OFFICIAL PLAN DOCUMENT
ERISA

SERVICE LLOYDS INSURANCE COMPANY

ORENDA EDUCATION INC DBA ORENDA CHARTER SCHOOLS

Work Related Injury Plan

July 1, 2012

OFFICIAL PLAN DOCUMENT

PLAN NO. 501

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ORENDA EDUCATION INC DBA ORENDA CHARTER SCHOOLS
WORK RELATED INJURY PLAN

This, the Orenda Education Inc dba Orenda Charter Schools Work Related Injury Plan is made and executed at Georgetown, Texas by Orenda Education Inc dba Orenda Charter Schools, a corporation (the "Company").

WITNESSETH THAT:

WHEREAS, the Company has rejected coverage for its Texas employees under the Texas Workers' Compensation Act, effective as of July 1, 2012; and

WHEREAS, the Company desires to establish an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), effective as of July 1, 2012, to provide a means by which the Company and other adopting employers can protect themselves from certain liabilities as nonsubscribers to the Texas workers' compensation insurance system by providing non-fringe disability, death, dismemberment and medical benefits with respect to any covered injury sustained by Texas employees in the course and scope of employment;

NOW, THEREFORE, in consideration of the premises, the Company hereby establishes this Plan to provide benefits and be administered in accordance with the following:

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., July 1, 2012, or (B) the time and date of his or her employment as a Covered Employee. Except to the limited extent provided under Article V 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.

ARTICLE II
MAKING A CLAIM FOR BENEFITS

2.1 **Notice of Injury**. The Participant (or a person acting on his or her behalf in the event Participant is incapacitated) must report every accident or fact that the Participant believes results, or might reasonably be expected to result, in an Injury. The Participant must provide verbal notice **immediately** after being injured at work to his or her manager then on duty, no matter how minor the Injury appears to be. **For an Injury due to an Accident or for a known exposure to an Occupational Disease, verbal notice must be provided by the end of the work-shift for the date of the Injury. For an actual Injury due to Cumulative Trauma or Occupational Disease, verbal notice must be provided within the earlier of (1) 24 hours after being medically diagnosed, or (2) 15 days after the Participant should have known of the Injury**.

2.2 **Providing Required Information**: An injured Participant (or a person acting on his or her behalf in the event Participant is incapacitated) and such Participant's manager then on duty (or such other person as the Plan Administrator may specify) must complete such Injury report, investigation, and authorization forms, file such written statements, provide such recorded statements (whether sworn or unsworn), and provide such proof and demonstrations (relating to the Injury or any prior or subsequent damage or harm suffered by the Participant, in or out of the Scope of Employment), in such manner and within such periods, as the Plan Administrator may from time-to-time direct. **The written accident report must be provided within 24 hours after the 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 Plan Administrator determines that good cause exists for failure to provide such information in a complete and timely manner.**

2.3 **Filing a Claim for Benefits**. A claim for Medical Benefits, Disability Benefits, or Dismemberment Benefits under the Plan shall be initiated by a Participant by (i) complying with the notice requirements of Section 2.1, (ii) providing required information pursuant to Section 2.2, and (iii) submitting to medical treatment in accordance with ARTICLE III. A claim for Medical Benefits can also be directly submitted on the behalf of a Participant to the Plan Administrator by a health care professional. A claim for Death Benefits under the Plan shall be initiated by a Beneficiary providing notice of entitlement thereto to the Plan Administrator within 90 days after the date of the Participant's death.

ARTICLE III
MEDICAL MANAGEMENT

3.1 **First and Continuing Treatment**:

(a) The first Covered Medical Expense (as further described in Section 3.3 below) must be incurred within 30 days following the date of the Injury; and

(b) No further amount shall be considered a Covered Medical Expense if the Participant does not receive medical treatment from an Approved Provider (or scheduled treatment with an Approved Provider has not been approved by the Plan Administrator) for a period of more than 180 days following the date of injury. This subsection (b), however, shall not apply to any Covered Medical Expense for testing and any follow up vaccination with respect to an Injury that involves a potential occupational exposure to a bloodborne pathogen.

3.2 **Approved Provider and Pre-Authorization Requirements**. The cost of a service or supply shall be a Covered Medical Expense only if:

(a) treatment is pre-approved by the Plan 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 Plan 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 claimant; 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 75 mile distance from the location of the Participant at the time of Injury (taking into account available transportation and the nature of the Injury); and

(3) the Plan Administrator receives notification of such Emergency Care within the later of 24 hours of the Participant's receipt of such care or the next business day; and

(4) after receiving primary Emergency Care, subsequent treatments are provided by, or at the direction of, an Approved Provider in accordance Section 3.2 (a) above.

3.3 Covered and Non-Covered Medical Expenses. The Plan pays 100% of expenses incurred by a Participant up to the Plan maximum for medical or dental services, procedures or supplies prescribed by or provided under the direction of an Approved Provider or for Emergency Care (as described in Section 3.2) that are Medically Necessary (as determined by the Approved Provider), Usual and Customary, and do not exceed the charge specified in any fee schedule approved or adopted by the Plan Administrator. Covered Medical Expenses shall include, but not be limited to, confinement within a Hospital or Skilled Nursing Facility and the Usual and Customary cost of Medically Necessary supplies, and ambulance hire, and those expenses incurred for Rehabilitation; but shall not include charges for:

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

(b) hypnosis, acupuncture, chiropractic treatment or chiropractic therapy;

(c) services performed by a person who normally lives with the Participant, the spouse of the Participant, a parent of the Participant or of the Participant's spouse, a child of the Participant or of the Participant's spouse, or a brother or sister of the Participant or of the Participant's spouse unless approved in advance by the Plan Administrator.

3.4 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 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. Failure to do so may lead to denial of Plan Benefits. The Plan Administrator may require that the Participant present an authorization and report form to, and submit to any form of drug and alcohol testing by, the treating Approved Provider or Emergency Care provider at the time of primary medical treatment. The Plan 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 Plan Administrator determines to be reasonably necessary or appropriate during the pendency of a claim for benefits under the Plan.

3.5 Initial Treatment and Denial. Any provision of this Plan to the contrary notwithstanding, an Employer may render first aid, or the Plan may pay for Emergency Care, Disability Benefits or 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 Injury or otherwise deny any or all further benefits under the provisions of this Plan.

3.6 Medical Provider Referrals. If the treating Approved Provider finds it necessary to refer a Participant to another healthcare provider, the treating Approved Provider must notify such Participant and the Plan Administrator of his or her desire to make the referral and the objectives of such referral. The Plan 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 Plan 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.

3.7 No Interference with Patient-Provider Relationship. Although benefits under this Plan are conditioned on a Participant's use of only Approved Providers, 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. The Employers, Plan Administrator, and Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other healthcare services provided by any Approved Provider or other healthcare service provider. Healthcare providers are not agents of the Plan, Employer, Plan Administrator, or Committee, and they are not liable or responsible for the acts or omissions of any healthcare provider. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of the attending Approved Provider and other healthcare providers based on their independent judgment for the provision of health care.

3.8 Professional Medical Review and Quality/Efficiency Features. The Plan Administrator shall have the discretion to assign Approved Providers and other healthcare providers or firms to a Participant's case in order to (1) coordinate and expedite medical treatment of the Participant, in consultation with the treating Approved Provider,

(2) facilitate such case management, quality, and efficiency measures and procedures as the Plan Administrator deems appropriate, based upon particular facts and circumstances, and (3) review the propriety of any and all treatment, services, and supplies, including charges for such treatment, services, and supplies.

3.9 **Second Medical Opinions**. The Plan reserves the right to require a second medical opinion from an Approved Provider selected by the Plan 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 Plan Administrator for the second opinion, all benefits under the Plan may be suspended and/or terminated. The Plan 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 Plan Administrator ("Physician A"), then the Participant shall have the right to be examined at his or her own expense by another physician ("Physician B"). If the diagnosis and treatment recommended by Physician B is contrary to that of Physician A, then the Plan Administrator shall designate a peer review physician who will evaluate the medical records and advise the Plan 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 may be suspended and/or terminated. The diagnosis and/or recommended treatment of the peer review physician or this last Approved Provider will be controlling. The fees and related expenses of the peer review physician 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).

3.10 **Use and Disclosure of Protected Health Information**. See Appendix A attached hereto.

ARTICLE IV
COVERED INJURIES

4.1 **Covered Injuries**. This Plan pays benefits only on account of damage or harm to the physical structure of the body caused solely as the result of either (1) an Accident or (2) an Occupational Disease or Cumulative Trauma. Such damage or harm must be incurred in, and directly and solely result from, an Occurrence in the Scope of Employment. A "covered injury" is an injury sustained by a Participant that relates to (a) an Accident or related series of Accidents occurring closely in time, or (b) exposure to an environmental or physical hazard that causes an Occupational Disease.

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

(a) the Participant's willful intention and attempt to injure himself or herself or to injure another person, whether the Participant was sane or insane;

(b) the Participant's participation in:

(1) an assault or a felony; or

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

(c) Accidental bodily injury, Occupational Disease or Cumulative Trauma occurring while the Participant was in a state of intoxication, or had otherwise lost the normal use of his or her mental or physical faculties as a result of the use of a drug or alcohol. [Such intoxication or loss of faculties may be established on the basis of the facts and circumstances of the Injury, the testimony of witnesses, admissions or statements of the Participant, or on such other basis as the Plan Administrator may determine.] For this purpose, the Employer adopts the following substance abuse policy. This policy is not subject to ERISA requirements or otherwise dependent

upon the benefit provisions of the Plan in any way, and is included herein strictly as a matter of convenience in documentation. The Participant shall be deemed to have been in a state of intoxication at the time of the Injury if the drug or alcohol test required by the Employer following the Injury finds:

(1) an alcohol concentration of 0.01 or more, where the terms "alcohol" and "alcohol concentration" have the meaning assigned in the Texas Alcoholic Beverage Code; or

(2) any level of (i) a controlled substance or controlled substance analog, as defined by the Controlled Substance Act, Texas Health and Safety Code; (ii) a dangerous drug, as defined by the Texas Health and Safety Code; (iii) an abusable glue or aerosol paint, as defined by the Texas Health and Safety Code; or (iv) any similar substance regulated under the laws of the State of Texas, above the cutoff levels applied by a SAMHSA certified lab; provided, however, that intoxication does not include the loss of normal use of mental or physical faculties resulting from the introduction into the body of a substance taken under and in accordance with a prescription written for the Participant by the Participant's doctor (unless the Participant should have reasonably known, due to prescription warnings or otherwise, that such loss of normal use might occur) or a substance listed above by inhalation or absorption accidental to the Participant's work for an Employer;

(d) Accidental bodily injury, Occupational Disease or Cumulative Trauma to the Participant if employment is in the violation of any law;

(e) the use of or exposure to:

(1) asbestos, asbestos fibers or asbestos products, silica, silica dust, or sand blasting; or

(2) the hazardous properties of nuclear material;

(f) a heart attack or stroke including cardiovascular accident or event, myocardial infarction, coronary occlusion or thrombosis, aneurysm, regardless of the cause;

(g) cumulative trauma (including carpal tunnel syndrome) unless directly related to, and caused by, Employee's work with the Company;

(h) injury or condition associated with lead or lead based materials; or mercury;

(i) the Participant's voluntary participation in any recreational, social or athletic activity not constituting part of the Participant's Scope of Employment at the time of the injury producing event;

(j) Pre-existing conditions which include injury or disease caused by, or diagnosed to be, the aggravation or re-injury of an injury or disease for which the Participant received medical treatment, care, advice, or prescriptions prior to the date the Participant's coverage became effective under the Plan;

(k) horseplay;

(l) directly or indirectly, contributed by, 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 of the loss:

(1) war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, mutiny, revolution, rebellion, insurrection, uprising, military

or usurped power, confiscation by order of any public authority or government de jure or de facto, martial law; or

(2) riots, strikes, or civil commotion.

(3) Any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure, or other body part resulting from: (i) poor or inappropriate posture; (ii) the natural results of aging; (iii) osteoarthritis, arthritis, or **degenerative process** (including, but not limited to) **degenerative joint disease**, **degenerative disc disease**, **degenerative spondylosis/ spondylolisthesis**, and **spinal stenosis**.

ARTICLE V
BENEFITS

Participants shall be entitled to receive under this Plan the benefits described in this Article V with respect to any Injury incurred (i) in the Scope of Employment by an Employer, and (ii) during his or her participation in this Plan.

5.1 Medical Benefits. Subject to the medical management and other provisions of this Plan, the Plan shall pay Medical Benefits to, or with respect to, a Participant for an Injury in an amount equal to all Covered Medical Expenses; provided, however, that Medical Benefits shall cease upon the earliest of:

(a) The date maximum medical improvement is achieved.

(b) The expiration of 156 weeks from the date of the Occurrence. This 156-week maximum medical benefit duration is calculated continuously from the date of the Occurrence, without regard to whether the Participant regularly requires medical treatment during such period or otherwise receives Medical Benefits continuously throughout such period;

(c) the date the Combined Benefit Limit is reached;

(d) involuntary termination of employment of the Participant with an Employer for Gross Misconduct; or violation of the Plan's terms; or

(e) as otherwise provided under ARTICLE VII.

5.2 Disability Benefits. If a Participant has been Disabled as diagnosed by a Plan approved physician (either partial or total as the result of an Injury for seven (7) full, consecutive calendar days, then from the eighth (8^{th}) full day of the Participant's Disability, the Plan shall begin payment of Disability Benefits equal to 75% of his or her average weekly wage; provided, however, that (1) such benefit payments shall be reduced as described in Article VI, (2) such benefit payments shall not exceed $700 per week; and (3) no Disability Benefits shall be payable to any Participant who is entitled to receive Death Benefits or Dismemberment Benefits.

(a) Disability Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week shall be prorated.

(b) Disability Benefits shall continue until the earliest of:

(1) the expiration of 156 weeks from the date of the Occurrence. This 156-week maximum disability benefit duration for Disability Benefits is calculated continuously from the date of the Occurrence, without regard to whether the Participant qualifies as Disabled at all times during such period or receives Disability Benefits continuously throughout such period;

(2) the date the Participant is certified by the treating Approved Provider to no longer be Disabled, without regard to whether the Participant returns to regular or light or modified duty on that date;

(3) the date the Combined Benefit Limit is reached;

(4) termination of the Participant's status as a Covered Employee; provided, however, that this paragraph (4) shall not apply if termination of employment is solely due to:

(A) application of a duration limit in the Employer's leave of absence policy, or

(B) elimination of the Participant's employment position;

(5) the date the Participant is placed in jail, has left the local area (over 100 miles from the store where the employee worked) for an extended period of time, or is similarly unavailable for work; provided, however, that this paragraph (5) shall operate to cease Disability Benefits only for such period of time that such Participant is unavailable for work; or

(6) the date any Death Benefit or Dismemberment Benefit becomes payable to or with respect to the Participant; or

(7) as otherwise provided under **ARTICLE VII.**

5.3 **Accidental Death Benefits**. In the event that a Participant dies as the direct and sole result of an Injury, then the Plan shall pay such Participant's Beneficiary an Accidental Death Benefit equal to the lesser of (1) 10 times the Participant's annualized Payroll, or (2) $250,000, whichever is less; provided, however, that this Death Benefit amount shall be reduced by the amount of any Disability Benefits payments with respect to the Injury and to the extent necessary to avoid exceeding the Combined Benefit Limit. The Accidental Death Benefit shall be paid to the Participant's Beneficiary as follows:

(a) 20% of the benefit shall be paid in a lump sum cash payment as soon as administratively possible following the death of the Participant and the determination of the proper Beneficiary; and

(b) the remainder of the benefit shall be paid in 35 equal monthly installments (without interest), commencing on the first day of the month following the initial lump sum payment.

Accidental Death Benefits payable under this Plan shall be in addition to Medical Benefits and Dismemberment Benefits payable to, or with respect to, the Participant; provided, however, that (1) the Combined Benefit Limit shall not be exceeded, (2) the combination of Death Benefits and Dismemberment Benefits payable to and with respect to a Participant shall not exceed $250,000, and (3) no interest in future Dismemberment Benefits survives after a Participant's death which results in the payment of benefits under this Section 5.3. In addition to the Death Benefits set forth above, but subject to the Combined Benefit Limit, the Plan shall reimburse reasonable burial expenses to any person who incurs liability therefore, up to $5,000.

5.4 **Dismemberment Benefits**. In the event a Participant suffers a loss described in the Schedule of Losses below as the direct and sole result of an Injury, then the Plan shall pay the Participant the amount set forth in such Schedule, which represents a percentage of an amount equal to the lesser of (1) 10 times the Participant's annualized Payroll, or (2) $250,000, whichever is less; provided, however, that this Dismemberment Benefit amount shall be reduced by the amount of any Disability Benefits payable with respect to the Injury and to the extent necessary to avoid exceeding the Combined Benefit Limit. The Dismemberment Benefit shall be paid as follows:

(a) 20% of the Dismemberment Benefit shall be paid in a lump sum cash payment as soon as administratively possible following the date of loss; and

(b) the remainder of the Dismemberment Benefit shall be paid in 35 equal monthly installments (without interest), commencing on the first day of the month following the initial lump sum payment.

SCHEDULE OF LOSSES

Loss of:	**Benefit Amount**:
Quadriplegia	100%
Paraplegia	100%
Hemiplegia	100%
Serious Burns Permanently Prohibiting Work in Any Capacity	100%
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Both Arms & Both Legs	100%
One Arm & One Leg	100%
Speech and Hearing	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
One Arm or One leg	50%
Thumb & Index Finger of Same Hand	25%
Speech	50%
Hearing	50%

(a) If the Participant suffers more than one Injury described above from any one Accident, related series of Accidents or Occupational Disease exposures only one of the applicable Dismemberment Benefits listed above, the largest single amount, will be payable with respect to such Accident or exposure.

(b) Permanent loss of use of a member of the body is the same as loss of such member. Prior to payment of the benefit, loss of use must be certified following the care of an Approved Provider 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 Provider that the loss of use is not reversible.

(c) Loss of Hand or Foot means the complete and permanent severance through or above the wrist or ankle joint. Loss of Sight means legally blind. Such loss correctable by surgery or lenses will not result in payment of a Dismemberment Benefit. Loss of Speech means the permanent loss of speech. Loss of Hearing means the permanent loss of hearing in both ears.

(d) Dismemberment Benefits shall be in addition to Medical Benefits; provided, however, that (1) the Combined Benefit Limit shall not be exceeded, and (2) payment of Dismemberment Benefits will cease in the event of the death of the Participant which results in the payment of Death Benefits.

ARTICLE VI
OTHER LIMITATIONS ON BENEFITS

6.1 **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 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 9.2) 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. Failure to cooperate with the employer may result in the denial of benefits.

6.2 **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.

6.3 **Discharge for Benefit Payments**. If the Plan 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 Plan 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 Plan 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 Plan Administrator or Committee shall operate as a complete discharge of all obligations of the Plan and the Plan Administrator and Committee, to the extent of the payments so made.

6.4 **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.

ARTICLE VII
CONTINUING BENEFITS

The Plan 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 any required drug or alcohol testing, or refuses to provide the Company and its designated representatives with (or access to) drug and alcohol testing information related to an Injury;

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

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

(d) the Participant refuses to submit to examination by an Approved Provider selected by the Plan Administrator (other than the treating Approved Provider) as required by the Plan Administrator with respect to any surgical procedure or other diagnosis or treatment opinion rendered by the treating Approved Provider for which the Plan 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 (including, but not limited to, any recommended treatment, therapy, course of action, abstinence, or rehabilitation program) of, or ceases to be under the care of, a treating Approved Provider;

(g) the Participant fails or refuses to allow an authorized representative of an Employer to accompany the Participant to an appointment with a health care provider;

(h) the Participant repeatedly fails to keep, or is late for, a scheduled appointment with a health care provider;

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

(j) the Participant fails or refuses to report in to the Participant's manager periodically, as directed, until able to return to work, including notice of expected recovery time after each appointment with the treating Approved Provider;

(k) the Participant fails to immediately inform the Participant's manager that he or she has been released by an Approved Provider to return to full or light or modified duty, or fails to timely report to work in accordance with such work release;

(l) the Participant receives benefits with respect to the Injury from, or the accident creates any liability for an Employer under, any workers' compensation law (whether or not any coverage for benefits is actually in force under such law), occupational disease law, unemployment compensation law, disability benefits law, or other similar law;

(m) the Participant has been untruthful in regard to any aspect of the required information supplied as part of the injury reporting or employment process;

(n) the Participant is untruthful or otherwise fails to fully cooperate with the Plan Administrator (including, but not limited to, failure to comply with the provisions of Section 2.2) or demonstrates bad faith in connection with the administration of the Plan, including, but not limited to, subrogation or coordination of benefits procedures; or

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

ARTICLE VIII
DETAILED CLAIMS FILING AND APPEAL PROCEDURES

8.1 **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 Death Benefits or Dismemberment 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 Plan Administrator's or Committee's right to deny another particular claim or all future claims for benefits under the Plan. As stated above, any failure by the Plan Administrator or Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Plan Administrator's or Committee's authority to apply such provisions thereafter.

8.2 **Who is a Claimant**. A claimant or a claimant's authorized representative may file a claim for benefits under the Plan, as well as an appeal of an Adverse Benefit Determination. References in Sections 8.3 and 8.4 to "claimant" shall include a Participant, a medical provider seeking payment for a service or supply, a Beneficiary, or a claimant's authorized representative, as applicable. 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 physician 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.

8.3 **Information to Submit**. Claims must include the information required by Section 8.2 and such other reasonable information requested by the Plan 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 Plan Administrator may require the claimant to provide a written and signed statement which provides that the Covered Medical Expense has not been reimbursed, or is not reimbursable under any other plan or program. Further, the Plan 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. The Plan 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.

8.4 **Submission of Medical Bills for Payment.** Approved Providers and Approved Facilities will be requested to invoice all health care-related charges directly to the Plan Administrator (or an Employer, which shall immediately transmit such invoice to the Plan Administrator). However, in the event that a Participant receives such an invoice or pays such a charge, all requests for payment or reimbursement of Covered Medical Expense must be filed with the Plan 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, Approved Facility, or other health care provider (in the case of Emergency Care) for such expenses.

8.5 **Incomplete Claim Submissions**. In the event that a claim, as originally submitted, is not complete, the Plan 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. In the event that the period of time for a particular claim is extended in accordance with the applicable provisions of this ARTICLE VIII 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 Plan Administrator receives the claimant's response to the request for additional information.

8.6 **Claims Review**.

(a) Notice of Initial Benefit Determination - The Plan 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 Plan Administrator shall notify the claimant of the Plan's initial 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 Plan 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 Plan 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 Plan 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 Plan 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 Plan Administrator has approved an ongoing course of medical treatment to be provided over a period of time or number of treatments:

(A) The Plan 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 Plan 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 Plan 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 Plan Administrator shall notify the claimant of the Plan's 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. The Plan Administrator may extend this 15-day 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. However, if the claimant (i) fails to follow the Plan's procedures for filing a non-urgent care, Pre-Service 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 a non-urgent care, Pre-Service Claim, then:

(A) The Plan Administrator shall notify the claimant as soon as possible, but not later than 5 days 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 Plan 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 at least 45 days to correct such failure.

(C) The Plan Administrator shall then notify the claimant of the Plan's initial benefit Determination within the 15-day (or, if extended, up to 30-day) time frame set forth above.

(4) Post-Service Medical Benefit, Disability Benefit, Death Benefit, and Dismemberment Benefit Claims – In the case of a Post-Service Claim for Medical Benefits or a claim for Disability Benefits, Death Benefits or Dismemberment Benefits, the Plan Administrator shall notify the claimant of an Adverse Benefit Determination within 30 days after its receipt of the claim. The Plan Administrator may extend this period up to an additional 15 days if the Plan 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.

(b) Manner and Content of Adverse Benefit Determinations – If the initial benefit Determination is an Adverse Benefit Determination, the Plan 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 Committee, the Plan offers no further voluntary levels of appeal and that the claimant can pursue his or her right to bring an 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 Adverse Benefit Determination to the Committee within the following number of days following his or her receipt of the Adverse Benefit Determination from the Plan Administrator:

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

(2) 60 days for a Death Benefit or Dismemberment Benefit claim.

If the Adverse Benefit Determination involves an Urgent Care Claim for Medical Benefits, the claimant may request orally or in writing for 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) Committee Consideration -- When reviewing the appeal of an Adverse Benefit Determination, the 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 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 Committee);

(3) The 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 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 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 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 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 Committee Determinations on the review of claims for Urgent Care, Pre-Service 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 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 Committee Determinations on the review of claims for Non-Urgent Care, Pre-Service Medical Benefits.

(3) **Post-Service Medical Benefit, Disability Benefit, Death Benefit, and Dismemberment Benefit Claims** – In the case of a Post-Service Claim for Medical Benefits or a claim for Disability Benefits, Death Benefits or Dismemberment Benefits, the Committee shall notify the claimant of the Plan's benefit Determination on review within 45 days after its receipt of the appeal request. The Committee may extend this period up to an additional 45 days on a claim for Disability Benefits, Death Benefits, or Dismemberment Benefits if the 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 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 Plan Administrator or

Committee, the Plan Administrator or 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 claims procedure has been exhausted.

ARTICLE IX
NATURE OF PAYMENTS AND SUBROGATION

9.1 Nature of Payments.

(a) No Admission of Liability: The Plan has been established and is maintained by the Employer to protect itself from certain liabilities as nonsubscribers to the Texas workers' compensation insurance system. Payments made under this Plan by an Employer shall not in any way constitute an admission of liability or responsibility by an Employer for an 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 an Injury.

9.2 Recovery From Third Parties And Excess Payments. If a Participant becomes entitled to or receives Plan benefits for any Injury caused by the negligence or other act or omission of any person or organization (including, but not limited to, an Employer), and is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury, whether by insurance, litigation, settlement or other proceeding, the Participant shall (i) subrogate his or her right to and reimburse the Plan out of said damages or other compensation to the extent of the Plan benefits paid to the Participant, and (ii) execute any assignment, lien form or other document requested by the Plan Administrator to enable the Plan to recover such Plan benefits. If (i) a Participant 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, in addition to all other legal and equitable remedies and rights of recovery that the Plan may have, the Plan shall have the right to terminate or suspend benefit payments and/or recover the reimbursement due to the Plan by withholding, offsetting and recovering such amount out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such Participant. The Plan shall also have the right to bring a lawsuit and assert a constructive trust or other equitable remedy against any and all persons that have assets that the Plan can claim rights to. The Plan has the right of first recovery from any judgment, settlement or other payment, regardless of whether the Participant has been "made whole." Any reimbursement of Plan benefits obtained by the Plan shall be held in trust and used to provide benefits under the Plan in accordance with the provisions of such trust agreement established by an Employer as may be approved by the Plan Administrator.

9.3 Notice Of Legal Proceedings. A Participant shall provide the Plan Administrator with prior written notice of the involvement of such Participant 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 Injury for which such Participant 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 Participant in any such lawsuit, settlement discussion or other proceeding. If a Participant neglects, fails or refuses to seek a recovery from any person or organization for any Injury caused by the negligence or other act or omission of such person or organization for which such Participant has received Plan benefits, the Plan shall have the right to institute a lawsuit or other proceeding or do any other act that in the opinion of the Plan Administrator may be necessary or desirable to recover the Plan benefits paid (and to be paid in the future) to the Participant, plus any costs and expenses incurred by the Plan in pursuing such recovery.

9.4 Assignment Of Rights. Upon the request of the Plan Administrator, a Participant shall assign to the Plan the right to intervene in or institute any lawsuit, settlement discussion, or other proceeding described in Section 9.3, and to use the name of the Participant 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. 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 Participant 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 Plan Administrator. The Participant shall release the Plan, the Employers, the Plan Administrator, the Plan Administrator, the 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.

9.5 Final Compromise And Settlement. At the Plan Administrator's option within three years after the date of the Occurrence, and at any time thereafter if the Plan Administrator elects to extend such three-year period after the date of the Occurrence, the Plan Administrator may notify the Participant of the Plan's intention to be released from any further known and unknown benefit and all other 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, Plan Administrator, Committee, and other interested parties with respect to such claims. In that event, the Plan Administrator may appoint an actuary, appraiser, and/or Approved Provider to investigate, determine, and capitalize such claims. The payment by the Plan and/or Employer of the value of such claims (as finally determined by the Plan Administrator) shall be made in such manner as the Plan Administrator may determine. No additional claims will be subsequently accepted with respect to such Injury. Any actuary or appraiser shall apply such rules, standards, and assumptions (present value discount, inflation, and mortality rates, etc.) as the Plan Administrator may reasonably 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 Plan 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 Plan Administrator's claim valuation, sign the release agreement presented by the Plan Administrator, or otherwise comply with the requirements of this Section or other provisions of the Plan. Prior or subsequent to the Plan Administrator's evaluation and determination of the value of a Participant's claims, the Plan 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.

ARTICLE X
ADMINISTRATION

10.1 Plan Administrator.

(a) Administrator: The Company shall be the Plan Administrator of the Plan. The Plan shall be administered on behalf of the Company and all other Employers by the Plan Administrator and Committee. Each Plan Administrator or member of the Committee so appointed shall serve in such office until his or her death, resignation, or removal by the Company. The Company may remove any Plan Administrator or member of the Committee with or without cause at any time, and may fill any vacancies in the Plan Administrator position or with respect to Committee

membership or add additional Plan Administrators or members to the Committee at any time and from time to time. The Committee shall act by a majority of its members at the time in office. The Committee may by such majority action authorize any one or more of its members to execute any document or documents on behalf of the Committee. The Plan Administrator and 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 Plan Administrator and 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. Members of the Committee shall receive no remuneration from the Plan for their services as Committee members. 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 Plan Administrator and 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 Plan Administrator and Committee shall perform all of the duties and may exercise all of the powers and discretion that the Plan Administrator and 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 Plan Administrator or Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Plan Administrator's or Committee's authority to apply such provisions thereafter. Every interpretation, choice, determination or other exercise by the Plan Administrator or 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 Plan Administrator or 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 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 Plan Administrator and/or 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 Plan Administrator's and Committee's authority shall include, but not be limited to, the power to allocate or delegate fiduciary and non-fiduciary responsibilities or duties among the members of the Committee or 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 an Employer, the directors, officers, partners, managers, or managers of an Employer, the Plan Administrator, the Plan Administrator or the 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.

10.2 **Plan Administrator and Committee Indemnity**. The Employer shall indemnify and hold harmless the actual Plan Administrator and the actual Committee, each actual member thereof, and any other Employee of an Employer to whom the Plan Administrator or 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 Plan Administrator or Committee or such a member or Employee under this Plan, except in the case of willful misconduct. The Employers shall be jointly and severally liable for any amounts owed pursuant to this Section.

10.3 **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 Injury. Said benefits shall be paid by or on behalf of such Employer at the direction of the Plan Administrator or Committee or its designated representative solely out of the general assets of such Employer or its insurer. No Employer shall

have an obligation to establish any fund or trust for the payment of benefits under this Plan. If any insurance benefits are paid directly by an insurance company to a Participant or beneficiary with respect to an Injury covered under this Plan, such payments shall be deemed to be made under this Plan by an Employer or shall otherwise be subject to the provisions of Section 6.1 or ARTICLE IX, as determined by the Plan Administrator.

10.4 Participation By Affiliates. With the consent of the Company, any incorporated or unincorporated trade or business which 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 may adopt and become an Employer under this Plan.

ARTICLE XI
DEFINITIONS

11.1 "Accident" or "Accidental" means an event which:

(a) was unforeseen, unplanned, and unexpected;

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

(c) occurred by chance or from unknown causes;

(d) results in physical injury to the Participant; and

(e) does not include ordinary diseases of life to which the general public is exposed outside of your assigned duties in your Scope of Employment or a disease resulting directly from an Accident.

Accidental bodily Injury does not include Occupational Disease unless it results directly from an Accident.

11.2 "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.

11.3 "Approved Provider" means a person duly licensed under Texas law as a Medical Doctor or Doctor of Osteopathy and either expressly approved by the Plan Administrator or included on an approved list of physicians adopted by the Plan Administrator. "Approved Provider" also includes a hospital, other medical care facility or medical service or supply provider either expressly approved by the Plan Administrator or included on an approved list of facilities adopted by the Plan Administrator. The Plan Administrator reserves the right to add to, delete from, or otherwise amend any designation or list of Approved Providers at any time.

11.4 "Beneficiary" means the person or persons determined in the following priority:

(a) If there is an Eligible Spouse, all Death Benefits shall be paid to the Eligible Spouse.

(b) If there is no Eligible Spouse, Death Benefits shall be paid in equal shares to the Eligible Children. If an Eligible Child has predeceased the Participant, Death Benefits that would have been paid to that child if he or she had survived the Participant shall be paid in equal shares per stirpes to the children of such deceased child.

(c) If the Participant is not survived by an Eligible Spouse or Eligible Child, any Death Benefits shall be paid to a surviving dependent (as determined in accordance with the support criteria set forth in section 152 of the Internal Revenue Code and such other rules as the Plan Administrator may prescribe) of the Participant who is a parent, sibling, or grandparent of the deceased Participant. If more than one of those dependents survives the Participant, any Death Benefits shall be divided among them in equal shares.

(d) If the Participant is not survived by an Eligible Spouse, Eligible Child, or dependent who is a parent, sibling, or grandparent, no Death Benefits shall be payable.

(e) For purposes of this Section:

(1) "Eligible Spouse" means the surviving spouse of the deceased Participant, recognized by a marriage certificate issued under the laws of the State of Texas or similar government authority, or by a Texas court decree of common law marriage (obtained at such person's sole initiative and expense).

(2) "Eligible Child" means a surviving child of the deceased Participant, whether by blood, marriage, or legal adoption, if the child is:

(A) under 18 years of age;

(B) enrolled as a full time student in an accredited educational institution and is less than 25 years of age; or

(C) because of a physical or mental handicap, a dependent (as determined in accordance with the support criteria set forth in section 152 of the Internal Revenue Code and such other rules as the Plan Administrator may prescribe) of the deceased Participant at the time of the Participant's death.

11.5 "Claims Administrator" means the individual or individuals or entity appointed by the Company to make initial Determinations of benefit claims under this Plan on behalf of the Company and all other Employers.

11.6 "Combined Benefit Limit" means the maximum amounts of all benefits payable under the Plan. Payments made for each form of benefit shall be counted towards the applicable Combined Benefit Limit, and benefit payments to or with respect to a Participant shall cease or be reduced in such manner as the Plan Administrator or Committee may determine when a Combined Benefit Limit is reached. The Combined Benefit Limits for this Plan are as follows:

(a) "Maximum Any One Employee Per Occurrence" - $250,000.

(b) "Maximum All Employees Per Occurrence" - $750,000. This is the aggregate limit of all benefits payable to or with respect to all Participant Injury claims arising out of a single Occurrence.

11.7 "Committee" means the individual or individuals appointed by the Company to make Determinations on appeal of benefit claims and otherwise administer the Plan on behalf of the Company and all other Employers. The Plan Administrator cannot serve as the Committee or as a member of the Committee, and no individual who is a subordinate of the Plan Administrator can serve as the Committee or as a member of the Committee.

11.8 "Company" means Orenda Education Inc dba Orenda Charter Schools or any successor thereto.

11.9 "Covered Medical Expense" means an amount described in Section 3.2.

11.10 "Covered Employee" means an Employee whose employment with the Employer is principally located within the State of Texas.

11.11 "Covered Injuries" means physical damage or harm described in ARTICLE IV.

11.12 "Cumulative Trauma" means damage to the physical structure of the Participant's body occurring as a result of repetitious, physically traumatic activities that occur in the Scope of Employment. Cumulative Trauma does not include Accidental bodily Injury or Occupational Disease. To be payable, the Cumulative Trauma must manifest itself and be diagnosed while this Plan is in effect.

11.13 "Death Benefits" means any benefit payable under Section 5.3.

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

11.15 "Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury, that:

- causes you to be unable to perform the normal duties for which you were employed;
- causes you to be under the regular care of an Approved Provider; or
- causes you to be unable to engage in light or modified duty or any other occupation for wage or profit.

Successive or recurrent periods of Disability will be considered one period if they are: (i) due to the same or related cause or causes; and (ii) separated by less than two weeks of continuous full-time, active work.

11.16 "Dismemberment Benefits" means any benefit payable under Section 5.4.

11.17 "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 exception for Emergency Care. Urgent Care Claims may not rise 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 Plan Administrator or Committee, with such advice and consultation from an Approved Provider as the Plan Administrator or Committee deems appropriate**.

11.18 "Employee" means:

(a) a person who is employed in the regular business of, and receives his or her 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; or

(b) a person (and any class of substantially similarly situated persons) determined to be a common law employee of an Employer by a court of competent jurisdiction, by an arbitrator (where a sole arbitrator presides), or by an arbitration panel majority.

This term does not include an independent contractor or third-party agent.

11.19 "Employer" means the Company and any other related trade or business that adopts the Plan pursuant to Section 9.4.

11.20 "Gross Misconduct" means the Employee's gross misconduct within the meaning of Section 4980B of the Internal Revenue Code, or any successor provision of law.

11.21 "Hospital" means a lawful institution which:

(a) is licensed as a hospital if required in its location;

(b) is open at all times;

(c) functions chiefly for the care and treatment of sick and injured persons as admitted inpatients;

(d) has a staff of one or more licensed physicians present at all times;

(e) provides 24-hour services of nurses; and

(f) has on its premises, or available on a prearranged basis, organized facilities for diagnosis and major surgery.

11.22 "Injury" means damage or harm to the physical structure of the body, as described in ARTICLE IV.

11.23 "Medical Benefits" means any benefit payable under Section 5.1.

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

(a) required, recognized, and professionally accepted nationally by physicians 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, an Approved Provider or other provider of medical services, supplies or procedures.

Even if the service, supply or procedure is Medically Necessary or may have been prescribed by an Approved Provider, this Plan will not cover services, supplies or procedures excluded from coverage under the terms of this Plan.

11.25 "Occupational Disease" means a condition marked by a pronounced deviation from the normal healthy state of a Participant arising out of such Participant's assigned duties in his or her Scope of Employment. Occupational Disease includes other diseases or infections that naturally result from the work-related disease. Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of a Participant's assigned duties in his or her Scope of Employment or a disease resulting directly from an Accident. To be payable, the Occupational Disease must manifest itself and be diagnosed while this Plan is in effect.

11.26 "Occurrence" means an Accident or related series of Accidents arising out of one event or accident. As respects Cumulative Trauma or Occupational Disease, "Occurrence" means the Participant's last day of last injurious exposure to the conditions causing or aggravating such Cumulative Trauma or Occupational Disease. Any provision of this Plan to the contrary notwithstanding, in order to be subject to this Plan document:

(a) the date of such Occurrence must be (1) on or after July 1, 2012, and (2) while this plan remains in effect; and

(b) a claim for benefits on an Injury due to Occupational Disease must in all events be made in accordance with ARTICLE II.

11. 27 "Ordinary Disease of Life" means ordinary diseases of life to which the general public is exposed outside the Employee's assigned duties in his scope of employment.

11.28 "Participant" means a Covered Employee who becomes eligible for benefits in accordance with ARTICLE I.

11.29 "Payroll" means money or substitutes for money, and includes:

(a) base pay;

(b) extra pay for overtime work;

(c) pay for holidays, vacations or periods of sickness; and

(d) payments for specific work performed made on any basis other than time worked, such as piece work, but not tip income of employees.

For purposes of calculating a Disability Benefit, the average weekly compensation to a Participant shall be determined, according to the definition of Payroll above, based on the most recent 13-week period, or the Participant's period of employment if shorter, prior to the Occurrence giving rise to the Disability.

11.30 "Plan" means the work related injury plan established or continued by the Employer in the form of this document. The name of the Plan is the Orenda Education Inc dba Orenda Charter Schools Work Related Injury 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 10.4.

11.31 "Plan Administrator" means the Company.

11.32 "Plan Year" means a 12 calendar month period beginning on the Plan's inception date and ending on the date 12 months after that date.

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

11.34 "**Pre-existing Condition**" means any condition, injury, illness, disease (whether or not previously diagnosed) that preceded Participant's accident, regardless of whether the pre-existing condition was repaired or rehabilitated. The Plan will not pay for aggravation of a pre-existing condition.

11.35 "Pre-Service Claim" means any claim for Medical Benefits with respect to which this Plan requires Plan Administrator approval in advance of obtaining medical care (i.e., any such claim that does not involve Emergency Care).

11.36 "Rehabilitation" means only those procedures which are performed for the purpose of restoring the function of motion, speech or vision lost as a result of a covered Accidental bodily Injury or Occupational Disease.

11.37 "Relevant" shall mean, with respect to the relation of a document, record or other information to a Participant's or beneficiary'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.

11.38 "Scope of Employment" means an activity of any kind or character that has to do with and originates in the work, business, trade or profession of an Employer, and that is performed by a Participant while engaged in or about the furtherance of the business of an Employer, including activities conducted on the premises of an Employer or at other locations designated by the Employer. This term does not include a Participant's presence at the Employer's business locations 1) at times not designated or scheduled as a regular work schedule, or 2) in the

capacity as a guest, customer, or invitee. This term also does not include a Participant's transportation to and from his or her place of employment, unless:

(a) the transportation is furnished as part of the employment arrangement or is paid for by an Employer, or the means of the transportation are under the control of an Employer; or

(b) the Participant is directed in his or her employment to proceed from one place to another place.

11.39 "Skilled Nursing Facility" means a section, ward, or wing of a hospital, or a free-standing healthcare 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 physicians;

(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.

11.40 "Disability Benefits" means any benefit payable under Section 5.2.

11.41 "Disabled" or "Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury that:

(a) causes the Participant to be unable to perform the normal duties for which he or she was employed;

(b) causes the Participant to be under the regular care of an Approved Provider; and

(c) causes the Participant to be unable to engage in light or modified duty or any other occupation for wage or profit.

11.42 "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 Plan 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 physician 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 Plan Administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the claimant's medical condition determines that a claim is an Urgent Care Claim and clearly communicates such determination to the Plan Administrator, such claim shall be treated as an Urgent Care Claim for purposes of this Plan. **The characterization of a claim as being an Urgent Care Claim solely impacts the timeframes and other procedures for claims processing under ARTICLE II, 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 Covered Medical Expense unless treatment is pre-approved by the Plan 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 rise 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 Plan Administrator or Committee, with such advice and consultation from an Approved Provider as the Plan Administrator or Committee deems appropriate.**

11.43 "Usual and Customary" means the expense is:

(a) usual when it is the fee regularly charged and which the patient is responsible to pay in the absence of insurance or other third party reimbursement, by a health care provider or physician for the given treatment, service or supply; and

(b) customary in relation to what other physicians and health care providers in the same geographic area are reimbursed for the same and similar treatment, service or supply.

ARTICLE XII
GENERAL PROVISIONS

12.1 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 all Employers, and at any time to terminate this Plan or any Employer's participation hereunder; provided, however, that no such amendment or termination shall reduce the amount of any benefit then due and payable to, or with respect to, a Participant under the Plan in connection with an Injury occurring prior to the date of such amendment or termination. Any such amendment or termination shall be pursuant to formal written action of a representative authorized to act on behalf of the Company.

12.2 Employment Noncontractual. The establishment of this Plan shall not enlarge or otherwise affect an Employee's "at will" employment by an Employer, and an 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.

12.3 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.

12.4 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.

12.5 **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.

12.6 **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 Texas.

IN WITNESS WHEREOF, this Plan has been executed by the Company this ____ day of _____, 20___, to be effective as of July 1, 2012.

ORENDA EDUCATION INC DBA ORENDA CHARTER SCHOOLS

By_____
(Signature and Title)

APPENDIX A

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective July 1, 2012, the Plan shall comply with the "Standards for Privacy of Individually Identifiable Health Information" (the "HIPAA Privacy Rules"), as specified under 45 CFR Part 160 and Part 164, Subparts A and E, to the extent that the Department of Health and Human Services ("HHS") determines that these rules apply to the Medical Benefits provided under the Plan. Unless otherwise indicated below, the terms used in this Appendix shall have the same meanings as defined in the Plan.

1.1 Employer Uses and Disclosures of PHI. The Employer shall use and disclose PHI provided by the Plan only to the extent such use and disclosure is:

(a) for Treatment, Payment or Health Care Operations, as permitted by and in compliance with section 164.506 of the HIPAA Privacy Rules; or

(b) as otherwise permitted or required for group health plans under section 164.502 of the HIPAA Privacy Rules.

1.2 Certification. The Plan shall not disclose PHI to the Employer unless the Employer provides the Plan with certification that the Employer agrees to comply with the following provisions. The Plan shall also limit the disclosure of PHI to the Employer for plan administration functions that the Employer performs only consistent with such provisions.

(a) The Employer shall not use or further disclose PHI other than as permitted or required by the plan documents for the Plan or as required by law;

(b) The Employer shall require any agents, including a subcontractor, to whom it provides PHI from the Plan to agree to the same restrictions and conditions that apply to the Employer with respect to PHI;

(c) The Employer shall not use or disclose PHI from the Plan for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;

(d) The Employer shall report to the Plan any use or disclosure of PHI provided by the Plan that is inconsistent with the purpose for which the PHI was provided, once the Employer becomes aware of such inconsistent use or disclosure;

(e) The Employer shall provide affected individuals with access to their PHI in accordance with section 164.524 of the HIPAA Privacy Rules;

(f) The Employer shall make PHI available for amendment by the affected individual and shall incorporate any amendments made into such PHI;

(g) The Employer shall make available to affected individuals information required in order to provide an accounting of any disclosures made by the Plan, but only to the extent that such disclosures must be accounted for under section 164.528 of the HIPAA Privacy Rules;

(h) The Employer shall make its internal practices, books, and records relating to the use and disclosure of PHI from the Plan available to HHS for determining Plan compliance with HIPAA Privacy Rules;

(i) If feasible, the Employer shall return or destroy all PHI received from the Plan that the Employer still maintains in any form and shall retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. Notwithstanding the foregoing, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures of such PHI to those purposes that make return or destruction of the PHI infeasible; and

(j) The Employer shall ensure that adequate separation has been established between the Employer and the Plan.

1.3 Separation Between Employer and Plan. The Plan's designated Plan Administrator, the Plan's Committee members and their respective staff members that are designated to perform Plan functions shall be the only Employees or other persons under the direct control of the Employer that shall be given access to PHI for use and disclosure.

(a) Access to and use of PHI by the above-referenced persons shall be restricted to the Plan Administrator functions that the Employer performs for the Plan.

(b) In the event that any of the above-referenced persons fails to comply with the requirements of the HIPAA Privacy Rules and this Appendix, an affected individual may bring a claim to resolve the noncompliance by contacting the Plan's HIPAA privacy contact person specified in the Plan's HIPAA Authorization for Release of Protected Health Information.

(1) The Plan shall respond to such claim within 30 days, subject to a 30-day extension. If the Plan disagrees with the complaint or the claim is otherwise denied in whole or in part, the Plan shall provide the affected individual with a written denial that explains the basis for the denial. The affected individual may then provide the Plan with a written statement of disagreement and/or take such further action as provided in the Plan's Notice of Privacy Practices or by law.

(2) The Employer shall ensure that this process provides appropriate sanctions for noncompliance and otherwise serves as an appropriate mechanism for noncompliance disputes.

1.4 Exceptions to Employer Uses and Disclosures. Notwithstanding the foregoing, the Plan may disclose the following information to the Employer:

(a) PHI to the extent specified in an authorization that complies with section 164.508 of the HIPAA Privacy Rules;

(b) Summary Health Information, if the Employer requests Summary Health Information for the limited purpose of either (1) obtaining premium bids for insurance coverage related to the Plan, or (2) modifying, amending or terminating the Plan;

(c) information on whether an affected individual is participating in the Plan; or

(d) determining light or modified duty.

1.5 **Definitions.** The following definitions shall apply to this Appendix:

(a) "Health Care Operations" shall mean any of the following activities that relate to functions covered under the HIPAA Privacy Rules:

(1) conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients about Treatment alternatives, and related functions that do not include Treatment;

(2) reviewing the competence or qualifications of health care professionals, evaluating provider performance, health plan performance, conducting training programs related to improving health care provider skills, accreditation, certification, licensing or credentialing activities;

(3) underwriting, premium rating and other activities related to creation, renewal or replacement of health insurance or Medical Benefits (including excess loss insurance);

(4) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(5) business planning and development, such as conducting cost-management analyses for managing and operating the Plan;

(6) business management and general administrative activities of the Plan, including (A) compliance with the HIPAA Privacy Rules, (B) customer service, (C) resolution of internal grievances, or (D) the sale, transfer, merger or consolidation of all or part of a Plan with another entity that is (or will be) covered by the HIPAA Privacy Rules (including due diligence related to such activity); and

(7) creating de-identified health information or a limited data set.

(b) **"Payment"** means Plan activities to determine (or fulfill its responsibility for) coverage and provision of benefits under the Plan, or obtain or provide reimbursement for the provision of health care. These activities must relate to the individual receiving health care, including, but not limited to:

(1) Eligibility or coverage determinations (including coordination of benefits) and adjudication or subrogation of Medical Benefit claims;

(2) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(3) Billing, claims management, collection activities, obtaining payment under a reinsurance contract and related health care data processing;

(4) Review of health care services with respect to medical necessity, Plan coverage, appropriateness of care or justification of charges;

(5) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review; and

(6) Subject to the HIPAA Privacy Rules, disclosure to consumer reporting agencies related to premium or reimbursement collection.

(c) **"Protected Health Information" or "PHI"** means the individually identifiable health information (including demographics) that is transmitted or maintained by electronic or any other form or medium and that:

(1) is created or received by the Plan or an Employer;

(2) relates to past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for health care for the individual; and

(3) identifies the individual (or there is a reasonable basis to believe that the information can be used to identify the individual).

As specified under the HIPAA Privacy Rules, PHI excludes individually identifiable health information contained in education records and employment records held by an Employer.

(d) **"Summary Health Information"** means individually identifiable health information:

(1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided Medical Benefits under the Plan; and

(2) from which the certain information that identifies the individual (as described in section 164.514(b)(2)(i) of the HIPAA Privacy Rules) has been deleted, except that geographic information need only be aggregated to the level of a five digit zip code.

(e) **"Treatment"** shall mean the provision, coordination or management of health care and related services by one or more health care providers, including coordination or management of health care by a health care provider with a third party, consultation between health care providers relating to a patient or the referral of a patient for health care from one health care provider to another.

APPENDIX B

ARBITRATION ACKNOWLEDGEMENT, SAFETY PLEDGE AND RECEIPT

RECEIPT OF MATERIALS. By my signature below, I acknowledge that I have received and read (or had the opportunity to read) the Summary Plan Description (the "SPD") for Orenda Education Inc dba Orenda Charter Schools Work Related Injury Plan and Arbitration Agreement, effective July 1, 2012.

INJURY NOTICE AND MEDICAL PROVIDERS. I understand and agree that if I am injured on the job, I must notify my manager or manager on duty by the end of my workshift on the date of the injury and receive any medical care from a Plan-approved physician in order to receive benefits under the Plan.

SAFETY PLEDGE. I agree to familiarize myself with Orenda Education Inc dba Orenda Charter Schools's safety program and to perform my job according to Orenda Education Inc dba Orenda Charter Schools's safety rules. I will also use any personal protective equipment that is provided to me. I also agree to immediately report to my manager any accident that involves another employee, a customer, a vendor, or me. I will also immediately report to my manager or the manager on duty any unsafe act, condition or equipment. I will also cooperate with any accident investigations, and actively participate in any safety training programs provided by Orenda Education Inc dba Orenda Charter Schools.

X_____ _____
Employee's Signature Date

_____ _____
Print Employee's Name Employee's Social Security No.

_____ _____
Employee's Work Location Department

X_____ _____
Parent or Legal Guardian Signature Date
(if employee under age 18)

_____
Print Parent or Legal Guardian Name

X_____ _____
For the Company Date

Revised 05/12/08