have any responsibility at any time for completing the claim form or obtaining the Participant's medical records.

A Participant's claim will be reviewed first and an initial decision regarding the claim will be made by a Vendor that has been engaged by the Employer to assist the Committee in evaluating disability claims under the Plan. Participants seeking disability benefits pursuant to the Plan must comply with requests made by the disability management Vendor for medical records and independent medical examinations and for all other requested documentation or information. It is the responsibility of the Participant and not the Employer, the Committee or the disability management Vendor to supply requested medical records, attend independent medical examinations and to provide all other requested documentation. A Participant will not be eligible for a Biweekly Disability Benefits pursuant to the Plan with respect to the Participant's disability if the Participant fails or refuses to supply the disability management Vendor with requested medical records or obtain a requested independent medical examination or fails to supply other requested information (by way of example, regarding other payments which might be offset against the Plan's payment) with 45 days from the date of the request by the disability management Vendor.

The Committee shall have full discretion and authority to determine all matters of fact, questions of eligibility or interpretation of the Plan's terms.

The Committee has delegated to the disability management Vendor the responsibility to act on behalf of the Committee in making the initial and follow up Claim decisions described in subsection b. below.

b. Review of Claim by Vendor.

(i) Period for Review of Claim (initial or for ongoing Total Disability Bi-Weekly Benefits). The disability management Vendor shall generally decide the Claim within 45 days of receipt and notify the Participant of the decision in writing. If the Claim is denied, or the Vendor determines that the Participant no longer qualifies for benefits under the Plan, the notice shall set forth the specific reason(s) for the decision, the pertinent provisions of the Plan on which the decision is based, a description of any additional information necessary to perfect the Claim or obtain an extension of benefits under the Plan and why such information is necessary, an explanation of the appeal procedures and applicable time limitations.

(ii) Extension of time to decide Claim and consequences of failure to provide requested information at initial Claim stage or to verify continuing Disability/qualification for benefits or to

apply for Social Security or other Bi-Weekly Income benefits to which the Claimant may be entitled.

(A) Extension of time. If the disability management Vendor determines that an extension of time to make the Claim decision is necessary due to special circumstances beyond the Employer's or the Vendor's control, it shall provide a written notice of the extension to the Claimant. The notice shall state the reason more time is needed, the date by which a decision is expected, the unresolved issues that prevent a decision on the Claim, and any additional information needed to resolve those issues. The extension shall be for a reasonable period determined by the Committee or the Vendor.

(B) Claimant's Failure to Provide Necessary Information extends period for decision. The Vendor's inability to render a decision may be the result of the Claimant's failure to submit necessary information. The Claimant shall have 45 days following issuance by the Vendor of a notice described in Subsection 5.06b(ii)(A) above to submit the necessary information. The period for the Vendor to render a decision on the claim shall be tolled from the date the notice that additional information is needed is sent to the Claimant until the date on which the Claimant responds to the notice.

(C) Claimant's failure to Provide Necessary Information may result in denial of initial Claim or denial of ongoing Disability benefits under the Plan. The Vendor may also periodically request information to determine if the Claimant remains qualified to receive Disability benefits under the Plan. If the Claimant fails to submit the necessary information within the 45-day time limit for either the initial Claim or to verify that the Claimant is still qualified for benefits under the Plan or for other requested information, the Vendor may deny the claim.

(D) Claimant's failure to apply for Social Security disability benefits or for other Bi-Weekly Income benefits to which Claimant may be entitled. Claimant is required to apply for Social Security disability benefits and for any other Bi-Weekly Income Benefits to which Claimant may be entitled. The Plan will reduce the amount of benefits it pays to Claimant by the amount paid to the Claimant by the Social Security Administration or any other benefits plan (also known as "offsetting" disability benefits). The Vendor may periodically request information from Claimant to show

that Claimant has applied for Social Security disability benefits or any other Bi-Weekly Income benefits to which Claimant may be entitled. Should the Claimant not provide the requested information within 45 days, the Vendor may reduce the benefits paid under the Plan by the amount the Vendor estimates Claimant would receive for Social Security disability benefits or any other Bi-Weekly Income benefits to which Claimant may be entitled. The offset amount will be determined in the Vendor's sole discretion.

c. Appeal of Denied Claim, Determination that Claimant no longer qualifies for Disability under the Plan or has failed to provide requested documentation or fails to file for Social Security or other Bi-Weekly Income benefits to which the Claimant may be entitled. If a Claim is denied or the Vendor determines that the Participant is no longer qualified for benefits under the Plan or the Vendor offsets the amount of benefits paid under the Plan by amounts which are or could have been received by the Claimant, the Claimant may initiate an appeal by submitting a written request for review to the Vendor within 90 days after the denial is issued to the Claimant. The Vendor will forward the appeal to the Committee. The Claimant may send a written statement of the issues and any other documents in support of the claim. The Claimant shall be entitled to copy and review all relevant documents, records and other information provided by the Vendor to the Committee free of charge. If the Claimant fails to file an appeal in writing within the 90-day timeframe, the denial of either the initial Claim or any Claim for an extension will stand and the Claimant shall be deemed to have forever waived any and all claim to future benefits.

d. Review of Appeal.

(i) Manner of Review. The Committee shall hear the appeal. No member of the Committee who reviews the appeal may have been involved in the initial adverse benefit determination or be a subordinate of any individual who made such initial adverse benefit determination. The Committee shall not afford deference to the initial determination, and shall take into account all documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial determination. The review shall be made in accordance with the Plan documents, and the Committee shall apply Plan provisions consistently with respect to similarly situated Claimants. The Committee shall have full discretion to determine all matters of fact, questions of eligibility or interpretation of the Plan relating to the appeal.

(ii) Initial Period of Review. The Committee shall render its decision generally within 45 days after receipt of the appeal and shall send the Claimant a written notice of its decision. If the appeal is denied, in whole or in part, then the notice shall set forth the specific reasons for the decision, the pertinent provisions of the Plan on which the decision is based, a statement that the Claimant is entitled to copies of, and access to, all documents records and other information considered by the Committee regarding the Claim free of charge.

(iii) Extension. If the Committee determines that there are special circumstances requiring an extension of time for review and processing of the appeal, the Committee shall send the Claimant a written notice of the extension which gives the reasons for the delay and the date by which the Plan expects to render the determination on appeal. The extension shall be for a reasonable period determined by the Committee.

(iv) Regularly Scheduled Meetings. In the event that at the time such a request for review is filed the Committee has established a practice of holding regularly scheduled meetings, such decision shall be made at a regular meeting, unless special circumstances require a further extension of time for processing.

e. Form of Notice to Claimant. All notices to the Claimant shall be given in writing or electronically and shall be written in a manner calculated to be understood by the Claimant.

f. Process after a Claim is approved. Once a Claim is approved, the Plan will commence payment according to its terms and limits. The Vendor may at reasonable intervals request verification of ongoing Disability via medical records or via an independent medical examination, and may request other relevant information (including by way of example evidence the Claimant applied for and/or is receiving other Bi-Weekly Income payments which would be offset against the Plan's disability payments); such requests will be treated according to the Plan's terms for an initial Claim.

Section 7.07 Use of Outside Vendors. The Employer retains the ability to contract with necessary Vendors, including disability management providers, to assist in the determination of Disability and the amount and duration of Bi-Weekly Disability Benefits and to perform such other services deemed necessary or advisable in connection with the administration of the Plan.

Section 7.08 Reliance on Reports and Certificates. The Committee is entitled to rely conclusively upon all tables, valuations, certificates, opinions and reports which may be furnished by an enrolled actuary, accountant, controller, counselor, Vendor and other expert engaged for such purposes.

Section 7.09 Committee Members to Avoid Conflicts of Interest. No member of the Committee may act, vote or otherwise influence a decision of the Committee specifically relating to his own or a relative's or domestic partner's benefits under the Plan or of those of an employee that reports to the Committee member or to which the Committee member directly reports.

Section 7.10 Availability of Documents. A copy of the Plan and any and all future amendments shall be available to any Participant or Eligible Employee at reasonable times during normal business hours of the Employer.

Section 7.11 Required Exhaustion of Claims Procedures. No legal action may be brought by any Claimant or other person to recover from or with respect to this Plan: (i) prior to the date such Claimant or other person has first exhausted all claims procedures and administrative remedies available under this Plan; or (ii) after the date that is twelve (12) months following the date the Claimant or other person has received a final decision on appeal with respect to any adverse benefit determination; or (iii) more than three years after the date of the Eligible Employee's Total Disability.

Section 7.12 Restriction on Venue. Any legal action brought by a Claimant relating to or arising under the Plan may only be brought in a state or federal court located in Dallas County, Texas. No other court is a proper venue for any such claim. A state or federal court located in Dallas County, Texas, shall have personal jurisdiction over Claimant and any other Participant named in the action.

## ARTICLE VIII.

## AMENDMENT OR TERMINATION

Section 8.01 Amendment. The Employer reserves the right to amend or modify this Plan in any way whatsoever, which right is exercised through its Board, except to the extent that the Board delegates that authority in accord with its own governance procedures.

Section 8.02 Termination. The Plan may be terminated in its entirety for any reason at any time as the Board shall determine. Termination of the Plan shall be by way of written documentation adopted by the Board.

## ARTICLE IX.

## LIABILITY AND INDEMNIFICATION

Section 9.01 Standard of Conduct. To the extent permitted by applicable law, no member of the Committee or Board shall be liable for anything done or omitted to be done by him or her in connection with the Plan unless the act or omission amounted to a failure to act in good faith. To the fullest extent permitted by Texas law for political subdivisions of the State of Texas, the Employer agrees to indemnify each person made, or threatened to be made, a party to a civil action or proceeding or against whom any

claim or demand is made, by reason of the fact that he, his testator or intestate was or is a member of the Committee, the Board or an employee of the Employer involved in any way with the administration of the Plan, against judgments, liens, amounts paid in settlement and reasonable expenses, including attorneys' fees actually and necessarily incurred as a result of such action or proceeding, or any appeal therein, or as a result of such claim or demand, if such member of the Committee or Board acted in good faith for a purpose which he or she reasonably believed to be in accordance with the intent of the Plan.

Section 9.02 Presumption of Good Faith. The termination of any such civil action or proceeding or the disposition of any such claim or demand, by judgment or settlement shall not in itself create a presumption that any such member of the Committee or Board did not act in good faith for a purpose which he or she reasonably believed to be in accordance with the intent of the Plan or that he or she had reasonable cause to believe that his or her conduct was unlawful.

Section 9.03 Unsuccessful Defense. In the case of a person who has been unsuccessful in the defense of a civil action or proceeding or claim or demand of the character described in Section 9.01, any indemnification under Sections 9.01, unless ordered by a court of competent jurisdiction or other tribunal, shall be made by the Employer only if authorized in the specific case:

a. by the Board acting by a quorum consisting of Board members who are not parties to such action, proceeding, claim or demand, upon a finding that the member of the Committee or employee of the Employer or the Board member(s) has met the standard of conduct set forth in Section 9.01, or

b. if a quorum under (a) is not obtainable with due diligence by the Board upon the opinion in writing of independent legal counsel (who may be counsel to the Employer) that indemnification is proper in the circumstances because the standard of conduct set forth in Section 9.01 has been met by such member of the Committee, employee of the Employer or Board member.

Section 9.04 Advance Payments. Expenses incurred in defending a civil action or proceeding or claim or demand may be paid by the Employer in advance of the final disposition of such action or proceeding, claim or demand, if authorized by a quorum of Board members who are not involved in the action, proceeding, claim or demand.

Section 9.05 Repayment of Advance Payments. All expenses incurred in defending a civil action or proceeding, claim or demand, which are advanced by the Employer under Section 9.04 shall be repaid in case the person receiving such advance is ultimately found, under the procedure set forth in this Article, not to be entitled to indemnification or, where indemnification is granted, to the extent the expense so advanced by the Employer exceeds the indemnification to which he or she is entitled.

Section 9.06 Right to Indemnification. Notwithstanding the failure of the Employer to provide indemnification in the manner set forth in Sections 9.03 or 9.04, and

despite any contrary resolution of the Board in the specific case, if the member of the Committee, employee of the Employer or Board member has met the standard of conduct set forth in Section 9.01, the person made or threatened to be made a party to the action or proceeding or against whom the claim or demand has been made shall have the legal right to indemnification from the Employer as a matter of contract by virtue of this Plan and the adoption and approval thereof by the Board. Such person shall have the right to enforce his or her right of indemnification against the Employer in any court of competent jurisdiction or other tribunal.

Section 9.07 Other Remedies. The foregoing rights of indemnification which are enforceable only to the extent allowed by applicable law in the State of Texas shall not be deemed to limit or diminish any right of indemnification provided by law or otherwise.

## ARTICLE X.

## GENERAL PROVISIONS

Section 10.01 No Guarantee of Employment. The Plan shall not be deemed to constitute a contract between the Employer and any Eligible Employee or to be a consideration or inducement for the employment of any Eligible Employees by the Employer. Nothing contained in the Plan shall be deemed to give any Eligible Employee the right to be retained in the service of the Employer or to interfere with the rights of the Employer to discharge him at any time.

Section 10.02 Subrogation/Reimbursement.

a. For purposes of this Section 10.02,

(i) the term “Responsible Party” means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person’s injury, illness, or condition. The term “Responsible Party” includes the liability insurer of such party or any insurance coverage;

(ii) the term “Insurance Coverage” refers to any coverage for expenses resulting from a Covered Person’s injury, illness or condition including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payment coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage; and

(iii) the term “Covered Person” includes anyone to whom, or on whose behalf, the Plan pays or provides any benefit, including a Claimant, his or her Estate or surviving heirs.

b. Immediately upon paying or providing any Bi-Weekly Disability Benefits under this Plan, the Plan shall be subrogated to (stand in the place of) all rights of

recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the Plan.

c. In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition of a Claimant, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

d. By accepting benefits from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of any injury, illness or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

e. Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to any Disability for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

f. By accepting benefits from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's claim.

g. The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than lost income. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

h. The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition and/or Disability sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Plan, the Committee or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to prove this information may result in the termination of benefits for the Covered Person or the institution of court proceedings against the Covered Person.

i. . The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

j. The Covered Person acknowledges that the Plan has the right to investigate regarding the injury, illness or condition resulting in a Disability to identify any Responsible Party. The Plan reserves the right to notify any Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

k. In the event that any claims made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Committee for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

l. By accepting benefits from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction or other tribunal as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Section 10.03 Payments to Minors and Incompetents. If the Committee determines that any person to whom a payment is due hereunder is unable to care for his or her affairs because of Disability or because such person is a minor, the Committee shall have the authority to cause the payments to be made to such person's guardian or legal representative. Payments made pursuant to such power shall, to the extent thereof, operate as a complete discharge of the obligations of the Employer.

Section 10.04 Nonalienation of Benefits. No benefit payable under the Plan shall be subject in any manner to anticipation, assignment or pledge; and any attempt to anticipate, assign or pledge the same shall be void; and no such benefits will in any manner be liable for or subject to the debts, liabilities, engagements or torts of any Participant; and if any Participant is adjudicated bankrupt or attempts to anticipate, assign

or pledge any benefits, then such benefits shall, in the discretion of the Committee, cease, and in this event, the Committee shall have the authority to cause the same or any part thereof to be held or applied to or for the benefit of the Participant in such manner as the Committee may deem proper.

Section 10.05 Governing Law. The provisions of the Plan shall be construed and enforced according to the laws of the State of Texas.

Section 10.06 Titles and Headings. The titles to articles and headings of sections in the Plan are for convenience of reference and, in case of any conflict, the text of the Plan, rather than such titles and headings, shall control.