CATHOLIC DIOCESE OF JACKSON

VISION PLAN

PRIESTS PLAN

PLAN DOCUMENT

EFFECTIVE: October 1, 2013
RESTATED: January 1, 2016

CONTRACT ADMINISTRATOR:

Boon-Chapman Benefit Administrators, Inc.

ADMINISTRATIVE INFORMATION

Name of Plan:	Catholic Diocese of Jackson Employee Benefit Plan
Plan Sponsor: Address:	Catholic Diocese of Jackson 237 East Amite Street Jackson, Mississippi 39201
Business Phone Number:	(601) 969-1880
Plan Sponsor ID Number (EIN):	64-0303073
Plan Number:	501
Plan Year:	January 1
Plan Benefits:	Vision
Fiduciaries: Address:	Catholic Diocese of Jackson 237 East Amite Street Jackson, Mississippi 39201
Designated Legal Agent: Address:	Aad de Lange Catholic Diocese of Jackson 237 East Amite Street Jackson, Mississippi 39201

(Legal process may also be served upon the plan sponsor or a fiduciary)

Contract Administrator:	Boon-Chapman Benefit Administrators, Inc.
Street Address:	9401 Amberglen Blvd., Bldg. I Austin, Texas 78729
Mailing Address:	P.O. Box 9201 Austin, Texas 78766
Phone:	(512) 454-2681 / (800) 252-9653
FAX:	(512) 459-1552

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ADOPTION OF THE PLAN DOCUMENT

Adoption
Plan sponsor hereby adopts this plan document as the written description of its employee welfare benefit plan (the "plan"). This plan document is a restatement of the plan, with benefit changes, and is effective on January 1, 2016.

Purpose of the Plan
The purpose of the plan is to provide certain benefits for eligible employees of the employer and their eligible dependents. The benefits provided by the plan include:

HEALTH CARE COVERAGES
Vision Coverage

Acceptance of the Plan Document
IN WITNESS WHEREOF, the plan sponsor has caused this instrument (pages 1-16 inclusive) to be executed, effective as of January 1, 2016.

CATHOLIC DIOCESE OF JACKSON

By: _____

Title: _____

Date: _____

SCHEDULE OF VISION BENEFITS

The following chart summarizes amounts paid by the plan and any additional explanation needed for your benefits. Please refer to the text for additional plan provisions, which may affect your benefits.

Benefit Description	Plan Benefit	Additional Limitations and Explanations
Vision Examination	Covered at 100%	Maximum Allowable Charge of $95. One visit per calendar year.
Refraction	Covered at 100%	Maximum Allowable Charge of $45 per calendar year
Materials (excluding contacts)	Covered at 100%	
Lenses (Per Pair)		Limited to 1 pair per calendar year.*
Single Vision	Up to $90	
Bi-Focal	Up to $110	
Tri-Focal	Up to $130	
Lenticular	Up to $150	
Frames	Up to $130**	Limited to 1 pair every 24 months.*
Contacts (Per Pair):	Up to $130***	Limited to 1 pair per calendar year.*

* One pair of standard lenses **OR** one pair of contact lenses will be covered by this plan during each frequency period.

**One frame for prescription lenses—frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance.

***One pair of contact lenses or a single purchase of a supply of contact lenses—in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials.

VISION CARE COVERAGES

Eligible Vision Expenses

About Your Vision Benefits
All benefits provided under this plan must satisfy some basic conditions. The following conditions are commonly included in vision benefit plans but are often overlooked or misunderstood.

Health Care Providers
The plan provides benefits only for covered services rendered by a physician or practitioner as those terms are defined in the Definitions section.

Benefit Year
The word year, as used in this document, refers to the benefit year which is the 12 month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the benefit year.

Benefit Maximums
Total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period and usually has a frequency limitation.

The benefit maximum amounts and frequency limitations are shown on the Schedule of Vision Benefits.

Covered Vision Benefits
When all of the provisions of this plan are satisfied, the plan will provide benefits as outlined on the Schedule of Vision Benefits only for the services and supplies listed in this section.

Vision examinations by a physician which include case history, visual acuity (clearness of vision), external examination and measurement; interior examination with opthalmoscope; pupillary reflexes and eye movements; retinoscopy (shadow test); subjective refraction; coordination measure (far and near); medicating agents for diagnostic purposes; and, analysis of findings with recommendations and prescription if required.

Glass or plastic lenses prescribed by a physician.

One (1) pair of frames to hold prescribed lenses.

One (1) pair of contact lenses as an alternative to conventional lenses.

Vision Limitations and Exclusions

The plan will not provide benefits for any of the items listed in this section. This list is intended to give you a general description of expenses for services and supplies not covered by this plan. The plan only covers those expenses for services and supplies specifically described as covered in the preceding section. There may be expenses in addition to those listed below which are not covered by the plan.

Drugs
Drugs or medications not used for the purpose of examination or tonometry.

Duplicate Services
Services received more frequently than outlined on the Schedule of Vision Benefits.

Government-Operated Facilities
Services furnished to the covered person in any veteran's hospital, military hospital or any institution or facility operated by the United States government (except for treatment of non-service-related disabilities), or by any state government or any agency or instrumentality of such government, for which the covered person has no legal obligation to pay.

HMO
Any services received from a Health Maintenance Organization (HMO) if the individual is a participant in the HMO.

Medical Services
Medical and/or surgical treatment of the eye.

Missed Appointments or Forms Completion
Missed appointments or expenses for preparing medical reports, itemized bills. or completion of claim forms.

No Charge/No Legal Requirement to Pay
Services for which no charge is made or for which a covered person is not required to pay, is not billed, or would not have been billed in the absence of coverage under this plan.

Non-Covered Services
Services not specifically listed as covered expenses, which include but are not limited to the following:

services in excess of the maximums as stated on the Schedule of Vision Benefits;

training or educational instruction and materials;

mailing and/or shipping and handling expenses;

expenses eligible for consideration under any other plan of the employer;

medical or surgical treatment of the eyes;

any eye examination, or any corrective eyewear, required by an employer as a condition of employment;

services or supplies not prescribed by a physician or rendered by a covered practitioner;

safety glasses or goggles;

any injury or illness when paid by Workers Compensation or similar law, or which is work-related;

charges in excess of the maximum allowable charge for the Service or Materials;

charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy;

magnification or low vision aids not shown as covered in the Schedule of Benefits;

any non-prescription eyeglasses, lenses or contact lenses;

spectacle lens treatments, "add-ons", or lens coatings not showin as covered in the Schedule of Benefits;

two pair of glasses, in lieu of bifocals or trifocals;

VDT (video display terminal)/computer eyeglass benefit;

special procedures, such as, but not limited to, orthoptics, vision training, or subnormal vision aids;

Other Coverage
Examinations, or lenses and/or frames ordered before the covered person was eligible for coverage or after coverage terminated. Services received before the covered person was eligible for coverage or after coverage terminated.

Relative or Resident Care
Charges or services performed by a person who ordinarily resides in the covered person's household or who is related to the covered person as a spouse, parent, child, brother, or sister, whether such relationship is by blood or exists in law.

Replacement
Replacement of a lost, missing, stolen or broken lenses, frames, or contacts.

Telephone Treatment or Consultation
Telephone treatment or consultation charges, unless otherwise specified.

Veteran's Hospital
See "Government-Operated Facilities."

Coordination of Benefits

All benefits provided under the health care coverages of this plan are subject to the following provisions and limitations, unless specifically stated otherwise.

Definitions

As used in this provision, the following terms shall have the meanings indicated:

Other Plan
Other plans include benefits, services, or treatment provided by:

group, blanket, or franchise insurance coverage;

group hospital or medical service pre-payment plans (HMOs, PPOs, EPOs);

group Blue Cross and Blue Shield coverage;

group automobile insurance;

individual auto insurance based upon the principles of no-fault coverage;

any coverage under labor-management trusteed plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;

any coverage under government programs including Medicare (Titles XVIII and XIX of the Social Security Act as enacted or thereafter amended), CHAMPUS, or any coverage required or provided by a statute. For purposes of implementing this provision, eligibility alone will constitute coverage; or

any group coverage sponsored by or provided through a school or other educational institution.

This Plan
The health care coverages of this plan.

Allowable Expense
Any usual, customary, and reasonable item of expense incurred while the person for whom claim is made is covered under this plan, at least a part of which is covered under any other plan. When a plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.

Claim Determination Period
A period that commences each January 1 and ends at 12 o'clock midnight on the next December 31, or that portion of such period during which the claimant has been covered under this plan.

Effect on Benefits Under This Plan

When Other Plan Does Not Contain a Coordination of Benefits Provision
As to any claim determination period to which this provision is applicable, the benefits that would be payable under this plan in the absence of this provision shall be reduced to the extent necessary so that the sum of all the benefits payable for such allowable expenses under this plan and all other plans shall not exceed the total of such allowable expenses. Benefits payable under the other plans include benefits that would have been payable had claim been duly made for them.

When Other Plan Contains a Coordination of Benefits Provision
If the other plan insuring the person covered by this plan contains a similar non-duplication of benefits provision that coordinates its benefits with those of this plan and would, according to its rules and the order

of benefit rules below, determine its benefits after the benefits of this plan have been determined, then the benefits of such other plan will not be considered for the purpose of determining the benefits due under this plan.

If, according to the other plan's rules and the order of benefit rules below, this plan is to determine its benefits after the other plan's benefits are determined, then the sum of all the benefits payable for allowable expenses under this plan and all other plans shall not exceed the total of such allowable expenses incurred during the claim determination period.

If the primary plan (i.e., plan that is to pay its benefits first) has a limitation for non-compliance with a utilization review-type of program, this plan will base its coordination only on the amounts that would have been paid if the participant had met the provisions of the primary plan.

If the primary plan has a PPO arrangement or a health maintenance organization (HMO) and the participant is penalized for failure to use these providers, this plan will base its coordination on the amounts that would have been paid if PPO or HMO providers had been used.

Order of Benefit Determination
The rules establishing the order of benefit determination are:

the benefits of a plan that covers the patient as an active employee shall be determined before the benefits of a plan that covers such patient as a retired employee or as a dependent;

the benefits of a plan for individuals with COBRA continuation coverage will be secondary to the plan covering the individual as an employee or a dependent of such employee;

the benefits of a plan that covers a person as an employee who is neither laid-off nor retired, or as that employee's dependent, are determined before those of a plan that covers a person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefit determination, the rule of the other plan will prevail;

when claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year, but:

(i) if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time; or

(ii) if the other plan does not have the rule described above under (i), and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits;

when claimant is a dependent child whose father and mother are legally separated or divorced:

the benefits of a plan that covers the patient as a dependent child of the parent with custody shall be determined first;

the plan of the spouse of the parent with custody will be determined second; and

the plan of the parent not having custody of the child will be determined third; or

if a court decree assigns financial responsibility for the health care expenses of a dependent child to one of the parents, the benefits of the assigned parent's plan will be determined first.

If none of the above rules establishes an order of benefit determination, the benefits of the plan that has covered the claimant for the longer period of time are determined before those of the plan that has covered that person for the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable to a person covered under this plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced, and such reduced amount shall be charged against any applicable benefit limit of the plan.

Right to Receive and Release Necessary Information
For the purpose of enforcing or determining the applicability of the terms of this provision of this plan or any similar provision of any other plan, the contract administrator may, without the consent of any person, release to or obtain from any insurance company, organization, or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under this plan shall furnish to the contract administrator such information as may be necessary to enforce this provision.

Special Provisions with Respect to Medicare

In accordance with the Tax Equity Fiscal Responsibility Act of 1983 (TEFRA), an active employee or spouse over age 65 who is eligible for Medicare may elect or reject coverage under this plan. If such person elects coverage under this plan, the benefits of this plan shall generally be determined before any benefits provided by Medicare. However, whenever this plan may lawfully assume a secondary position it will do so and benefits will be determined in accordance with the coordination of benefits provision above.

When this plan may lawfully assume a secondary position and an employee or dependent becomes eligible for the program of benefits provided under Medicare, he is deemed to be covered by both Medicare parts A and B for all purposes under this plan. An employee or dependent is considered to be covered by Medicare on the earliest date any coverage of him under Medicare could have been effective had he applied for Medicare in a timely manner.

Subrogation

In the event that the plan provides benefits for injury, illness, or other loss, (the "injury") to any person, the plan shall be subrogated to all present and future rights of recovery that person or his heirs, guardians, executors, or other representatives (individually or collectively called "covered person") may have arising out of the injury. The plan's right of subrogation includes, without limitation, all rights of recovery a covered person has:

against any person, insurer, or other entity that provides, or is in any way responsible for providing, payment, compensation, or indemnification arising out of the injury;

arising under state, federal, or local law;

pursuant to motor vehicle medical payments or reimbursement coverage or no-fault or personal injury protection (PIP) coverages;

pursuant to any motor vehicle insurance or uninsured motorist or underinsured motorist insurance or coverage;

under premises medical payments insurance or coverage or under homeowner's, renters, or owner's, landlord's, and tenant's (OLT) medical payments or liability insurance or coverage;

pursuant to school, athletic team, club, special event, sporting event, travel, or any other specific risk accident insurance or coverage; and

under workers' compensation laws or regulations or pursuant to any group accident and health insurance policy or any pre-paid health or accident benefit plan.

When the plan receives notice of an injury claim, it shall be entitled to assert a subrogation lien to the extent it has become or may become obligated to provide injury-related benefits. Notice of the plan's right of subrogation, or of the lien that it claims, is sufficient to establish its subrogation rights with respect to insurers, third parties, attorneys, and other persons or entities against whom a covered person may have a right of recovery arising out of the injury. The plan is not required to intervene in a personal injury or other action brought by a covered person in order to establish or maintain the plan's subrogation rights. The plan is authorized, but not required, to initiate legal action in its name or in the name of the covered person in order to enforce the plan's subrogation rights.

The covered person and anyone acting on his behalf shall provide the plan with information it deems necessary to protect its right of subrogation. The covered person is required to contact the plan prior to the settlement of an injury claim in order to determine the then-current amount of the plan's subrogation claim. The covered person shall do nothing to prejudice the plan's subrogation rights and shall cooperate with the plan in the enforcement of its rights. Neither a covered person nor his attorney is authorized to accept subrogation reimbursement payments on behalf of the plan or to settle or otherwise compromise the plan's subrogation rights without the plan's written consent, and the plan will not be responsible for any expenses or fees incurred in connection with a recovery unless it shall have agreed in writing to pay such expenses or fees. The amount of the plan's subrogation interest shall be deducted first from any recovery obtained by or on behalf of a covered person.

The plan sponsor has full and final discretionary authority to determine eligibility for benefits and to interpret plan rules and provisions, including its subrogation and coordination rules. The plan sponsor is also vested with full and final discretionary authority to reduce, settle, or otherwise compromise the amount of the plan's subrogation interest where, in the sole discretion of the benefit committee, circumstances warrant such reduction.

Eligibility and Effective Dates

Eligibility Requirements — Employees
In order to be eligible to participate in the health care coverages of the plan an employee must be a full time employee or regular part-time employee working at least 32 hours per week in active employment for the employer performing all customary duties of his occupation at his usual place of employment. See schedule of benefits for requirements.

An employee shall be deemed in active employment on each day of a regular paid vacation or on a regular non-working day on which he is not totally disabled, provided he was actively at work on the last preceding regular working day.

Effective Date — Employees
Eligible employees who are in active employment and enrolled on the effective date of the plan document and who were validly covered under the employer's plan of health care coverage that this plan replaces will be covered on the plan document's effective date. All other employees will be effective as shown in the Schedule of Benefits.

This plan may provide contributory coverage (each employee pays a part of the cost of his own coverage). An eligible employee's coverage is effective, subject to the effective date provision in the Schedule of Benefits, upon completion of the forms provided by the contract administrator for such purpose.

If an employee fails to enroll within 31 days of completion of the waiting period, the employee's coverage will be effective only in accordance with the late enrollment provision below.

Eligibility Requirements — Dependents
An eligible dependent of an employee is:

a spouse. Such spouse must have met all requirements of a valid marriage contract in the state of marriage;

any unmarried natural child under the age of 19 (including any legally adopted child or a child placed in the home awaiting the employee's adoption; a stepchild under the age of nineteen living with the employee in a parent and child relationship and dependent on the employee for support; a foster child or grandchild under age nineteen if obtained by legal custody and dependent on employee for support.) Support is evidenced by the employee being able to claim such dependent as an exemption for federal income tax purposes. The custody and financial requirements are waived if the employee or the employee's eligible legal spouse are required to provide the child with coverage due to court order, divorce decree, or Qualified Medical Child Support Order;

an unmarried student over age 19 but under age 25, if such child meets all of the requirements of the preceding paragraph, except age, and is in full-time school attendance for five calendar months or more each calendar year at a qualified educational institution.

As used herein, the term "qualified educational institution" shall mean high schools, junior colleges or other two-year colleges granting two-year degrees, universities or colleges granting four-year degrees or post-graduate degrees, proprietary schools such as business colleges, professional schools, and trade and technical schools that are established as other than evening schools exclusively.

"Full-time school attendance" means 12 units or more per semester in all of the above except proprietary schools. In a proprietary school, "full-time school attendance" shall mean a minimum of 25 hours of classroom attendance per week on a five-day per week schedule.

Cessation of full-time school attendance shall terminate coverage with respect to the student, however, if cessation is due to school vacation, coverage shall terminate on the date the school

reconvenes; if cessation is due to graduation, coverage shall terminate on the last day of the month following such graduation; or if cessation is due to disability that prevents the student's full-time school attendance, coverage shall terminate on the first day of the school's next regular session following the date established by a physician's written statement to the contract administrator that the student is capable of full-time school attendance.

An eligible dependent does not include:

any person who is on active duty in a military service;

any person who is eligible as an employee under the plan; or

any person who is covered as a dependent of another employee under the plan.

Effective Date — Dependents
This plan provides coverage for eligible dependents (each employee may pay at least a portion of the cost of coverage for his dependents). Coverage for dependents who are eligible and enrolled concurrently with the employee will be effective on the employee's effective date. Dependents not enrolled when employee is initially eligible or acquired later may become covered only if the employee makes written application for coverage for such dependents in a form furnished by the plan sponsor or contract administrator for that purpose, subject to the effective date provision below. See exception for newborn children. If application is made and received by contract administrator:

on or before the date of eligibility, dependent coverage shall be effective on the date of eligibility;

after the date of eligibility but within 31 days of that date, the dependents shall become covered on the date application is received; or

after 31 days beyond the date of eligibility, dependent coverage will be effective only in accordance with the late enrollment provision below.

If dependents are to be enrolled, the employee must cover (or apply for coverage on — see late enrollment provision below) all eligible dependents.

A dependent's coverage will not become effective prior to the employee's effective date.

Late Enrollment
If you or your dependents are not enrolled within 31 days of the date you become eligible, you may enroll in this plan during the enrollment periods only. The first enrollment period is August 15 through September 15. The second enrollment period is December 1 through January 15. For late enrollment, coverage begins on October 1 for the first enrollment period or February 1 for the second enrollment period.

Exception for Late Entrant From Another Plan
If the employee or dependents are eligible to participate in this plan, but choose instead to participate in another employer’s group health plan, they may participate in this plan without submitting evidence of good health if coverage is lost due to spouse’s death, divorce, loss of employment or cancellation of the group plan and if enrolled within 31 days of the date the coverage under the other plan ends. At the time of enrollment in this plan, a termination notice must be submitted form the prior plan. Employee and eligible dependents are subject to all limitations, provisions and requirements of this plan upon enrollment. In no event will coverage for dependents become effective prior to employee’s effective date.

Newborn/Adopted Children
A newborn baby or adopted child will be covered from birth or the date adopted child is placed in the custody of the employee if employee has dependent coverage in effect on other family members at the time of birth or adoptive placement; however, the dependent must be enrolled within 30 days of birth or adoptive placement. If dependent coverage is not in effect, the newborn or adopted child must be enrolled within 31 days of birth or adoptive placement, and coverage under the plan will become effective on the date of birth or placement. After 31 days, the late enrollment provision above will apply.

Effective Date Provision
If an employee is not in active employment on the date coverage would otherwise become effective, the coverage will not become effective until the date he returns to active employment. If an employee is not in active employment on the date he would otherwise be subject to any change in coverage or benefits as the result of an amendment to the plan or a change in the person's classification, the change in coverage or benefits shall not become effective until he returns to active employment.

In order for a dependent's coverage to become effective on the date it is scheduled, the dependent must not be confined to a hospital or skilled nursing facility on that date. If the dependent is confined, his coverage will not become effective until the day following his discharge from the facility. The same limitations apply to any scheduled change in coverage or benefits. Further, a dependent's coverage or change in coverage shall not become effective until the employee's coverage or change in coverage has also become effective. NOTE: This limitation does not apply to dependents born while the employee is covered under the plan.

Transfer of Coverage
If a husband and wife are both employees and are covered as employees under this plan, and one of them terminates, the terminating spouse and any of his eligible and enrolled dependents will be permitted to immediately enroll under the remaining employee's coverage without having to provide evidence of good health. Such new coverage shall be deemed a continuation of prior coverage and shall not operate to reduce or increase any coverage to which such person was entitled while enrolled as an employee or as a dependent of the terminated employee.

Adjustments for Prior Coverage
To the extent that coverages hereunder are a replacement of the prior plan offered by the Employer Group, any deductibles satisfied, with respect to such covered persons under the prior coverage, will be deemed to be deductibles satisfied under the Plan. Any contiguous periods a covered person was covered under prior coverage(s) of the Employer Group will be deemed to be time covered under the Plan. Documentation of satisfied deductibles is the responsibility of the covered person.

If on the date the prior plan is replaced with this Plan an employee is totally disabled, coverage under this Plan will be provided to the employee and his covered dependents, upon payment of the required contributions, in accordance with the "Extension of Coverage During Absence from Work" provision of this Plan.

Claims Procedures for Health Care Coverage

Proof of Loss
Written proof covering the details of loss for which a health care claim is made should be furnished to the contract administrator within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event later than 12 months from the date on which covered charges were incurred.

How To File a Claim
The appropriate claim forms and identification cards may be obtained directly from Sample Company. The following general steps should be followed in order to file a claim:

1. Complete the employee portion of the claim form in full. Answer all questions, even if the answer is "none" or "N/A" (does not apply).

2. Attach all necessary documentation of expenses to the claim form. Documentation must include:

   a) a description of services or supplies provided, detailing the charge for each supply or service;
   b) the diagnosis;
   c) the date(s) of service;
   d) the patient's name;
   e) the provider's name, address, phone number and degree;
   f) the federal tax identification number of the provider.

3. Complete a separate claim form for each person for whom benefits are being requested.

4. If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form sent to this plan.

5. Mail completed claim forms to:

   Boon-Chapman
   P.O. Box 9201
   Austin, Texas 78766

6. If you have any questions concerning a claim, please call 1-800-252-9653.

All claims must be filed with the plan by March 31 of each year for expenses incurred during the previous year.

How to Appeal a Denial of Benefits
If you believe a claim was improperly settled, the following process is available:

1. Within 60 days of receipt of the claim, you may request, in writing or verbally, that the plan conduct a review of the processed claim. The plan will review the processed claim and inform you whether or not an error was made. Any errors will be corrected promptly.

2. If you are not satisfied with the above review, a written request for a second review may be submitted to the plan within 60 days of the first review. The request should state, in clear and concise terms, the reason for disagreement with the way the claim was processed. When the written request is received, the claim will be reviewed again and the results of this review furnished in writing to you within 60 days in most cases, but in no case more than 120 days.

All requests for a review of denied benefits should include a copy of the initial denial letter and any other pertinent information. Send all information to:

Boon-Chapman
P.O. Box 9201
Austin, Texas 78766

Requests for appeal which do not comply with this procedure will not be considered, except in extraordinary circumstances.

GENERAL PLAN INFORMATION

Funding - Sources and Uses

Employee Obligations
The health care coverage afforded to an employee by this plan shall be at least partially funded by the employer. If an employee elects to enroll dependents under the plan, the employee may be responsible for payment of all or a portion of the dependent contributions suitable to cover such enrollment. For active employees, the employer shall deduct such costs on a regular basis from the employee's wages or salary.

Employer Obligations
The employer shall also make contributions to the plan for health care coverage. These contributions and those paid by employee, if any, shall be placed in a special account or accounts administered by the contract administrator.

Plan-Funded Benefits
The contributions will be applied to provide the benefits under the plan.

Insurance Policy
Contributions may be used to purchase insurance coverage to ensure that the plan will meet its self-funded health care coverage obligations. The policy may be reviewed upon request submitted to the contract administrator. The contract administrator is also available to answer any questions about the coverages. The provisions of the plan document in no way modify those of any insurance policy.

Administration Expenses
Contributions will also be used to pay administrative expenses of the plan in accordance with the terms and conditions of an administration agreement between the plan sponsor and the contract administrator.

Taxes
Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverages of the plan shall be paid by the plan sponsor.

Administrative Provisions

Administration
The benefits of the plan are administered by one or more contract administrators under the terms and conditions of administration agreements between the plan sponsor and contract administrator.

Alternative Care
In addition to the benefits specified herein, the Plan has the discretion to provide benefits that would not otherwise be payable when and for so long as it determines that such benefits are less than the benefits the Plan would have to pay if it did not pay them.

If the plan decides to pay such benefits in one instance, it shall not be obligated to provide the same or similar benefits in any other instance, nor shall such action waive the Contract Administrator’s right to administer the Plan thereafter in strict accordance with the provisions of the Plan Document.

Amendment or Termination of the Plan
The plan sponsor expects the plan to be permanent, but since future conditions affecting the plan sponsor or employer cannot be anticipated or foreseen, the plan sponsor must necessarily and does hereby reserve the right:

to determine eligibility for benefits or to construe the terms of the plan;

to alter or postpone the method of payment of any benefit;

to amend any provision of these administrative provisions;

to make any modifications or amendments to the plan as are necessary or appropriate to qualify or maintain the plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code; and

to terminate, suspend, withdraw, amend, or modify the plan in whole or in part at any time.

Annual Statements
If required by law, the plan sponsor shall furnish to each employee, within a reasonable period of time following the close of a plan year, a written statement showing the amounts paid or expenses incurred by the plan sponsor for plan benefits during the prior plan year.

Anticipation, Alienation, Sale, or Transfer
No benefit payable under the provisions of the plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to so anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge shall be void; nor shall such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of or claims against any employee, covered dependent, or beneficiary, including claims of creditors, claims for alimony or support, or any like or unlike claims.

Discrepancies
In the event of a discrepancy between the booklet provided to employees (the "Summary Plan Description") and the plan document, the plan document will prevail.

Entire Contract
The plan document, any amendments, and the individual applications, if any, of covered persons shall constitute the entire contract between the parties. The plan does not constitute a contract of employment or in any way affect the rights of an employer to discharge any employee.

Facility of Payment
Every person receiving or claiming benefits under the plan shall be presumed to be mentally and physically competent and of age. However, in the event the plan determines that an employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the employee has not provided the plan with an address at which he can be located for payment, the plan may, during the lifetime of the employee, pay any amount otherwise payable to the employee to the husband, wife, or relative by blood of the employee or to any other person or institution determined by the plan to be equitably entitled thereto; or in the case of the death of the employee before all amounts payable have been paid, the plan may pay any such amount to one or more of the following surviving relatives of the employee: lawful spouse, child or children, mother, father, brother, or sister, or to the employee's estate, as the plan sponsor in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the plan.

If a guardian, conservator, or other person legally vested with the care of the estate of any person receiving or claiming benefits under the plan is appointed by a court of competent jurisdiction, payments shall be made to such guardian, conservator, or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the fiduciaries. To the extent permitted by law, any such payment so made shall be a complete discharge of any liability therefor under the plan.

Fiduciaries
Fiduciaries shall serve at the discretion of the plan sponsor and shall serve without compensation, but they shall be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. The plan sponsor may at any time and from time to time remove any fiduciary or appoint new fiduciaries. Any fiduciary may resign at any time upon 30 days' notice in writing delivered to the plan sponsor. Fiduciaries may act, at a meeting or without a meeting, by a majority of the fiduciaries at the time in office. The fiduciaries may appoint a member as their secretary, who shall have such powers and responsibilities relating to the administration of benefits under the plan as the fiduciaries shall delegate.

Fiduciary Responsibility, Authority, and Discretion
Fiduciaries shall discharge their duties under the plan solely in the interest of the employees and their beneficiaries and for the exclusive purpose of providing benefits to employees and their beneficiaries and defraying the reasonable expenses of administering the plan.

The fiduciaries shall administer the plan and shall have the authority to exercise the powers and discretion conferred on them by the plan and shall have such other powers and authority necessary or proper for the administration of the plan as determined from time to time by the plan sponsor.

The fiduciaries may adopt such rules and procedures for the administration of the plan as they consider advisable and shall have full power and authority to enforce, construe, interpret, and administer the plan.

In carrying out their responsibilities under the plan, fiduciaries shall have discretionary authority to interpret the terms of the plan and plan document and to determine eligibility for and entitlement to plan benefits in accordance with the terms of the plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The fiduciaries may employ such agents, attorneys, accountants, investment advisors, or other persons (who also may be employed by the employer) as in their opinion may be desirable for the administration of the plan, and they may pay any such person reasonable compensation. The fiduciaries may delegate to any agent, attorney, accountant, or other person selected by them any power or duty vested in, imposed upon, or granted to them by the plan.

Force Majeure
Should the performance of any act required by the plan be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations under the plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology shall also include the feminine, and the definition of any term in the singular shall also include the plural.

Illegality of Particular Provision
The illegality of any particular provision of the plan document shall not affect the other provisions, but the plan document shall be construed in all respects as if such invalid provision were omitted.

Incontestability
No statement made by any person covered under the plan relating to the person's good health shall be used in contesting the validity of the coverage with respect to which such statement was made after such coverage has been in force prior to the contest for a period of two years during such person's lifetime, nor unless it is contained in a written instrument signed by such person.

All statements made by the person covered shall be deemed representations and not warranties, and no statement made by any person covered shall void the coverage or be used in any contest, unless a copy of the instrument containing the statement is or has been furnished to such person or to such person's beneficiary.

Indemnification
To the extent permitted by law, employees of the employer, the fiduciaries, and all agents and representatives of the fiduciaries shall be indemnified by the plan sponsor and saved harmless against any claims and conduct relating to the administration of the plan, except claims arising from gross negligence, willful neglect, or willful misconduct. The employer reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No employee, dependent, or other beneficiary shall have any right or claim to benefits from the plan, except as specified herein. Any dispute as to benefits under this plan shall be resolved by the plan sponsor under and pursuant to the plan document. No action may be brought for benefits provided by the plan or an amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the plan, and then action may only be brought within one year after the date of such decision.

Physical Examination and Autopsy
The plan, at its own expense, shall have the right and opportunity to have a physician of its choice examine the covered person when and as often as it may reasonably require during the pendency of any claim and to make an autopsy in case of death, where it is not forbidden by law.

Reimbursements
Whenever any benefit payments that should have been made under the plan have been made by another party, the plan sponsor and the contract administrator shall be authorized to pay such benefits to the other party, provided, however, that the amounts so paid will be deemed to be benefit payments under the plan, and the plan shall be fully discharged from liability for such payments to the full extent thereof.

Right of Recovery
Whenever any benefit payments have been made by the plan in excess of the maximum amount required under the terms of the plan document, the plan shall have the right to recover all such excess amounts from any persons, insurance companies, or other payees, and the employee or dependent shall make a good-faith attempt to assist the contract administrator in such recovery.

The plan may, in its sole discretion, pay benefits for care or services covered hereunder pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent such care or services have been provided, the plan shall be entitled to recoup and recover the amount paid therefor from the covered person or the provider of service in the event it is determined that such care or services are not covered hereunder. The covered person or his parent or guardian shall execute and deliver to the plan all assignments and other documents necessary or useful to the plan for the purpose of enforcing its rights under this provision.

Rights Against the Employer
Neither the establishment of the plan, nor any modification thereof, nor any distributions hereunder shall be construed as giving to any employee or any person any legal or equitable rights against the plan sponsor or its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the employer.

Substitution
The plan sponsor shall be substituted for all rights of an employee to recover attorney fees against any adverse party. Employees shall do nothing to prejudice such rights of the plan sponsor, and, further, they agree to perform all acts necessary to preserve and take advantage of such rights. If payment has been made by the plan in such instances and if the adverse party reimburses the employee directly, the plan shall have the right to recover such payment from an employee.

Titles or Headings
Where titles or headings precede explanatory text throughout the plan document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the plan document and will not affect the validity, construction, or effect of the plan document provisions.

Type of Plan
This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for eligible employees of the employer, their eligible dependents, and qualified beneficiaries under COBRA.

Workers' Compensation
The benefits provided by the plan are not in lieu of and do not affect any requirement for coverage by workers' compensation insurance laws or similar legislation.