Occupational Injury Summary Plan Description
&
THE RIGHT PLAN

Solving Injury Grievances Here Together

Dear McDonald's Employee:

We all know that accidents on the job happen from time to time. And when they do, you want to receive prompt, professional medical treatment with very little hassle. You also want a paycheck even if you need to stay home to recover. We have developed and now updated an occupational injury plan, called the Safe Workers Ahead program, with these goals in mind. This updated program is effective for all on-the-job injuries that occur on or after May 1, 2004 or such later date specified in Section A.1.of the enclosed Adoption Agreement.

We also understand that problems can occur even in the best workplaces. And we want to be sure that you know exactly what process to follow if you need some help to get the matter resolved...in a way that is fair and fast. That's why we've developed and now updated a program called The Right Plan ("Resolving Injury Grievances Here Together"). This updated program is also effective May 1, 2004 or such later date specified in Section A.1. of the enclosed Adoption Agreement. This Program does not take away your legal rights - it only changes the method for resolving work-related injury disputes from a long, expensive and unpleasant lawsuit to a process that lets you and your employer resolve your differences together in a timely and objective manner.

We hope you never need this injury benefit coverage. But if you are hurt at work, you will have a plan designed to take care of you and your family's needs.

And we hope you never have a work-related injury problem. But if you ever do, you will have a process designed to deal with the situation quickly and fairly.

Sincerely,

Your McDonald's Owner/Operator

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"Why has your Employer started this program?"
Your employer, as named in Section A of the enclosed Adoption Agreement (the "Employer"), created this occupational injury plan (the "Plan") because we wanted to have a better administrative system for helping employees who are hurt at work. The Texas Workers' Compensation System is a huge bureaucracy, making it tougher for injured employees to receive prompt, fair attention. Texas Workers' Comp has also been plagued by abuses, which raises the costs for companies and requires honest employees to work harder. **In short, we think McDonald's can do a better job managing its own occupational injury plan outside of the state workers' compensation system**.

By making this change, we are doing what **many other companies in Texas** have done over the past 10 years, including Popeye's and Church's Chicken, Randall's/Tom Thumb, Minyard's and HEB Grocery, Pappas Restaurants, Long John Silver's and Wendy's restaurants, and thousands of other Texas employers.

"How will the Plan affect me?"
The Plan pays for covered medical care and makes sure you receive a paycheck if you need to stay home because of an on-the-job injury.

"What are some of the requirements of the Plan?"

- All injuries must be **reported by the end of the work shift (if possible), but no later than 24 hours after that work shift**. If you need medical care, we want you to receive it immediately.

- We have selected and **approved certain doctors and other healthcare providers** that must be used in order to receive the injury benefits. This helps ensure that you receive high quality care from **occupational specialists**.

"What are the advantages of the Plan?"

- Prompt handling of your injury benefit claims, and More personalized attention

"If I can't go to work because of an on-the-job injury, is there a waiting period before my wage replacement benefits will begin?"
No. Instead of the seven-day waiting period that is required by Texas Workers' Compensation, the Plan starts replacing your wages with a paycheck from the first day you miss work.

"What other benefits are provided?"

The enclosed Adoption Agreement provides a summary of the benefits. More information on benefits is provided later in this booklet.

"If I have a workplace injury, how do I get Plan Benefits?"

- Report Your Injury Immediately. By the end of your work shift (if possible), but no later than 24 hours after that work shift.
- Fill out an Employee Accident Report Form.
- Use Approved Doctors and other Approved Healthcare Providers.
- Submit to a Drug and Alcohol Screen.
- Follow the Doctor's Orders.
- WELCOME BACK!

"What if I have a problem with benefit payments?"

The Employer and its team of claim adjusters will make benefit decisions and address any problems related to benefit payments. This program also includes a formal process for appealing benefit decisions and arbitration procedures that help resolve any disputes that may arise between you and the Employer...quickly and fairly.

"Does this affect my health insurance or other benefits?"

Absolutely not! They are totally separate.

"When does the Plan take effect?"

It is effective for all injuries that occur on or after May I, 2004 or such later date specified in Section A.1. of the enclosed Adoption Agreement.

THE RIGHT PLAN HIGHLIGHTS

"Why has the Employer started this program?"
At McDonald's, we're committed to you and the Employer working together to maintain good relationships. But we know that sometimes these relationships can break down and result in misunderstandings or disagreements between us. So we've developed a three-step process for **Resolving Injury Grievances Here Together** called The RIGHT Plan that we believe is a faster and better way to solve work-related problems.

"What are the program steps?"
This program has three steps:

Two Internal Steps - that take place with the Employer, **and**

One External Step - that require assistance from a neutral third party from outside the Employer

Your concern may be resolved in one Step, or all three. Each Step must be followed in sequence so that we have every opportunity to work together toward an agreeable resolution of the issue. Here is some more detail on each step:

INTERNAL PROCEDURES:
Step 1. Communication
Talking it out one-on-one with your restaurant manager can usually solve a problem.

Step 2. Internal Mediation
Sometimes it is helpful to get a third party involved in the process to hear both sides of an issue. If you've already talked with your restaurant manager and still feel that your questions haven't been answered to your satisfaction, you can request that the restaurant owner get involved formally. To do this, simply complete a "Request for Internal Mediation" form (available from your restaurant manager). He or she (or someone he or she designates) will talk with you and any other people who might know something about the problem, and then will meet with you to talk about what he or she found out and present possible solutions to the problem.

These two internal steps should resolve most, if not all, workplace issues that may arise.

EXTERNAL PROCEDURES:
Step 3. Arbitration
If you have a work-related problem that involves a legally protected right that could not be settled through Steps 1 or 2 of the program, you may request arbitration. Arbitration is a process where both you and the Employer agree to have an impartial outside person make a final and binding decision that you and the Employer must stick to. The outside person - called an arbitrator - acts like a judge and jury in the arbitration process. He or she listens carefully to the information each party presents, makes a decision on the problem and decides what award is appropriate (if any). The goal of arbitration is to resolve problems quickly, fairly, and finally.
Under arbitration, you will need to:

- Request Arbitration - you will need to complete a "Request for Arbitration Form" (available from your restaurant manager) and send the original to the American Arbitration Association (or "AAA"), and a copy to the restaurant owner.

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- Choose an Arbitrator - you and the Employer will need to choose an arbitrator from a list of arbitrators that will be sent to you by AAA.
- Pay a Filing Fee - you will need to pay a filing fee at the time you turn in your "Request for Arbitration Form." This fee will be $125. The Employer will pay the remaining portion of this fee plus additional fees and expenses charged by the arbitrator or AAA.
- Attend a Hearing - You and the Employer will then attend a hearing where both parties can present their side of the story. You can also present evidence, give testimony and have a lawyer represent you at the hearing; however, if you choose not to have a lawyer at the hearing, the Employer will also not bring a lawyer to the hearing. After hearing both sides, the arbitrator will make a final and binding decision. If you win, the arbitrator may award you anything you could have received from a court of law

"Is this three-step process mandatory?"

Yes. The Right Plan is a mandatory condition of your employment, which you accept and agree to by becoming employed or continuing your employment with the Employer at any time on or after May 1, 2004.
The Employer is also mutually bound to use this program for any covered claim.

"What are the advantages of The RIGHT Plan?"

Less For Lawyers ... More For You

The arbitration process can be free from legal representation. If you do not hire a lawyer to represent you in the arbitration hearing, the Employer will not bring a lawyer to the hearing either. By not involving lawyers, you will not have to share any award you receive from an arbitrator with an attorney. If hired on a "contingency basis" - which means the lawyer's fees are a certain percentage of any amount you are awarded - lawyers typically receive 33% to 50% of a courtroom award or settlement.

Protected Rights

Arbitration offers protection similar to a court of law. You keep your legal right to seek damages. It is only the process that changes from a lengthy, expensive trial to a quick resolution with a fair, experienced arbitrator. And the arbitrator, just like a judge or jury, may award you anything you might seek through a court of law.

Fast Decisions

When a problem is taken to court, it can take years to settle. But with arbitration, decisions can be reached in just a couple of months.

Fair Decisions

Courts hear all types of cases ranging from car accidents to divorces. Judges and juries do not specialize in solving employment problems. But arbitrators do. Plus, the arbitrator is objective and does not have any relationship with the Employer.

Better Relationships

Arbitration is less formal than a courtroom trial and emphasizes a straightforward, open exchange of information. For this reason, it is much more likely to preserve the working relationship than a trial, which often draws clear battle lines and closes the lines of communication.

Your Employer is excited about being able to provide you with the Occupational Injury Plan and The RIGHT Plan.

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OCCUPATIONAL INJURY PLAN DETAIL

INTRODUCTION

Your Employer has rejected coverage for its Texas employees under the Texas Workers' Compensation Act and established an occupational injury plan (the "Plan"). This Plan is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The Employer is committed to providing loss of income protection and helping you pay medical expenses which might otherwise present a financial burden to you if you are injured on the job. This booklet has been prepared to help you understand your benefits under the Plan. Please read it carefully.

In order for the benefits described in this booklet to apply, the date of the on-the-job Injury must be on or after the Plan's Effective Date. "Effective Date" means May 1, 2004 or such later date specified in Section A.l. of the Adoption Agreement. Such date may either be the original effective date of this Plan, or if this document is a continuation and restatement of a preexisting occupational injury benefit plan, the restatement effective date.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

The following notice is being provided as required by Texas law:

COVERAGE: The Employer has elected not to obtain workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. Your employer is required to provide you with the coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY HOTLINE: The Commission has established a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupation health or safety violation. Contact the Division of Workers' Health & Safety at 1-800-452-9595.

Your Injury Plan: The Employer **DOES PROVIDE** to all eligible Texas employees, without cost, the Injury Plan described in this booklet.

Our Safety Program: The success of our company largely depends upon you following all of our safety rules and procedures and **immediately notifying your supervisor first** of any unsafe working condition or injury, no matter how minor. As mentioned above, you will not be suspended, terminated, or discriminated against because you in good faith report an unsafe condition or potential occupational health or safety violation.

ELIGIBILITY

You automatically become a participant in the Plan on the later of (1) the Effective Date, or (2) or the time and date that you satisfy the following:

- you work in the State of Texas in the regular business of the Employer (this includes those employees working temporarily outside the State of Texas but under the direction and control of and in the regular business of the Employer);
- you are under the direction and control of the Employer; and
- you receive your pay on a regular basis by means of a salary, commission or wage directly from the Employer.

The Plan does not cover independent contractors or agents of a third-party.

ARBITRATION OF INJURY AND BENEFITS DISPUTES

Your employment by the Employer and your participation in this Plan is subject to the terms of this Plan and **"THE RIGHT PLAN" WHICH IS A TT ACHED TO THIS BOOKLET. THE RIGHT PLAN IS AN EMPLOYER POLICY PROVIDING THAT ALL CLAIMS OR DISPUTES IN ANY WAY RELATING TO AN ON-THE JOB INJURY OR ILLNESS, OR DEATH CAUSED BY OCCUPATIONAL INJURY OR ILLNESS ARE SUBJECT TO BINDING ARBITRATION. THIS BINDING ARBITRATION WILL BE THE SOLE AND EXCLUSIVE REMEDY FOR RESOLVING ANY SUCH CLAIM OR DISPUTE. NEITHER YOU, YOUR BENEFICIARIES, SPOUSE, HEIRS, LEGAL REPRESENTATIVES, OR ASSIGNS NOR THE EMPLOYER SHALL BE ENTITLED TO A JURY TRIAL ON ANY SUCH CLAIM OR DISPUTE. BY**

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REMAINING IN THE EMPLOY OF THE EMPLOYER ON OR AFTER THE EFFECTIVE DATE SPECIFIED IN THE ADOPTION AGREEMENT, YOU INDICATE THAT YOU UNDERSTAND AND VOLUNTARILY AGREE TO THIS BINDING ARBITRATION POLICY.

The Employer is obligated to pay benefits under and in accordance with the terms of this Plan, and the arbitration policy will remain in effect with respect to the Employer and you, even if you refuse benefits under this Plan, benefits cease, or you voluntarily or involuntarily terminate employment with the Employer.

HOW THE PLAN WORKS

Procedure In Event Of Injury

- Notify your supervisor immediately after being injured at work, no matter how minor the Injury appears to be. This verbal notice must be provided by the end of the work shift for the date of the Injury (if possible), but no later than 24 hours after the end of that work shift. A written report must be submitted within 24 hours after the Injury is reported as required above.

- If necessary, the Claims Administrator will assist you in arranging for appropriate medical treatment. You do not have the right to select and have the Plan pay for your choice of a primary care provider or provider of specialty medical care, even if such provider is an Approved Physician or Approved Facility.

- In order to receive any benefits under this Plan, **treatment must be pre-approved** by the Claims Administrator and you must receive medical care from an **Approved Physician or Approved Facility immediately (and not more than 14 days after the date of Injury)**. You may use a non-approved physician or facility only if the following requirements are satisfied:

  - **First**, the treatment is provided for Emergency Care (as described further in the MEDICAL BENEFITS section of this booklet);

  - **Second**, an Approved Physician or Approved Facility is not available, or is not within a reasonable distance from your location, at the time of your Injury (taking into account the nature of your Injury);

  - **Third**, you provide notice to the Claims Administrator of such Emergency Care within the later of 24 hours after your receipt of such care or the next business day;

  - **And finally**, after receiving treatment for primary Emergency Care, subsequent treatments must be provided by, or at the direction of, an Approved Physician or Approved Facility.

- Initial medical care must include alcohol and drug testing (if required by your Employer), and you must either provide the Employer with this alcohol and drug testing information or authorize the Employer to gain access to this information.

- You must also follow the procedures described below in the REQUESTING BENEFITS section of this booklet.

Approved Healthcare Providers

As mentioned above, you must receive all medical care from **Approved Physicians or Approved Facilities (acting within the scope of their license) pre-approved by the Claims Administrator** (except in limited situations involving Emergency Care). The terms "Approved Physician" and "Approved Facility" are capitalized and used throughout this booklet and have the following meaning:

- Approved Facility - A hospital or other medical care facility or medical service or supply provider either expressly approved by the Claims Administrator, included on an approved list of facilities adopted by the Claims Administrator, or otherwise approved in writing by the Claims Administrator upon the request of a Plan participant.

- Approved Physician - A person duly licensed under Texas law as a Medical Doctor or Doctor of Osteopathy and either expressly approved by the Claims Administrator, included on an approved list of physicians adopted by the Claims Administrator, or otherwise approved in writing by the Claims Administrator upon the request of a Plan participant.

Any list of Approved Physicians and Approved Facilities will be furnished to you, without charge, as a separate document. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any such list of Approved Physicians or Approved Facilities at any time. **No Approved Physician or Approved Facility is an agent of the Employer. Although benefits under this Plan are conditioned on your use of only Approved Physicians and Approved Facilities, you remain entitled to seek any medical care you deem appropriate from any provider of your choice at your own expense. In addition, the Plan is not intended to affect your relationship with your healthcare providers. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of you and your attending Approved Physician and other healthcare providers based on their independent judgment for the provision of health care.**

For purposes of this Plan, all determinations relating to your physical condition and the payment of benefits (for example, inability to return to work or results of a prior injury) must be made by an Approved Physician. You must follow fully and

completely the advice of, and the course of medical treatment prescribed by, the treating Approved Physician, and must keep all scheduled appointments to fulfill the prescribed medical treatment plan. The Claims Administrator will have the right to require you to be examined or reexamined by an Approved Physician as often as they determine to be reasonably necessary or appropriate while you are receiving or claiming benefits under the Plan.

Funding
The Employer currently pays the entire cost to provide your coverage under this Plan and pays Plan benefits solely out of the general assets of the Employer. The Employer has the right, but no obligation, to obtain insurance contracts to provide funds to the Employer that can be used by the Employer to pay all or any portion of a benefit under the Plan; but no benefits under the Plan are guaranteed under any contract or policy of insurance and the Employer will be solely responsible for the payment of claims under this Plan. If the Employer has purchased an insurance policy, the purpose of which (in whole or in part) is to provide funds to the Employer for Plan benefits or that may be used to reimburse the Employer for Plan benefits, then:

- **benefit payments under this Plan shall not be payable or shall immediately cease in the event that benefits coverage is not available to the Employer or ceases under such policy for any reason; and**

- no such insurance policy proceeds shall be considered "plan assets" for purposes of ERISA. Policy proceeds shall constitute a part of the general assets of the Employer. Any such insurance policy shall be owned by, and all amounts under the policy shall be payable to the Employer, and you shall not have any interest in, or right to, any amounts payable under the policy (even though certain benefit payment, reporting or other requirements of this Plan may relate to requirements of such insurance policy).

COVERED AND NON-COVERED INJURIES

Covered Injuries
The Plan pays benefits only on account of damage or harm to the physical structure of the body resulting from an "Accident" (which means a sudden, unforeseen, unusual, specific event that occurs at an identifiable time and place). Any such damage or harm must occur or arise during the Course and Scope of Employment by the Employer (as further described in the Plan document). In order to be subject to the provisions of this booklet, **the date of the Injury must be on or after the Effective Date**. Any provision of this Plan to the contrary notwithstanding, if the Employer has purchased an insurance policy as described above, the purpose of which (in whole or in part) is to pay Plan benefits to a participant or reimburse the Employer for Plan benefits, then the Accident must have occurred during the policy period. For purposes of this Plan, all injuries resulting to an Accident or related series of Accidents will be considered a single Injury.

Types of Non-Covered Injuries
The term "Injury," as used in this booklet, does not include:

- Any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure or other body part resulting from use of a video display terminal or keyboard or cash register, poor or inappropriate posture, the natural results of aging, osteoarthritis, arthritis, or degenerative process, factors to which the general public is exposed, or other circumstances-prescribed by the Claims Administrator which do not directly and solely result from your Course and Scope of Employment;

- Diagnostic labels which imply generalized musculoskeletal aches and pains in the absence of any demonstrable- primary pathophysiology, such as Fibrositis, Fibromyalgia, Myofascial Pain Syndrome, Myositis, or Chronic Fatigue Syndrome;

- Except to the extent provided under the section of this booklet entitled "Medical Requiring Specific Approval in Writing or by Electronic Notice," any mental injury, emotional distress, chronic fatigue syndrome, mental trauma or similar injury to the mental or emotional state of a participant, including, without limitation, any physical manifestations resulting from such mental or emotional state, and any mental or emotional damage or harm that arises primarily from a personnel action, including, but not limited to, a transfer, promotion, demotion or termination of employment or other disciplinary action;

- Damage or harm to the physical structure of the body, such as carpal tunnel syndrome, occurring (or alleged to have occurred) as the result of repetitious, physically traumatic activities that occur over time;

- Any illness or disease, howsoever acquired, unless contracted following and as the direct result of an otherwise covered Injury;

- Ptomaine or bacterial infection, except when resulting from accidental ingestion or accidental inhalation of poisonous food substances, and except pyogenic infection which occurs with and as a result of an accidental cut or wound;

- Damage or harm resulting from airborne contaminants not commonly found in the Employer's normal working environment, including, but not limited to, pollen, fungi, and mold;

- Damage or harm resulting from job stress;

- your horseplay, scuffling, fighting, or similar inappropriate behavior was a proximate cause of the Injury;

- A heart attack, stroke, or aneurysm;

- Hernia, unless such hernia is an inguinal hernia that-

  - appeared suddenly and immediately following the Injury; and
  - did not exist in any degree prior to the Injury; and
  - was accompanied by pain.

Any preexisting condition, except to the limited extent (if any) that an Approved Physician clearly confirms an identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a preexisting condition; provided, however, that

  - coverage for such aggravation will be provided only if and to the extent that the Approved Physician -

- confirms that the preexisting condition has been previously repaired or rehabilitated; and

- prescribes services or supplies that are medically necessary to treat such aggravation and likely to return you to pre-Injury status; and

  - no coverage will be provided if the preexisting condition was a major contributing cause of the Injury.

Non-Covered Injury Circumstances
Furthermore, no benefits will be payable under the Plan if:

- your employment is not principally located in the State of Texas;

- the Injury occurred while you were in a state of intoxication (which would include, but not be limited to, an alcohol concentration of 0.08 or more, or the presence of any level of a controlled substance), or had otherwise lost the normal use of your mental or physical faculties as a result of the use of a drug or alcohol;

- the injury giving rise to the Total Disability is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo, and you have not availed yourself of such treatment;

- the Injury was caused by your willful intention at attempt to injure yourself or another person, whether you were sane or insane;

- the Injury occurred while you were employed in violation of any law;

- your horseplay, scuffling, fighting, or similar inappropriate behavior was a proximate cause of the Injury;

- the Injury was incurred while you were "on suspension," "laid off," on leave of absence for any other reason or otherwise outside of the Course and Scope of Employment by the Employer;

- the Injury arose out of an act of a third person intended to injure you because of personal reasons and not directed at you as an employee or because of your employment;

- the Injury arose out of your voluntary participation in an off-duty recreational, social or athletic activity not constituting part of your work-related duties, except where these activities are expressly required in writing by where these activities are expressly required in writing by your Employer (more than an invitation or request to participate or attend);

- the Injury arose out of an act of God, unless your employment exposes you to a greater risk of Injury from an act of God than ordinarily applies to the general public;

- the alleged Injury is feigned or an attempt to defraud the Employer;

- it is determined that the Injury occurred, in whole or in part, in connection with your (1) violation of employment policies or safety rules (including, but not limited to, willful disregard of express direction by a supervisor), or (2) failure to obtain available assistance provided for your benefit to accomplish a particular task or to properly utilize available appropriate equipment or appliances;

- the Injury arose out of a declared or undeclared act of war, armed invasion, aggression, riot or act of civil disturbance, strike, act of foreign enemies, 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 any act of terrorism;

- the Injury arose out an atomic explosion or other release of nuclear energy (except when nuclear energy is being used solely for medical treatment of an illness), whether in peace time or at time of war, and whether intended or accidental;

- the Injury arose out of your participation in the commission, or attempted commission, of any crime;

- the Injury occurred while you were traveling or flying in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation if you are:
  - flying in any aircraft that is rocket propelled;
  - flying in any aircraft used for aerobatics, racing or an endurance test, crop dusting, seeding, fertilizing, or spraying, fighting a fire, any exploration or pipe or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting or any test or experimental usage;
  - flying when a special permit or waiver from the proper authority has to be issued;
  - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
  - riding as a passenger in an aircraft owned, leased, or operated by the Employer; or.
- the injury did not occur during the Course and Scope of Employment.

"Course and Scope of Employment" means an activity of any kind or character for which you were hired and that has to do with, and originates in, the work, business, trade or profession of the Employer, and that is performed by you in the furtherance of the affairs or business of the Employer. The term includes activities conducted on the premises of the Employer or at other locations designated by the Employer.
This term does not include:

- transportation to and from your place of employment, unless:
  - the transportation is furnished as part of the employment arrangement or is paid for by the Employer (but this does not include travel to your usual place of employment in a vehicle owned by the Employer and driven by you);
  - the means of the transportation are under the control of the Employer; or
  - you are directed in your employment to proceed from one place to another place.
- travel by you in furtherance of the affairs or business of the Employer if such travel is also in furtherance of personal or private affairs by you, unless:
  - the travel to the place where the Injury occurred would have been made even had there been no personal or private affairs by you to be furthered by the travel; and
  - the travel would not have been made had there been no affairs or business of the Employer to be furthered by the travel.
- any injury occurring while you are on a work break, unless (1) the injury occurs while you are on a work break inside the Employer's facility, (2) such work break was authorized by your supervisor, (3) you are scheduled to return to work that same day following such work break, (4) you are not required to clock out for such work break under the Employer's timekeeping rules, and (5) you have not clocked out for the Employer.

WAGE REPLACEMENT BENEFITS

Benefit Computation
If you become Totally Disabled due to a covered Injury, this Plan provides Wage Replacement Benefits. If you have been Totally Disabled as the result of the Injury for the number of consecutive working days (if any) specified in the Adoption Agreement as the "Waiting Period" (days on which you would normally be at work), then the Plan will begin payment of Wage Replacement Benefits equal to your Percentage of Pre-Injury Pay specified in the Adoption Agreement; provided, however, that such benefit payments (1) will be reduced as described in the "Offset For Other Benefits" section of this booklet, and (2) will not exceed the Maximum Weekly Disability Benefit Amount specified in the Adoption Agreement.

Wage Replacement Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week will be prorated. Only your normal, scheduled workdays will be considered in calculating benefits (based upon your employment status as of the date of Total Disability begins).

When Wage Replacement Benefits Cease
Wage Replacement Benefits will continue until the earliest of:

- the expiration of the Maximum Disability Benefit Period specified in the Adoption Agreement (which period begins on the date such benefits begin to accrue). This Maximum Disability Benefit Period for Wage Replacement Benefits is calculated continuously from the date of the Injury, regardless of whether or not you qualify as Totally Disabled at all times during such period or receive Wage Replacement Benefits continuously throughout such period;
- the date you are certified by the treating Approved Physician to no longer be Totally Disabled, without regard to whether you return to regular or Modified

Duty on that date; provided, however, that Wage Replacement Benefits may restart if you -

- have been released and actually returned to Modified Duty,
- have made a good faith effort to comply with the treating Approved Physician's instructions and carry out your responsibilities in the Modified Duty position, and
- are again determined by an Approved Physician to be Totally Disabled;

- the date any Combined Limit specified in the Adoption Agreement (and further explained in the formal Plan document) is reached,

- termination of all your employment with the Employer;
- provided, however, that this paragraph will not apply if termination of employment is solely due to elimination of your employment position;

- the date you are placed in jail, are deported or detained by or at the request of any government agency or foreign government, have left the local area for an extended period of time, or are similarly unavailable for work; provided, however, that this paragraph shall operate to cease Wage Replacement Benefits only for such period of time that you are unavailable for work; or

- as otherwise provided under the CONTINUING BENEFITS section below.

Other Benefit Reductions
Wage Replacement Benefits are generally considered taxable income, and all appropriate amounts will be withheld. Also, amounts legally garnished may be withheld and appropriate Pre-Injury Pay deductions for such items as retirement plan contributions and insurance premiums will continue to be withheld unless you provide instructions to the contrary in accordance with applicable program rules and procedures.
Also see the "Offset For Other Benefits" section of this booklet.

"Total Disability" or "Totally Disabled" means a medically demonstrable anatomical or physiological abnormality caused by an Injury, and commencing within six months from the date of Injury, which (1) causes you to be unable to perform the normal duties for which you were employed; (2) causes you to be under the regular care of an Approved Physician; and (3) causes you to be unable to engage in Modified Duty or any other occupation for wage or profit. "Pre-injury Pay" is defined in the formal Plan document and does not include any overtime, tips, bonuses, commissions, benefits or other extraordinary compensation. "Modified Duty" is those functions of your job which you are able to perform, taking into account your Injury, or other work for which you have been or can be trained.

MEDICAL BENEFITS

The Employer is committed to providing medical attention to help protect you against the financial hardship that may be caused by a covered Injury. Subject to the medical management and other provisions of this Plan, medical services and supplies are covered at 100% (referred to below as "Covered Charges"), with no co-pays, deductibles or other out-of-pocket expense to you, provided that all of the following requirements are satisfied. The service or supply must be medically necessary, based on the nature of the Injury, as and when provided, and (1) cure or relieve the effects naturally resulting from the Injury; (2) promote recovery; or (3) otherwise enhance your ability to return to or retain employment. Such services and supplies are also subject to the other medical management provisions of the Plan. Coverage also requires satisfaction of the following requirements:

First and Continuing Treatment
- The first Covered Charge must be incurred within 14 days following the date of your Injury; and

- No further amount shall be considered a Covered Charge if you do not receive medical treatment from an Approved Physician for a period of more than 60 days.

Approved Provider and Pre-Authorization Requirements
The cost of a service or supply shall be a Covered Charge only if:

- Treatment is pre-approved by the Claims Administrator and furnished by or under the direction of an Approved Physician or Approved Facility, acting within the scope of the Approved Physician's or Approved Facility's license. Such pre-approval may include authorization for multiple visits to an Approved Physician or Approved Facility, and may be verbal, in writing, or by electronic notice; provided, however that some services or supplies require the specific approval of the Claims Administrator in writing or by electronic notice, as described below. The Claims Administrator will not deny a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize your life or health; 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 Physician or Approved Facility; or

- Treatment is provided as Emergency Care and (1) an Approved Physician or Approved Facility is not within reasonable proximity to your location (taking into account available transportation and the nature of the injury); and (2) the Claims Administrator receives notification of such Emergency Care within the later of 24 hours of your

receipt of such care or the next business day; and (3) after receiving primary Emergency Care, subsequent treatments are provided by, or at the direction of, an Approved Physician or Approved Facility in accordance with the paragraph above.

"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 (1) result in death, disfigurement, or permanent disability, or (2) 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 above exception for Emergency Care. "Urgent Care Claims" (as discussed in this booklet's claims procedures) may not arise to the level of involving Emergency Care. Any decision by you to seek treatment from" an urgent care clinic or hospital emergency room does not necessarily involve Emergency Care. That determination shall be made within the sole administrative discretion of the Claims Administrator or Committee, with such advice and consultation from an Approved Physician as the Claims Administrator or Committee deems appropriate. If you obtain treatment from a non-approved healthcare provider and the Claims Administrator or Committee determines that your situation has not satisfied all of the above requirements, your claim for benefits will be denied. For this reason, we strongly suggest that you always seek approval for treatment from the Claims Administrator, even when you need Emergency Care.**

Covered Medical
Subject to the restrictions and limitations set out elsewhere in this Plan, Covered Charges will include the cost of the following:

- Approved Physician visits - at a Approved Facility (including charges for an operating or emergency room), Approved Physician's office or, in the case of home health care, at your home, including second opinion services requested by the Claims Administrator, and charges for a registered nurse;

- Medical supplies approved by the Approved Physician, including the following:

  - Prescription drugs (generic unless trade name drugs are requested by an Approved Physician) and over the-counter drugs such as analgesics prescribed by an Approved Physician;
  - Blood and other fluids (other than allergy, insulin, and similar drugs) injected into the circulatory system (but only to the extent not available through any refund or allowance by a blood bank or similar organization);
  - Oxygen and its administration;
  - Upon the written advice or prescription of an Approved Physician and only if obtained from an Approved Facility, rental or purchase of a wheelchair, assisted breathing apparatus, or other mechanical equipment necessary for the treatment of respiratory paralysis, and similar internal or external durable medical equipment designed primarily for therapeutic purposes;
  - Surgical dressings, bandages, splints, casts, crutches, syringes, needles, trusses, and braces dispensed by an Approved Physician or Approved Facility; and
  - Other items approved by the Claims Administrator;

- Outpatient services and supplies, including ambulatory day surgery, x-ray examinations, laboratory tests, diagnostic services, and nuclear medicine;

- Anesthesia and its administration;

- Radiology and pathology, including interpretive services of an Approved Physician;

- Ambulance services - professional ground ambulance service or, if no other means of transportation can reasonably suffice for delivery to the closest appropriate Approved Facility, air ambulance, regularly scheduled railroad, or airlines;

- Eyeglasses or contact lenses - one pair per Injury up to $250, inclusive of professional office visit charges;

- External hearing aid - up to $600 per ear, inclusive of professional office visit charges;

Medical Requiring Specific Approval in Writing or by Electronic Notice. Subject to the restrictions and limitations set out elsewhere in this Plan, Covered Charges **shall also include the cost of the following so long as the Claims Administrator specifically approves such charges in advance and in writing or by electronic notice:**

- Admission to an Approved Facility (including semiprivate room and board), including MRI, CAT Scan, and other such testing;

- Occupational and physical therapy provided by an Approved Physician or a licensed occupational therapist or licensed physical therapist; provided, however, that such services shall be subject to case management approval regarding the number of visits, the types, and amount of services provided during such visits;

- Inpatient rehabilitation services provided in a medical rehabilitation hospital; provided, however, that such services shall be subject to continued stay review by the Claims Administrator and case management approval regarding the types and amount of services provided;

- Surgery that restores a reasonable, normal pre-Injury functioning;

- Services of a dentist or licensed oral surgeons - services for treatment and repair of broken teeth, fractures and dislocations of the jaw, or the replacement of sound, natural teeth (excluding temporomandibular junction dysfunction services) when the injured participant seeks treatment as soon as possible after the Injury;

- Home health care (with respect to physical needs only) up to 75 visits per Plan Year and up to eight hours per visit for the first two weeks of home health care and up to four hours per visit thereafter;

- Skilled nursing care, provided that an Approved Physician monitors your progress at least once during each 30-day period of confinement;

- Orthotics, arch supports, corrective shoes, special bras or girdles, corrective appliances, prostheses, or any similar item;

- Organ and tissue transplant services not otherwise covered by some form of expense payment program, excluding the donor's transportation costs, organ procurement costs and the donor's surgical expenses;

- Charges for telephone consultations with you, your family, Approved Physicians or other health care providers;

- Mental health services (to the extent not otherwise covered by the Employer's Employee Assistance Program), but only when such services are provided for mental or emotional damage or harm resulting from you being the victim of, or witness to, a traumatic event occurring during your Course and Scope of Employment; and provided, that the cost of such services will not exceed $500, and this coverage applies solely to Medical Benefits coverage and will not result in any payment of Wage Replacement Benefits or other benefits under this Plan;

- Services rendered primarily for training, testing, evaluation, counseling, or educational purposes; and

- Reasonable travel, meal and lodging expenses related to medical treatment that requires travel greater than 20 miles from your residence (one way), in accordance with rules prescribed by the Texas Workers' Compensation Commission, as interpreted by the Claims Administrator for application under this Plan and approved by the attending Approved Physician.

Non-Covered Medical

Any provision of this Plan to the contrary notwithstanding, Covered Charges shall not include the cost of the following:

- Charges incurred prior to your date of participation in the Plan, or prior to your date of Injury;

- Charges rendered after your Medical Benefits under this Plan terminate;

- Expenses which are not medically necessary, as determined by the Claims Administrator;

- Expenses that exceed any fee schedule adopted by the Claims Administrator or the usual, customary and reasonable charge for the same or similar treatment, services or supplies in your geographic area;

- Services or supplies payable by any government or subdivision or agency thereof, or any other applicable third-party payor;

- Services or supplies which are experimental, investigative, or for the purposes of research, including, but not limited to, services and supplies that have not been approved by the American Medical Association, the Federal Drug Administration, the appropriate medical specialty society, or the appropriate governmental agency, all phases of clinical trials, all treatment protocols based upon or similar to those used in clinical trials, or any treatment not generally accepted by the doctor's profession in the United States as safe and effective for diagnosis and treatment;

- Services or supplies performed or provided while you are not covered by the Plan;

- Services or supplies for which you are not legally obligated to payor for which no charge would be made in the absence of the Plan;

- Services for the evaluation or treatment of mental or psychological damage or harm, except to the extent provided above;

- Services or supplies for personal comfort or convenience, such as a private room, television, telephone, radio, guest trays, and similar items;

- Fraudulent claims or claims not filed in good faith as determined by the Claims Administrator;

- Cancelled appointment charges;

- Self-administered services;

- Services or supplies to which your condition is persistently non-responsive;

- Services or supplies relating to pre-existing conditions, except to the limited extent (if any) that an Approved Physician clearly confirms an identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a preexisting condition; provided, however, that: --

  - coverage for such aggravation will be provided only if and to the extent that the Approved Physician -

    - confirms that the preexisting condition has been previously repaired or rehabilitated, and
    - prescribes services or supplies that are medically necessary to treat such aggravation and likely to return you to pre-Injury status; and

  - no coverage will be provided if the preexisting condition was a major contributing cause of the Injury;

- Acupuncture, behavior modification, pain management, hypnosis, biofeedback, or any service or supply ancillary to any of these;
- Chiropractic or spinal manipulation services;

- Substance abuse services;

- Services and supplies provided in or out of a rest home, convalescent facility, nursing home, or other institution that only assists with activities of daily living such as bathing, dressing, walking, eating, preparing special diets, or the supervision of taking medications, no matter by whom recommended or furnished;

- Charges for the purchase, rental or repair of bedding, or environmental control devices including but not limited to, an air conditioner, humidifier, dehumidifier, or air purifier, and charges for jacuzzis, saunas, vans, or structural changes to your residence or moving expenses;

- Charges for services performed by:

  - a person who normally lives with you;
  - your spouse;
  - a parent of you or of your spouse;
  - a child of you or of your spouse; or
  - a brother or sister of you or of your spouse; or

- The cost of any other service or supply not specified above as a covered charge.

Initial Treatment and Denial
Any provision of this Plan to the contrary notwithstanding, the Employer may render first aid, or the Plan may pay for Emergency Care, or the Plan may otherwise pay Wage Replacement Benefits or pay for a medical evaluation or treatment of a participant, and the Plan can still make a subsequent determination that you have not suffered a covered Injury or otherwise deny any or all further benefits under the provisions of this Plan.

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

No Interference with Patient-Provider Relationship
Although benefits under this Plan are conditioned on your use of only Approved Physicians and Approved Facilities, you remain entitled to seek any medical care that you deem appropriate from any provider of your choice at your own expense. You just need to know that such medical expenses will not be payable under this Plan and that such action may result in a complete denial of all benefits or other termination of your benefits under this Plan. The Employer, Claims Administrator, Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other healthcare services provided by any Approved Physician, Approved Facility or other designated healthcare service provider. Healthcare providers are not agents of the Plan, Employer, Claims Administrator, or Committee, and they are not liable or responsible for the acts or omissions of any health care provider. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of the attending Approved Physician and other healthcare providers based on their independent judgment for the provision of health care.

Time To Request Payment Or Reimbursement
Medical expenses will be paid by the Employer directly to the healthcare provider. However, if you should be required to pay an otherwise covered charge, all requests for reimbursement of covered charges must be filed with the Administrator or its designated representative within 30 days from the date such expenses are incurred or, if later, the date you receive an invoice for such expenses.

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

When Medical Benefits Cease
Medical Benefits will cease upon the earliest of:

- expiration of the Maximum Medical Benefit Period specified in the Adoption Agreement (which period begins on the date of the Injury),
- reaching the Maximum Medical Benefit Amount specified in the Adoption Agreement,
- reaching the Combined Limits specified in the Adoption Agreement,
- involuntary termination of your employment with the Employer for gross misconduct, or
- your failure to comply with the requirements specified under the CONTINUING BENEFITS Section of this booklet.

REQUESTING BENEFITS

Notice of Injury
You (or a person acting on your behalf) must provide verbal notice of an Injury immediately to your supervisor. **This verbal notice must be provided by the end of the work shift for the date of the Injury (if possible), but no later than 24 hours after that work shift.** You must also notify your supervisor (verbally or in writing) of your expected recovery time (1) immediately after receiving your first medical treatment for an Injury, and (2) after each following appointment with your treating Approved Physician.

Providing Required Information
You (or a person acting on your behalf) and your supervisor (or such other person as the Claims 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 you suffered, in or out of the Course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may require. This information, together with any witness statement forms supplied by witnesses to the Injury, will be delivered to the Claims Administrator or its designated representative as your request for benefits. **The written incident report must be provided within 24 hours after the Injury is reported as required above.**

An immediate report to your supervisor is essential so that the facts regarding your injury can be promptly verified by the Claims Administrator and appropriate benefits can be paid.
No benefits will be payable under the Plan if:

- notice is not provided to your supervisor as provided above, unless (1) your supervisor has actual knowledge of the Injury, or (2) the Claims Administrator determines that good cause exists for failure to give notice in a timely manner; or
- all required information is not provided to your supervisor as provided above, unless the Claims Administrator determines that good cause exists for failure to provide such information in a timely manner.

Claims Procedures
For a complete description of claims procedures for this Plan, see the "Occupational Injury Plan Claims Procedures" booklet posted in your store or available from the person identified in Item 6 of the Adoption Agreement.

CONTINUING BENEFITS

Subject to the limitations and other rules and procedures described in this booklet, your benefits under this Plan will begin or continue as long as you -

- submit to any drug and alcohol testing (if required by the Claims Administrator, treating Physician or Emergency Care provider), and provide the Employer with this alcohol and drug testing information or authorize the Employer to gain access to this information;
- receive prior approval for all medical care;
- utilize only Approved Physicians and Approved Facilities (except in the case of Emergency Care, as explained in the "Procedure In Event of Injury" and MEDICAL BENEFITS sections of this booklet);
- submit to examination by an Approved Physician selected by the Claims Administrator (other than the treating Approved Physician) as required by the Claims Administrator with respect to any surgical procedure or other diagnosis or treatment opinion rendered by the treating Approved Physician for which the Claims Administrator considers a second medical opinion advisable;
- are responsive to treatment. Non-responsiveness would include, but not be limited to, non-responsiveness due to the need for participant behavioral modification recommended by the treating Approved Physician;
- provide accurate information to, and follow the directions (including, but not limited to, any recommended treatment, therapy, course of action, abstinence, or rehabilitation program) and continue to be under the care of a treating Approved Physician; -
- keep and are on time for all scheduled appointments with health care providers;
- allow an authorized representative of the Employer to go with you to appointments with health care providers;

- do not engage in conduct which hinders your recovery;
- report in to your supervisor periodically as directed until you are able to return to work, including notice of expected recovery time after each appointment with the treating Approved Physician;
- immediately inform your supervisor that you have been released by an Approved Physician to return to full or Modified Duty, and timely report to work in accordance with such work release;
- personally pick up your check for Wage Replacement benefits provided under the Plan; provided, that this requirement may be waived by the Claims Administrator upon a showing that you are physically or geographically unable to comply, in which case the check will be personally delivered or mailed, in the discretion of the Employer, directly to you;
- do not receive benefits with respect to the Injury from, and the incident does not create any liability for the 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;
- are truthful in regard to .every aspect of the required information supplied as part of the Injury reporting or employment process;
- are truthful and otherwise fully cooperate with the Claims Administrator (including, but not limited to, the requirements on providing information) and do not demonstrate bad faith in connection with the administration of the Plan, including, but not limited to, subrogation or coordination of benefits procedures; and
- comply with the provisions of this summary plan description, the Plan, and the rules and procedures adopted by the Claims Administrator for the administration of the Plan.

OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFITS

Offset For Other Benefits The Plan reserves the right to reduce your benefits, in accordance with the coordination of benefits provisions of the official Plan document, so that the total from all benefit plans under which you are covered does not exceed 100% of the benefits provided under this Plan. You must cooperate with the Employer in furnishing it copies of other policies, coverages or plans which may be applicable to the Injury and in completing and returning to the 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 you.

Recovery From Third Parties and Access Payments
If you become entitled to or receive benefits under the Plan for any Injury caused by another person or organization and become entitled to or otherwise collect any other compensation in connection" with such Injury, whether by insurance, litigation, settlement or other proceeding, you must (I) reimburse the Plan out of such other compensation to the extent of any Plan benefits that you have received, and (2) execute any documents requested by the Claims Administrator to enable the Plan to recover such benefits. If (1) you do not reimburse the Plan or otherwise comply with these provisions, or (2) payments are made under the Plan based upon 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 you. The Plan shall also have the right to bring a lawsuit and assert a constructive trust or other equitable recovery 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 you have been "made whole." The Plan's subrogation rights will not be reduced by attorneys' fees or expenses incurred in pursuing recovery against a third party and the "common fund" doctrine shall not apply. Any attorneys' fees and/or expenses incurred by or at the request of you or your attorney in a third party action shall be your sole responsibility.

Notice of Legal Proceedings
You must provide the Claims Administrator with prior written notice of your involvement in any lawsuit, settlement discussion or other proceeding aimed at recovering, from another person or organization, damages or other compensation related to any Injury for which you have received (or may in the future file a claim to receive) benefits under the Plan. The Plan will have the right to intervene in any such lawsuit, settlement discussion or other proceeding. If you do not seek recovery from any person or organization that has caused your Injury, the Plan will have the right to begin a lawsuit or other proceeding or do any other act that in the opinion of the Claims Administrator may be necessary or desirable to recover Plan benefits paid or to be paid in the future (including costs and expenses).

Assignment of Rights
Upon the request of the Claims Administrator, you must assign to the Plan the right to begin or intervene in any lawsuit, settlement discussion or other proceeding described above, and to use your name for that purpose. The Plan will have all of the rights and privileges with respect to any such proceeding (such as the right to select legal counselor pursue appeals) that you would have. You must provide all reasonable aid in any such proceeding as requested by the

Claims Administrator. You must also release the Plan, the Employer, the Claims Administrator, the Committee and their representatives from any claims that may arise out of the pursuit or handling by the Plan of any such lawsuit, settlement discussion or other proceeding.

Right To Receive And Release Necessary Information
The Claims Administrator may, without the consent of or notice to any person or organization, release to or obtain from any person or organization, information needed to implement Plan provisions. When you request benefits, you must furnish all information requested by the Claims Administrator.

AMENDMENT OR TERMINATION OF PLAN

The Employer presently intends to continue the Plan indefinitely. However, the Employer reserves the right to amend, modify, or terminate the Plan at any time. Any such amendment or termination will be pursuant to formal written action of a representative authorized to act on behalf of the Employer. No amendment or termination of the Plan will reduce the amount of any benefit payable under the Plan to or with respect to a participant in connection with an Injury occurring prior to the date of such amendment or termination.

GENERAL INFORMATION

Type Of Plan
A welfare benefit plan providing wage replacement and/or medical benefits due to an Injury.

See the Adoption Agreement for ...

- Plan Name
- Name and Address of Employer (who is the Plan Sponsor and Plan Administrator)
- Contact Person and Telephone Number for Claims Administrator
- Name and Address of Person Designated as Agent for Service of Legal Process
- Employer and Plan Identification Numbers

Plan Year
The Plan generally operates and keeps its records on the basis of the 12 calendar month period ending each December 31.

ERISA RIGHTS STATEMENT

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites) all documents governing the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may request arbitration under the Employer's arbitration program, called "The RIGHT Plan." In such a case, an arbitrator may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control ofthe Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may request arbitration under The RIGHT Plan. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the

U.S. Department of Labor, or you may request arbitration under The RIGHT Plan. An arbitrator will decide who should pay court costs and legal fees. If you are successful, an arbitrator may order the person you have brought a claim against to pay these costs and fees. If you lose, an arbitrator may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
EFFECTIVE DATE April 14, 2004

THIS EMPLOYEE INJURY BENEFIT PLAN SHALL COMPLY WITH THE "STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION" (THE "HIP AA PRIVACY RULES"), AS OF THE ABOVE DATE. IN THAT EVENT, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT AN ASSOCIATE MAY BE USED AND DISCLOSED AND HOW AN ASSOCIATE CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Plan shall take reasonable steps to ensure the privacy of your Protected Health Information to the extent that the privacy requirements of the Health Insurance Portability and Accountability Act ("HIPAA") apply to health benefits provided under this Plan.

"Protected Health Information" or "PHI" includes any individually identifiable health information that is transmitted or maintained by the Plan, but **does not include** (1) individually identifiable health information contained in education records and employment records held by an Company (for example, health information contained in a request for leave under the Family and Medical Leave Act), or (2) "de-identified information", which is information that does not identify you and there is no reasonable basis to believe that it can be used to identify you.

This Notice is being provided in order to inform you, your spouse and your dependents (hereafter "you", as applicable) of (1) the Plan's uses and disclosures of your PHI, (2) the Plan's rights and responsibilities with respect to your PHI, and (3) your privacy rights with respect to your PHI. **Unless otherwise indicated below, the terms used in this Appendix shall have the same meanings as defined in the Plan.**

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Plan may use and disclose your PHI in the following situations **without first obtaining your written consent or authorization:**

Uses and Disclosures Directly to You

- Access to Your PHI - Upon your request, the Plan is required to give you access to certain PHI in order for you to inspect and copy it.
- **Accounting of Your PHI** - Upon your request, the Plan is required to provide you with an accounting of certain disclosures of your PHI that the Plan has made.

Treatment, Payment or Health Care Operations \

- **General Rule** - The Plan may use or disclose your PHI in the following situations that relate to treatment, payment or health care operations:
  - **Treatment - The Plan may disclose your PHI to a doctor, hospital or other health care provider in order for you to receive medical treatment.** "Treatment" includes the provision, coordination or management of health care and related services and includes, but is not limited to, consultations and referrals between one or more of your health care providers.
  - **Payment - The Plan may use your PHI and disclose your PHI to another health plan or health care provider in order to pay claims under the Plan**. For example, the Plan may tell a doctor whether you are eligible for coverage and whether the bill can be paid by the Plan. "Payment" activities also include things such as coverage determinations, billing, claims management, coordination of benefits, subrogation, plan reimbursement, reviews of medical necessity, utilization review and preauthorization.
  - **Plan's Health Care Operations - The Plan may use your PHI for the Plan's health care operations**. For example, the Plan may use your PHI to review the accuracy of its claims processing. "Health Care Operations" includes, but is not limited to, (1) quality assessment and improvement, (2) reviewing qualifications of health care professionals, (3) underwriting, premium rating and other insurance activities relating to creating, renewing or replacing health insurance contracts (including excess loss insurance), (4) conducting or arranging for medical review, legal services and audit functions, including fraud and abuse detection, and compliance programs, (5) business planning and development, (6) business management activities, such as customer service, resolution of internal grievances, and due diligence activities related to the sale or transfer of assets to another entity, and (7) creating de-identified health information in certain cases.
  - **Another Entity's Health Care Operations - The Plan may also disclose your PHI to another health**

plan or health care provider for the health care operations of the entity that receives the PHI, provided that each entity either has or had a relationship with you, the PHI pertains to this relationship and the disclosure is for (1) health care operations, or (2) health care fraud and abuse detection or compliance purposes.

- **Contact with Affected Individual** - The Plan may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.
- **Exception: Psychotherapy Notes** - Your written authorization generally must be obtained before the Plan will use or disclose psychotherapy notes about you. "Psychotherapy notes" are separately filed notes about your conversations with your mental health professional during a counseling session. They do not, however, include summary information about your mental health treatment. In addition, the Plan may use and disclose such notes when directly needed to defend itself against litigation filed by you. (Note that psychotherapy is not a covered Medical Benefit under the Plan.)

Uses and Disclosures to Plan Sponsor

The Plan may disclose PHI to your Company in its capacity as the plan sponsor for the Plan for the sole purpose of permitting the Company to perform plan administration functions that are consistent with the following rules:

- **Uses and Disclosures of PHI** - The Company shall use and disclose PHI provided by the Plan only to the extent ~ that the use and disclosure is permitted or required under the HIP AA Privacy Rules.
  - The Company 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;
  - The Company 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 Company with respect to PHI;
  - The Company shall not use or disclose PHI from the Plan for employment-related actions and decisions or in connection with any other benefit of the Company;
  - The Company 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 Company becomes aware of such inconsistent use or disclosure;
  - The Company shall provide you with access to your PHI in accordance with the HIP AA Privacy Rules;
  - The Company shall make PHI available for amendment by you and shall incorporate any amendments made into your PHI;
  - The Company shall make available to you information required in order to provide an accounting of any disclosures of your PHI made by the Plan, to extent that these disclosures must be accounted for under the HIP AA Privacy Rules;
  - The Company shall make its internal practices, books, and records relating to the use and disclosure of PHI from the Plan available to the Department of Health and Human Services to determine Plan compliance with the HIP AA Privacy Rules;
  - If feasible, the Company shall return or destroy all PHI received from the Plan that the Company 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. However, if this return or destruction is not feasible, the Company shall limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible; and
  - The Company shall ensure that adequate separation has been established between the Company, in its capacity as plan sponsor, and the Plan.
- **Separation Between Company and the Plan** - The Plan's designated Claims Administrator, the Plan's designated 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 Company that shall be given access to PHI for use and disclosure. Their access to and use of PHI shall be restricted to the Plan Administrator functions that the Company, in its capacity as plan sponsor, performs for the Plan. In the event that any of these persons fails to comply with the requirements of the HIP AA Privacy Rules, you may submit a complaint in writing to the Contact Person listed at the end of this Notice.
- **Exceptions** - The Plan may disclose to the Company as plan sponsor without complying with the requirements of this Section if the disclosure involves:
  - PHI to the extent specified in a valid, written authorization from you;
  - summary health information, if the Company requests summary health information for the limited purpose of (1) obtaining premium bids for insurance coverage related to the Plan, or (2) modifying, amending or terminating the Plan; or
  - information on whether an individual is participating in the Plan.

Uses and Disclosures Requiring An Opportunity for You to Agree or Object

- **Permitted Uses and Disclosures** - The Plan may use or disclose PHI in the following situations in which you have been informed in advance of the use or disclosure and have the opportunity to agree to, prohibit or restrict the use or disclosure in accordance with the HIP AA Privacy Rules:
  - disclosure to your family member, other relative, or a close personal friend (or any person you identify) of PHI that is directly relevant to the person's

involvement with your care or payment related to your care; or

- disclosure of PHI to notify, or assist in the notification of (including identifying or locating) your family member, a personal representative (or another person responsible for your care) of your location, general condition, or death.

– Requirements When You Are Present - If you are present for, or otherwise available prior to, a use or disclosure specified above, the Plan must:
  - obtain your agreement;
  - provide you with the opportunity to object to the disclosure and determine that you do not express an objection; or
  - reasonably infer from the circumstances, based on the exercise of professional judgment, that you do not object to the disclosure.
– **Requirements When You Are Not Present** - If you are not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of your capacity or an emergency circumstance, the Plan may, in the exercise of professional judgment, determine (and make reasonable inferences as to) whether the disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your health care.
– **Disaster Relief Purposes** - The Plan may use or disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such groups the uses or disclosures specified in Paragraph 1 of this Section. The requirements of Paragraphs 2 and 3 of this Section will apply to the extent that the Plan, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

Other Special Circumstances

– **Required by Law** - To the extent that the use or disclosure is required by law and complies with and is limited to the relevant requirements of the law. For example, the Plan must disclose your PHI when requested by the U.S. Department of Health and Human Services in order to investigate or determine whether the Plan is in compliance with HIP AA Privacy Rules.
– Public Health - For public health activities, including disclosure to (1) a public health authority authorized by law to collect information to prevent or control disease or conduct public health surveillance, (2) a public health authority empowered by law to receive reports of child abuse or neglect, (3) under certain circumstances, a person subject to the jurisdiction of the Food and Drug Administration (FDA), (4) a person exposed to a communicable disease, or (5) in certain circumstances, an employer regarding workplace-related medical surveillance activities;
– **Public Safety** - To an authorized government authority when the Plan reasonable believes that you are a victim of abuse, neglect or domestic violence, or the extent necessary to avert a serious and imminent threat to health and safety.
– **Health Oversight** - For health oversight activities authorized by law, such as fraud or abuse 'audits, investigations and civil, administrative or criminal proceedings (unless the activity does not arise out of and is not directly related to the receipt of health care or qualification for public health benefits).
– **Judicial/Administration Proceedings** - For judicial and administrative proceedings, such as responding to a court order, subpoena, discovery request or other lawful process, when certain conditions are met.
– **Law Enforcement** - For law enforcement purposes to a law enforcement official, provided that the requesting party must satisfy certain HIP AA Privacy Rule requirements' when PHI is to be disclosed for identification and location purposes, Death - For certain uses and disclosures to coroners, medical examiners and funeral directors related to decedents, subject to the specific limitations of the HIP AA Privacy Rules.
– **Organ Donation** - To organ procurement organizations, regarding cadaveric organs, eyes or tissue for donation purposes.
– **Research** - For research purposes provided that an Institution Review Board or privacy board approves the waiver of individual authorization required under the HIPAA Privacy Rules and certain other conditions are met.
– **Military and National Security** - For specialized government functions, such as separation or discharge from the military, to determine eligibility for veterans' health benefits, national security or lawful intelligence activities, or for protective services; and
– **Workers' Compensation** - To the extent necessary to comply with workers' compensation or other similar programs established by law.

PLAN RIGHTS AND RESPONSIBILITIES

Authorization

Except as otherwise indicated in this Notice, the Plan will only make uses and disclosures of your PHI with your valid, written authorization. You have the right to revoke this authorization at any time, provided that your revocation is made in writing to the Contact Person listed at the end of this Notice, Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Such revocation may, however, impact the Plan's ability to investigate and pay your claim for benefits.

Notice

The Plan is required by law to maintain the privacy of PHI and to provide you with this Notice of its legal duties and privacy practices with respect to PHI. The Plan is required to abide by the terms of the Notice currently in effect and shall not use or disclose PHI in a manner that is inconsistent with this Notice. However, the Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that it maintains. The Plan

may provide this revised Notice by distributing amended benefit materials, by distributing a summary of material modifications to the Plan's SPD or by providing the Notice as a separate document.

Minimum Necessary

When using or disclosing PHI or when requesting PHI, the Plan shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. However, this minimum necessary requirement shall not apply to:

- disclosures to or requests by a health care provider for treatment;
- permitted or required uses or disclosures made to you;
- uses or disclosures that are made in accordance with a valid written authorization from you;
- required disclosures made to the Department of Health and Human Services; and
- uses or disclosures that are otherwise required by law, including compliance with the HIP AA Privacy Rules.

Agreed Restrictions

If you and the Plan agree to a restriction of your PHI, the Plan may not use or disclose PHI in violation of the restriction, except to the limited extent that the restricted PHI is needed to provide you with emergency care and the health care provider providing emergency care agrees not to further use or disclose the PHI. You and the Plan may not agree to restrictions with respect to:

- required disclosures to you, as specified under the HIP AA Privacy Rules; or
- uses and disclosures that are required or permitted under the HIP AA Privacy Rule without your authorization or agreement (See the Section of this Notice entitled "Other Special Circumstances").

De-Identified Information

The Plan may use PHI to create information that is not individually identifiable health information ("de-identified information") or disclose PHI only to a Business Associate for that purpose, regardless of whether the Plan will use the de-identified information. The HIP AA Privacy Rules do not apply to de-identified information that meets the standard and implementation specifications of the HIP AA Privacy Rules, unless:

- the Plan discloses a code or other means of record identification that is designed to enable de-identified information to be re-identified; or
- the de-identified information is otherwise re-identified.

Business Associates

A "Business Associate" is generally a third party that provides certain services to or on behalf of the Plan (such as claims administration services, billing, legal, actuarial, accounting, consulting, data aggregation, etc.) and the services involve the use or disclosure of PHI. The Plan may disclose PHI to a Business Associate and may allow a Business Associate to create or receive PHI on its behalf, if the Plan obtains satisfactory assurance that the Business Associate will appropriately safeguard the PHI. The Plan shall document these satisfactory assurances through a written contract or other written arrangement with the Business Associate and must ensure that these satisfactory assurances satisfy the HIP AA Privacy Rules that apply to Business Associate communications. However, this requirement shall not apply:

- if the Plan discloses PHI to a health care provider concerning your treatment; and if the Plan discloses PHI to the Company in its capacity as plan sponsor for the Plan, provided that the Plan complies with the requirements for these disclosures (refer to the "Uses and Disclosures to Plan Sponsor" Section of this Notice).

Personal Representatives

For purposes of using and disclosing PHI, the Plan must treat your personal representative as if it were you, in accordance with the HIP AA Privacy Rules. Your personal representative will be required to produce evidence of his/her authority to act on your behalf (for example, a court order of appointment or a notarized power of attorney) before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny access to your PHI to a personal representative.

Other Uses and Disclosures

A workforce member of the Plan may disclose PHI if the workforce member is a "whistleblower" or victim of a crime, provided that these disclosures are made in accordance with the standards of the HIPAA Privacy Rules.

YOUR RIGHTS

Rights of Individuals Regarding Protected Health Information

- **Restrictions on PHI** - You have the right to request restrictions on uses and disclosures of PHI to carry out treatment, payment or health care operations. However, the Plan is not required to agree to a restriction.
- **Alternate Communications** - You have the right to request that the Plan communicate PHI to you by alternative means or at alternative locations, if you clearly state that the disclosure of all or part of that information could endanger you. These requests must be reasonable and may be conditioned upon you providing, when appropriate, information as to how payment, if any, will be handled and specification of an alternative address or other method of contact.
- **Access** - You have the right to inspect and copy your PHI that the Plan maintains for "payment" activities as described in the Section of this Notice entitled "Treatment, Payment and Health Care Operations", subject to certain exceptions specified in the HIP AA Privacy Rules. If you request copies, the Plan may charge a reasonable fee for locating, copying and mailing your PHI to you.

- **Amendments** – You have the right to amend and make corrections to your PHI and any agreed upon amendment will be either attached to or included in your PHI records. However, your amendment request may be denied if the PHI subject to your request:
  - Was not created by the Plan, unless you provide a reasonable basis to believe that the originator of the PHI is no longer able to make your requested amendment;
  - Is not part of your PHI that the Plan maintains for "payment" activities; or
  - Is already accurate and complete.
- **Accounting** – You have the right to receive an accounting of disclosures of your PHI that were made by the Plan within the six (6) years prior to the date of your request, except for disclosures:
  - That apply to the treatment, payment and health care operations of the Plan;
  - That were made to you or that were made pursuant to a valid, written authorization;
  - That occurred prior to the Effective Date of this Notice;
  - As part of a limited data set, as provided under the HIPAA Privacy Rules;
  - For national security or intelligence purposes as provided by law;
  - To correctional institutions or other custodial law enforcement officials as permitted by the HIPAA Privacy Rules; or
  - Incidental to a use or disclosure required or permitted by HIPAA Privacy Rules.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting that you request.

- **Copy of This Notice** – You have the right to obtain a paper copy of this Notice upon request, including individuals who agree to receive this Notice electronically.
- **Complaints** – You may complain to the Plan or the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Exercising Your Rights

You or your specified representative may exercise any of your rights specified in this section by submitting a written request to the Contact Person listed at the end of this Notice. You will receive a response to your request within 30 days, subject to a 30-day extension. If your request is denied in whole or in part, the Plan shall provide you with a written denial that explains the basis for the denial. If you disagree with a denial of your request or complaint, you may provide a written statement to the Contact Person and/or take any further action provided in this Notice by law.

CONTACT PERSON

For further information regarding privacy rights or this Notice, please contact the person identified in Item 6 on the Adoption Agreement.

THE RIGHT PLAN DETAIL

The RIGHT Idea

Your McDonald's owner operator (the "Employer") believes in doing things the right way... when serving our customers ... preparing our food ... working with our employees. And that's especially true when it comes to workplace safety. That's why we are committed to eliminating unsafe practices and conditions in our restaurants.

But sometimes, despite our best efforts, accidents happen and someone gets hurt. Usually it's just a minor cut or bruise, but occasionally it's a more serious injury. And if this happens, we're committed to paying medical and short-term disability benefits as described in the attached occupational injury plan booklet.

But now and then, a disagreement may arise about the injury benefits payable or another issue related to the accident.

Solving Problems the RIGHT Way

We believe the best way to resolve disagreements related to on-the-job injuries is to work it out ... talk it out ... together. Taking problems to court just isn't a good solution ... for you or the Employer.

So, we developed The RIGHT Plan. It is a three-step process for, **R**esolving **I**njury **G**rievances **H**ere **T**ogether. A process to get results.

This program originally became effective on April 1, 1996. These mandatory procedures have been updated, effective as of May 1, 2004 or such later date specified in the Adoption Agreement for the Occupational Injury Plan (the "Effective Date"). This program is the required and exclusive way to resolve all disputes related to occupational injury or illness, or death caused by occupational injury or illness. The types of disputes covered by the program are explained in more detail later in this booklet.

You must use the new process rather than courtroom litigation to solve all covered disputes that arise on or after the Effective Date. This updated RIGHT Plan also applies to covered disputes that relate to matters occurring before the Effective Date if you have not raised the matter under the RIGHT Plan rules as they existed before the Effective Date or otherwise filed a legal action in any court or with any governmental agency on the matter prior to such date.

This program, including its arbitration component, is an essential element of your employment relationship. It is a mandatory condition of your employment which you accept and agree to by receiving a copy of this program booklet and becoming employed or continuing your employment with the Employer at any time on or after the Effective Date. Neither your signature nor any other written agreement to this RIGHT Plan is necessary in order for the following three step process to apply to both you (and your family or other representatives) and the Employer on the covered claims listed below.

Getting the RIGHT Answers to Problems

The RIGHT Plan applies only to disagreements you have with the Employer relating to a workplace injury or illness.

Problems you may have with your work schedule, your work assignment, uniforms, disputes with your co-workers, or other matters should continue to be resolved with your restaurant manager. The RIGHT Plan will not apply to these types of issues (additional issues not covered by The RIGHT Plan are listed in detail in the Program Rules found later in this booklet).

The RIGHT Steps

You will use the following three-step process to resolve problems involving an on-the-job injury:

1) **Communication**
2) **Internal Mediation**
3) **Arbitration**

Step 1 - Communication
Many times, problems arise because of misunderstandings. In these cases, the problems can usually be resolved by talking it out one-on-one with your restaurant manager. To make sure both sides understand each other, the Employer will designate a translator to help out when appropriate. And, because we understand that some problems are very sensitive, the Employer will make an effort to keep your concerns confidential whenever possible.

Step 2 - Internal Mediation
Getting a third party involved in the process to hear both sides of the issue can sometimes be helpful. If you've already talked with your restaurant manager and still feel like your problem hasn't been resolved, or if you simply don't feel you can talk to anyone about your concern, you can request that the restaurant owner formally look into it.

Rev. 1/30/2004

→ **Complete a Request for Internal Mediation form**. Forms are available from your restaurant manager. Once you've completed the form, forward the original copy to the restaurant owner.

→ **The Restaurant Owner Investigates**. Once the restaurant owner has received your request, you will receive a notice that your request is being reviewed. Then, the restaurant owner or someone he or she designates will talk with you and any other people who might know something about the problem.

→ **Meet With the Restaurant Owner**. The restaurant owner or someone he or she designates will meet with you to talk about what he or she found out and present possible solutions to the problem.

Step 3 - Arbitration

Solving certain issues may require a binding decision from a person outside the Employer; a person who knows the law and has the expertise to make wise, fair judgments. Arbitration is a process where both you and the Employer agree to have an impartial arbitrator make a final and binding decision that you and the Employer must stick to. The arbitrator will be from the American Arbitration Association ("AAA") (or other administrative resource you and the Employer agree to use).
The arbitrator (and the AAA or any other administrative resource) will make sure the arbitration process is completely objective and follows specific legal guidelines.

The arbitrator is like a judge. He or she listens carefully to the information each party presents, and then makes a decision on the claim, deciding on any award he or she believes is appropriate. Arbitration is a formal process which is governed by rules and legal standards. The goal of arbitration is to resolve problems quickly and fairly, while trying to maintain the relationship between you and the other party. Here's how the arbitration process works.

→ **Request arbitration**.

To request arbitration, simply complete a "Request for Arbitration Form" (available from your restaurant manager) and send the original to the AAA, and a copy to the restaurant owner. Addresses are on the form.

Except for claims for benefits under the Employer's occupational injury benefit plan (which has it's own internal claims review process), you and the Employer must complete the first two steps of The RIGHT Plan before requesting arbitration.

→ **Choose an arbitrator**.

Once the AAA receives your request, it will send both you and the Employer a list of arbitrators with a brief biography of each. For all arbitration proceedings, regardless of the location of the dispute, the parties will jointly select and utilize one arbitrator from a AAA panel of arbitrators associated with the Dallas, Texas or Houston, Texas AAA office. You will then need to remove the names of arbitrators you do not want to hear your case and list the remaining arbitrators in order of preference. The Employer will do likewise. You and the Employer then return the list to the AAA, and the AAA will assign an arbitrator to your case.

→ **Pay filing fee and arbitration fee.**

To use the arbitration process, a filing fee is required. The arbitrator also charges a fee for his or her time and there may also be other administrative expenses payable to AAA.

The AAA filing fee will be at least $625. Your share of this cost is $125 and must be paid when you submit a request for arbitration (or, if this process is challenged by you, when arbitration is compelled by court order). Your portion of the filing fee will typically be less than the filing fees and related costs you would have paid to pursue a lawsuit in court. The Employer will then pay the remainder of the AAA filing fee.
The Employer will also pay the arbitrator's entire fee and any other AAA administrative expenses; provided, however, that you may elect to also pay up to one-half of these fees and expenses, if you want to.

The only reason the Employer pays more of this expense is to make it less costly for you. Because the arbitrator is completely neutral, his or her decision will not be affected by who pays a greater share of the expense. In fact, the arbitrator typically does not even know how the amounts paid ,are divided between the parties.

If the arbitrator rules in your favor on all claims, the Employer will reimburse you for your $125 filing fee.

→ **Attend the hearing.**

The AAA will notify you and the Employer of the place, date and time of the hearing. The location of each arbitration proceeding will be established on a regional basis and will depend on the geographic location of your employment. During the hearing, you and the Employer present the facts. You may choose to hire a lawyer to participate in the hearing with you. If you do, you will be responsible for paying your lawyer's fees. If you choose not to hire a lawyer, the Employer will also participate in the hearing without a lawyer.

→ **A Decision is made.**

Based on the facts presented, the arbitrator will make a final and binding decision. If you win, the arbitrator may award you anything you could have received from a court of law.

Why Arbitration is the RIGHT Choice

Arbitration offers several advantages to both you and the Employer:

1. Less for lawyers ... more for you. The arbitration process can be free from legal representation. If you do not hire a lawyer to represent you in the arbitration hearing, the Employer will not bring a lawyer to the hearing either. By not involving lawyers, you will not have to share any award you receive from an arbitrator with an attorney. If hired on a "contingency basis" - which means the lawyer's fees are a certain percentage of any amount you are awarded - lawyers typically receive 33% to 50% of a courtroom award or settlement.

2. Protected rights. Arbitration offers protection similar to a court of law. You keep your legal right to seek damages. It is only the process that changes from a lengthy, expensive trial to a quick resolution with a fair, experienced arbitrator. And the arbitrator, just like a judge or jury, may award you anything you might seek through a court of law.

3. Fast decisions. When a problem is taken to court, it can take years to settle. But with arbitration, decisions can be reached in just a couple of months.

4. Fair decisions. Courts hear all types of cases ranging from car accidents to divorces. Judges and juries do not specialize in solving employment problems. But arbitrators do. Plus, the arbitrator is objective and does not have any relationship with the Employer.

5. Better relationships. Arbitration is less formal than a courtroom trial and emphasizes a straightforward, open exchange of information. For this reason, it is much more likely to preserve the working relationship than a trial, which often draws clear battle lines and closes the lines of communication.

More About the AAA

The AAA: The Best in the Business
The American Arbitration Association was founded in 1926 to assist individuals and companies in solving problems outside the courtroom. It is a nonprofit organization dedicated to providing quality, objective service in settling disputes through mediation and arbitration. The AAA has no connection with the Employer. It is a completely independent firm that administers more than tens of thousands of claims a year across the United States. The AAA is considered a leading resource in administering fair, cost-effective resolution of work-related disagreements.

The Arbitrators
The AAA has over 100 neutral persons to serve as employment dispute mediators and arbitrators. These individuals come from a variety of industries and educational backgrounds, and have no relationship to the Employer or its representatives. The arbitrator selected cannot have any personal or financial interest in the dispute. Before accepting an appointment, the arbitrator must disclose to the AAA any information that may prevent a prompt meeting or hearing, or create an appearance of bias. If any such information is presented to the AAA, the AAA will communicate that information to you and the Employer. Depending on the way you and the Employer respond, the AAA may disqualify that individual.

The Address
American Arbitration Association
Attn: Regional Claims Administrator
Two Galleria Tower, Suite 1750
13455 Noel Road Dallas, TX 75240-6620
Telephone: 800-426-8792

What Do I Need to Do?

Current employees as of the Effective Date, and employees hired on or after the Effective Date, will automatically be covered by The RIGHT Plan, as updated herein. Keep this booklet for your records.

It is important that you understand that The RIGHT Plan is a condition of employment, and is the only method for resolving disputes involving on-the-job injuries or illnesses ... rather than the courtroom. This updated program becomes effective for all employees and the Employer as of the Effective Date.

Information for Parents and Guardians

If you are unmarried and under 18 years of age, we recognize that your parents or legal guardian will be interested in this program and involved in your decision to work for the Employer. So, we want them to be informed about this program and how it affects you. It is your responsibility to provide this booklet to your parents or legal guardian so that they too will understand The RIGHT Plan.

The RIGHT Plan Program Rules

In addition to the rules set forth above, here are some more details:

Covered Claims: Claims and disputes covered by The RIGHT Plan include only those disputes listed below that you may now or in the future have against the owner operator of the McDonald's franchise where you work (the "Employer") or against its former, current or future officers, directors, shareholders, employees, representatives, agents, subsidiaries, affiliates, successors, and/or assigns, in their personal or official capacity as such, or against the Employer's occupational injury plan or any person or entity

involved in the administration of occupational injury benefits, and all such claims that the Employer may now or in the future have against you. This even applies to claims relating to matters occurring before the Effective Date if not pursued under the RIGHT Plan rules as they existed before the Effective Date or through filing a legal action in any court or with any governmental agency on the matter prior to such date.

The claims covered by The RIGHT Plan include:

1. any legal or equitable claim or dispute relating to enforcement or interpretation of The RIGHT Plan; and

2. any legal or equitable claim by or with respect to you for any form of physical or psychological damage, harm or death which relates to an accident, occupational disease, or cumulative trauma (including, but not limited to, claims of negligence or gross negligence or discrimination; claims for assault, battery, negligent hiring/training/supervision/retention, emotional distress, retaliatory discharge, or violation of any other non-criminal federal, state or other governmental common law, statute, regulation or ordinance in connection with a job-related injury, regardless of whether the common law doctrine was recognized or whether the statute, regulation or ordinance was enacted before or after the Effective Date of this updated Plan); and

3. any legal or equitable claim under the Employee Retirement Income Security Act ("ERISA") for benefits, fiduciary breach, or other problem or relief relating to benefits under the Employer's occupational injury plan.

This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute. Neither you, your beneficiaries, spouse, children, heirs, legal representatives executors, administrators, guardians, heirs, successors, assigns or any other person or entity claiming by or through you nor the Employer shall be entitled to a jury trial on any such claim or dispute. The arbitrator is authorized to determine whether the parties have validly agreed to arbitrate and whether any particular dispute between the parties falls within the scope of this arbitration policy. The arbitrator has exclusive authority to resolve any dispute relating to the applicability or enforceability of this arbitration requirement. Neither you nor the Employer shall be entitled to a bench or jury trial on any claim covered by this Plan.

Claims Not Covered: Claims or disputes not covered by The RIGHT Plan include:

1. any general employment-related claim including, but not limited to, sexual harassment, discrimination based on age, sex, race, color, disability or religion, and tort claims that do not relate to an on-the-job injury or illness;

2. any claim by an employee relating to any employee benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), other than claims relating to the Employer's occupational injury plan;

3. any criminal complaint or proceedings;

4. restitution by an employee for a criminal act for which the employee has been found guilty or has pleaded guilty or no contest or nolo contendere;

5. any claim by the Employer for injunctive or other equitable relief for employee violation of contract, covenant against competition, unfair competition or the use or disclosure of trade secrets or other confidential information.

Neither you nor the Employer has to submit items 1 through 5 above to arbitration under this program and may seek and obtain relief from a court.

Pre-Arbitration Requirement: The RIGHT Plan requires that both parties exhaust the first two steps of the program explained in this booklet before submitting their claim to arbitration. The only exception is for claims under the Employer's occupational injury plan, which may be submitted directly to arbitration after exhausting such plan's administrative claims procedure.

Required Notice of All Claims: When you seek arbitration, you must give written notice of any claim to the other party within the applicable statute of limitations. The day of the occurrence shall be counted for purposes of determining the applicable period. If such notice is not given, the claim shall be void and deemed waived.

You must send a written Request for Arbitration Form to the American Arbitration Association in care of the Regional Claims Administrator at 13455 Noel Road, Two Galleria Tower, Suite 1750, Dallas, Texas, 75240-6620. You must also send a copy of the Request for Arbitration Form to the Employer. The Request for Arbitration Form is available from your restaurant manager. This Form must be sent to the AAA and the Employer by certified or registered mail, return receipt requested. If the Employer wishes to request arbitration, it will give notice to you at the last address recorded in your personnel file. The party requesting arbitration must identify and describe the nature of all claims asserted and the facts on which the claims are based.

Representation: You and the Employer may be represented during the pre-arbitration procedures (as defined below) or at the arbitration hearing by an attorney or other representative. If you elect not to hire an attorney to be

present at the arbitration hearing, then the Employer will agree not to hire an attorney to be present at such hearing.

Arbitration Procedural Rules and Applicable Law: Any arbitration will be administered by the American Arbitration Association under its then-current National Rules for the Resolution of Employment Disputes, (except to the extent that a different rule is set forth herein or as the parties may otherwise agree). The arbitrator selected by the parties in accordance with those rules shall be an attorney licensed to practice in the State of Texas. If the dispute is a benefits dispute, the arbitrator must have ERISA legal experience. If the dispute is a personal injury dispute, the arbitrator must have personal injury legal experience. The arbitrator shall apply the substantive law (and the laws of remedies, if applicable), in the state in which the claim arose (other than the Texas General Arbitration Act), or federal law, or both, depending upon the claims asserted. The arbitrator shall also apply the Federal Rules of Evidence.

Pre-Arbitration Procedures: You and the Employer have the right to take the deposition of one individual and any expert witness designated by another party. Any such deposition shall not be in the form of written questions. The subpoena rights specified below shall be applicable to depositions taken pursuant to this paragraph. Additional depositions and other forms of discovery may be had only where the arbitrator selected under The RIGHT Plan so orders, upon a showing of substantial need. At least 30 days before the arbitration, you and the Employer must exchange lists of witnesses, including any experts, and copies of all exhibits intended to be used at the arbitration.

Subpoenas: You and the Employer have the right to subpoena witnesses to the arbitration in accordance with the Federal Rules of Civil Procedure.

Dispositive Motions: The arbitrator will have the authority to consider and grant motions dispositive of all or part of any claim, using the standards governing such motions under the Federal Rules of Civil Procedure. This includes motions of summary judgment, which, if granted, allow a party, prior to the arbitration, to either (A) have all or part of the other party's claim dismissed or (B) obtain an affirmative finding on a claim brought by that party.

Burden of Proof and Arbitrator's Authority: The arbitration process herein is not a negotiation or mediation. The burden of proof for any claim brought to arbitration by either party will be the same burden of proof that exists in a court. The arbitrator shall have no power to vary or ignore the terms of this Program and shall be bound by controlling law and (except as otherwise provided herein) the Federal Rules of Evidence. The arbitrator is authorized only to rule on the claims set forth in the Request for Arbitration Form, any counterclaim(s), and the answer(s) made to such claims and counterclaims. The arbitrator is not authorized to modify the powers granted to him or her under this document, or to "split-the-baby", or to otherwise make any award merely on the basis of what he or she determines to be fair or just.

Form of Decision: Upon the request of either party, the arbitrator shall provide brief, written findings of fact, and conclusions of law, and reasons for his or her decision. All decisions rendered by an arbitrator under The RIGHT Plan will be final and binding, kept confidential and shall not have the effect of a precedent.

A Court May Enforce The Arbitrator's Decision: The parties shall be precluded from bringing or raising in court any dispute which was or could have been raised pursuant to this procedure. The judgment or the award rendered by the arbitrator may be entered in any court having jurisdiction thereof; provided, however, that any motion seeking to vacate or modify the arbitrator's award must be brought in the United States District Court for the Northern District of Texas, Dallas Division. The standard for a motion seeking to vacate or modify the arbitrator's award will be the same standard utilized by the U.S. Fifth Circuit Court of Appeals. The Federal Rules of Civil Procedure will govern all deadlines for a motion to vacate or modify.

Arbitration and Award To Be Private: The arbitrator shall maintain the privacy of the hearings unless the law provides to the contrary. Any person having a direct interest in the arbitration is entitled to attend the hearings. The arbitrator shall otherwise have the power to require the exclusion of any witness or person, other than a party, counselor expert, during the testimony of any other witness or during the hearing.

Arbitration Fees and Costs: There are two types of administrative fees and costs for arbitration: a filing fee with the American Arbitration Association and payment to the arbitrator for his or her services and expenses. Such fees and other expenses shall be allocated as follows:

1. The AAA filing fee will be at least $625. Your share of this cost is $125 and must be paid when you submit a request for arbitration (or, if this process is challenged by you, when arbitration is compelled by court order). The Employer will then pay the remainder of the AAA filing fee. The Employer will also pay all of the arbitrator's fee and any other AAA administrative expenses; provided, however, that you may elect to also pay up to one-half of these fees and expenses, if you want to. If the arbitrator rules in your favor on all claims, the Employer will reimburse you for your share of these fees and expenses.

2. If the Employer initiates the arbitration (by means other than a motion in court to compel arbitration), you will pay no portion of the AAA or arbitrator fees.

3. You or the Employer, at its additional expense, may arrange for and pay the cost of a court reporter to provide a stenographic record of the proceedings;

4. Each party shall also be responsible for their own attorney's fees, if any; however, if any party prevails on a statutory claim which allows the prevailing party to be awarded attorney's fees, or if there is a written agreement providing for fees, the arbitrator may award reasonable fees to the prevailing party. The arbitrator shall determine the prevailing party in accordance with the meaning of "prevailing party" under the Civil Rights Attorney's Fees Awards Act of 1976;

5. The arbitrator shall also assess attorney's fees against you or the Employer upon a showing by the other party that the first party's claim is frivolous, or unreasonable, or factually or legally groundless; and

6. If either party pursues a claim covered by The RIGHT Plan by any means other than arbitration, the responding party shall be entitled to dismissal of such action, and the recovery of all costs and attorney's fees and expenses related to such action.

Confidentiality: The arbitrator's decision is confidential and neither you nor the Employer may publicly disclose the terms of any award, unless agreed to in writing by the other party, subpoenaed by a court to testify, or required by law as communication to the Internal Revenue Service.

Interstate Commerce: The Employer is engaged in transactions involving interstate commerce (e.g., purchasing goods and services from outside Texas which are shipped to Texas and providing goods and services to customers traveling on interstate roadways) and your employment involves such commerce. The Federal Arbitration Act will govern the interpretation, enforcement, and proceedings under The RIGHT Plan. Unless contrary to applicable law or otherwise provided above, any lawsuits challenging the validity or enforceability of this Plan, seeking to compel arbitration under this Section, or otherwise related to this Plan shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

Requirements for Modification or Revocation of Plan: The RIGHT Plan will survive the termination of your employment. It can be revoked or modified by the Employer at any time in writing signed by an officer of the Employer that specifically states an intent to revoke or modify this policy; provided, however, that any such revocation or modification shall only be effective with respect to all injuries occurring on or after the actual date of such revocation or modification. No employee's oral or written acknowledgment or agreement is necessary for this updated Employer policy to be effective and apply to all employees on and after the Effective Date.

Sole and Entire Program Rules: These Program Rules for The RIGHT Plan (and those items specifically incorporated herein by reference) are the complete rules of the program on the subject of arbitration of covered disputes. The Program Rules take the place of any other verbal or written understanding on this subject. No party should rely upon any statements, oral or written, on the subject of arbitration or the effect, enforceability or meaning of the Program Rules, except as specifically stated in the Program Rules. If any provision of the Program Rules is found to be void or otherwise unenforceable, in whole or in part, such determination shall not affect the validity of the remainder of the Program Rules.

Not An Employment Agreement: The RIGHT Plan and its Program Rules are not and shall not be construed to create any contract of employment, expressed or implied. Nor does The RIGHT Plan or its Program Rules in any way alter the at-will status of your employment.

Binding Effect: The RIGHT Plan is mutual and equally binding upon, and applies to any such claims that may be brought by, an Employer and you and your spouse, children, beneficiaries, representatives, executors, administrators, guardians, heirs, successors, assigns or any other person or entity claiming by or through you. This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute. This Plan applies to all Texas employees of the Employer without regard to whether they have completed and signed any type of receipt form or agreement.. Adequate consideration for this Plan is represented by, among other things, eligibility for (and not necessarily any receipt of) benefits under the Employer's occupational injury plan and the fact that it is mutually binding on both the Employer and you. Any actual payment of benefits under this occupational injury plan to or with respect to you shall serve as further consideration for and represent your further agreement to the provisions of this Plan. Your continued employment with the Employer after receiving notice hereof will also constitute adequate consideration for enforcement of this arbitration requirement. This arbitration provision shall remain in effect with respect to the Employer and you, without regard to your refusal of benefits under the occupational injury plan, return of benefit payments under such plan to the Employer, ineligibility for or cessation of benefits under such plan in accordance with its terms, or any voluntary or involuntary termination of your employment with the Employer. These arbitration provisions are not subject to ERISA requirements or otherwise dependent upon the benefit provisions of the occupational injury plan in any way, and may be attached to such plan's booklet strictly as a matter of convenience in documentation.

Authorization for Initial Treatment and Prescription Services

_____

Employee Name Printed | Social Security Number | Store Number

TO: APPROVED PROVIDER
The above-referenced employee has reported sustaining an occupational injury related to his or her employment with the McDonald's Owner Operator indicated below (the "Employer"). You are authorized to provide medically necessary treatment and/or prescription services, subject to the terms of the Employer's occupational injury plan, for conditions related to the reported injury. All referrals to other approved medical providers must be approved in advance by contacting the Employer at the phone number below.

If this box is signed and dated, the employee is required to submit to a drug/alcohol screen. Please - conduct a drug/alcohol screen for your panel of controlled substances and alcohol, in addition to treating the occupational injury. The results of the drug/alcohol screen must be reported confidentially only to the Employer Representative specified below.

X_____ _____
Employer Representative Signature Date

The attached Physician's Report of Employee Injury ("Report") must be completed by the treating physician.
Please provide the employee with a copy of this Report and attach a copy to your billing document.

Your charges for medically necessary services will be paid directly by the Employer, subject to the terms of the Employer's occupational injury plan. To facilitate prompt payment, submit your billing document and a copy of the Report (physicians only) to the Employer at:

_____

_____

Treatment and/or billing inquiries should be directed to the Employer at (___)_____-_____
or at the above address. For authorization to release medical records and other information relating to the above employee's occupational injury, please refer to the attached "Authorization for Release of Health Information".

_____
Name of Owner Operator Employer

X_____ _____
Employer Representative Signature Date

HIPAA Authorization for Release of Health Information

By my signature, I do hereby authorize and give permission to all healthcare providers who provide medical care or related services to me, to disclose any of my medical records or other protected health information (such as x-rays, diagnostic test results, MRI test results, physician narratives, physical therapy notes, prescription records and other medical reports) to the following persons duly acting on behalf of the Occupational Injury Plan (the "Plan"): (1) the Executive Vice President of, and any claims adjuster, claims supervisor or authorized staff member for, CMI Barron Risk Management, and (2) any other person designated by my Employer as Claims Administrator, Final Review Officer or Committee member for the Plan. My permission is also give to such healthcare providers and Plan representatives to fully discuss my diagnosis, treatment, condition, and prognosis. I further authorize such healthcare providers and Plan representatives to use and disclose such information for the purposes specified below to my employer, the McDonald's Owner Operator indicated below ("Employer"), and any medical case manager, re-pricing company, accounting or payroll representative, insurance agent, insurance carrier, consultant, or attorney.

I understand that the persons listed above will use and disclose my health information for the following purposes: (1) to evaluate and authorize treatment of any alleged injury while working at my Employer; (2) to make a determination of applicable benefits and make payment of Plan benefits, if any (including without limitation pre-authorization and concurrent review of my medical treatment); (3) the assessment of my ability to qualify for leave or return to full/modified duty; and (4) liability and safety evaluations.

By signing below, I understand and acknowledge that (1) this Authorization shall expire on the date upon which I am no longer eligible for Plan benefits; (2) I have a right to revoke this Authorization by contacting in writing my Employer - however, this revocation will not apply to any use or disclosure made prior to my Employer's receipt of my revocation; (3) the Plan may not condition treatment, payment, enrollment or eligibility for benefits solely on whether I sign this Authorization; (4) there is a potential that my protected health information used and disclosed in accordance with this Authorization may be redisclosed by certain persons receiving this information and may then no longer be protected by federal law; and (5) I am entitled to a copy of this Authorization. A photocopy of this Authorization shall be considered as effective as the original.

If Employee is under age 18, a parent or legal guardian must also sign below.

X_____ _____
Employee Signature Date

_____
Employee Name Printed Social Security Number Store Number

X_____ _____
Parent/Personal Representative Date

(If signed by a personal representative (such as a legal guardian), please describe the representative's authority to act for the Employee:_____**)**

_____
Name of Owner Operator Employer

Rev. 1/30/2004