KOHL'S

TEXAS ASSOCIATE ACCIDENT PROGRAM

(Effective January 31, 2010)

SUMMARY PLAN DESCRIPTION

NOTICE TO ENGLISH SPEAKING ASSOCIATES: This booklet contains a summary in English of your program rights and benefits under the Kohl's Texas Associate Accident Program ("TAAP"). If you have difficulty understanding any part of this booklet, or would like a Spanish version of this booklet, contact the TAAP Administrator at N56 W17000 Ridgewood Drive, Menomonee Falls, Wisconsin 53051, (262) 703-3790. Office hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday.

AVISO A LOS ASCOIADOS: QUE NO HABLAN INGLES: Este folleto contiene un resumen en inglés de los derechos y beneficios de su programa de Kohl's Texas Associate Accident Program ("TAAP"). Si tiene dificultad en entender cualquiera parte de este folleto o quiere obtener una copiadle folleto en español, contacte a TAAP Administrator en el N56 W17000 Ridgewood Drive, Menomonee Falls, Wisconsin 53051, (262) 703-3790. Las horas de oficina son de 8:00 a.m. a 5:00 p.m., de lunes a viernes.

Rev. 12/30/09

Dear Associate:

Although safety is a top priority at Kohl's Department Stores, Inc., we all understand that work-related injuries will occur from time to time. When they do, you deserve prompt, professional medical treatment without any inconvenience, and salary continuation if you need to recover at home. With these goals in mind, we have developed a program called the Kohl's Texas Associate Accident Program. Under this Program, Kohl's Department Stores, Inc. pays the entire cost for injury benefit coverage.

This Program is effective for all eligible on-the-job injuries occurring on or after January 31, 2010.

We sincerely hope you never need to make a claim for benefits due to a work-related injury. However, if you are injured at work, you can rest assured that this valuable benefit Program is available to protect you and your family.

Sincerely,

Julie Layton
Director of Risk Management

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Program Highlights

Why is the Company starting this Program?

Kohl's Department Stores, Inc. (the "Company") has created the Kohl's Texas Associate Accident Program (the "Program") because we want a better administrative system for helping associates who are hurt at work. We believe that the Texas Workers' Compensation System does not provide associates with the most efficient process for assisting those who sustain a work-related injury; therefore, we have developed a program to provide more efficient, quality, and effective care than afforded by the current workers' compensation system. We are joining in with many other nationally recognized businesses across Texas who have adopted similar programs for their associates.

How will the Program affect me?

If you are injured on the job, the Company will provide you with many benefits under the Program, including paying for your covered medical care and making sure you receive a paycheck if you need to stay at home to recover. The Company pays the entire cost of the Program.

What are the advantages of the Program?

We expect the Program to better fit your needs in several ways, including:

- *Faster handling of your injury benefit claims*
- *More personalized attention to you if you are hurt on the job*

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 Program starts replacing your wages with a paycheck from the first full day that you miss work.

What are some of the requirements of the Program?

All accidents and injuries will need to be reported immediately – no later than the end of the next business day following the date of the Injury. ***You will not get in any trouble for reporting! In fact, your injury might otherwise get worse, and we want you to receive the medical care you need.***

To receive Program benefits, you may only use physicians, hospitals and clinics that have been approved by the Claims Administrator. These approved physicians and approved facilities have been chosen for their ability to provide occupational injury medical services. ***If you are not satisfied with the decision or diagnosis by an approved physician, you can get a second medical opinion from another physician (as described later in this booklet).***

How are benefit payments handled?

Program benefit decisions will be made by Kohl's and any concerns you may have will be addressed directly by Kohl's or its Claims Administrators. You will find this to be a much easier and faster process than working through the state system and individuals with whom you are not familiar. We expect to provide a better service when addressing the needs of our injured associates.

Rev. 12/30/09

What if I am not satisfied with how my benefit claim is handled?

You have the opportunity to file an appeal with an Appeals Committee. On appeal, the Appeals Committee will conduct an independent review of the claim and you can submit additional information supporting payment of the claim.

What if I have other issues related to my injury?

This program includes arbitration procedures to resolve other injury-related disputes between you and the Company quickly and fairly. Arbitration is a process in which a skilled, independent arbitrator (similar to a judge) hears both sides of the situation and then makes a final and binding decision.

What are the advantages of arbitration?

Protected Rights

Arbitration offers the same fundamental protections as a court of law. 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 often takes years to conclude. During that time, your time, money and energy that could be better used are tied up with paying expensive legal fees and court costs, having delays and wading through endless paperwork. But with arbitration, hearings can often be scheduled within a month or so of your request and decisions can be reached in just a few months.

Fair Decisions

Courts hear all types of cases ranging from car accidents to divorces. Judges and juries do not specialize in solving work-related problems. But arbitrators do. More importantly, the arbitrator is objective and does not have any relationship with the Company.

Does this Program directly affect my health insurance or other benefits?

No. This Program is a separate program from your health insurance and other benefits and applies only when injuries happen on the job.

When does this Program take effect?

It is effective for all on-the-job injuries involving Texas associates that occur on or after January 31, 2010.

PROGRAM BENEFITS

Medical Benefits

Pays for care from approved health care providers if you are injured at work	**100%** of covered charges for up to **120 weeks**

Wage Replacement Benefits

Pays you weekly income if you need time at home to recover	Starting on the **first** full day of disability pays **85%** of your "lost wages" for up to **120 weeks;** Pays up to **$1,000** per week

Death Benefits

Provides payment to eligible beneficiaries if death occurs on the job	**$250,000** (paid 20% down and remainder over 35 months)

Burial Benefit

Provides reimbursement for burial expenses	Up to **$6,000**

Dismemberment Benefits

Provides a payment for loss or loss of use of a member of the body	Up to **$250,000,** based upon the severity of the injury (paid 20% down and remainder over 35 months)

Please see the Program Detail section of this booklet for a more complete description of benefits, maximum benefits limits, taxation issues, applicable exclusions, and other limitations and requirements you must satisfy in order to receive benefits.

How does the Program work?

Take a look at the example below to see how the Program's benefits might work if you have an injury.

Pat, who is a Sales Associate, suffers a back injury. Pat, who earns $500 a week, is not able to return to work until three weeks after the accident. Pat's total covered medical charges following the accident are $3,000. In this example, Pat would be eligible to receive **$4,275** under the Program.

Pat would receive:

- $3,000 in Medical Benefits (100% of all covered medical charges)
- $1,275 in Wage Replacement Benefits (85% of lost wages for the three weeks of disability)

*Of course, **Pat's case is just an example** and might not be like your situation at all if you're injured on the job. You may be entitled to receive more or less benefits than those provided in this example, depending on the severity of your injury and other factors.*

This example simply illustrates what a difference having great benefit protection under the Program can make in certain situations.

Reporting an Injury

What should I do if I am injured on the job?

The Company has set up procedures to make sure you receive treatment for your injuries in an efficient, quick manner. By following these and other Program rules, your covered medical bills will be paid and your paycheck will continue even if you need to stay at home to recover. More detailed information on these procedures is found later in this booklet.

1. Report Your Injury Immediately

You must report your injury to your manager by the end of the next business day following the date of the Injury. Don't wait! Your injury might get worse and we want to help you.

2. Fill Out an Incident Report

You must complete a report that provides details of the incident that resulted in your injury within 24 hours after the Injury is reported. You and the Company will then work together to investigate your claim.

3. Use an Approved Physician or Approved Facility for Medical Treatment

In order to receive injury benefits, you must use physicians, hospitals, clinics and other health care providers and facilities that have been approved by the Program's Claims Administrator. You must also receive your first medical treatment from an Approved Physician or Approved Facility within 14 days after the date of your injury.

4. Submit to a Drug and/or Alcohol Screen

If you require offsite medical treatment for your injury, you must submit to a drug and/or alcohol test, in accordance with the Company's substance abuse policy.

5. Follow the Doctor's Orders

You must follow the approved physician's instructions and keep all scheduled appointments with health care providers.

6. Keep the Company Informed

You must keep the Company informed about your return to work status and any change in your restrictions. This includes providing your manager with a completed Physician's Report form (or similar work status report form) within 24 hours after each medical visit with your Approved Physician.

PROGRAM DETAIL

INTRODUCTION

Kohl's Department Stores, Inc. (the "Company") is committed to providing loss of income protection and helping you pay medical expenses that might otherwise present a financial burden to you if you are injured on the job. To accomplish this, the Company has implemented a benefit program called the Kohl's Texas Associate Accident Program (the "Program"). This booklet has been prepared to help you understand your benefits under the Program. Please read it carefully.

If any conflict arises between the information contained in this booklet and the provisions of the formal plan document, the plan document will control. Certain terms used in this booklet are capitalized and defined in the DEFINITIONS section of this booklet.

Except as otherwise provided in this booklet, benefits and other requirements described in this booklet are effective for all covered Injuries occurring on or after January 31, 2010.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

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

COVERAGE: Kohl's Department Stores, Inc. 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 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 Division 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 occupational health or safety violation. Contact Workers' Health & Safety at 1-800-452-9595.

COBERTURA: Kohl's Department Stores, Inc. ha elegido no obtener cobertura de compensación para trabajadores. Como empleado de un empleador que ha elegido no obtener seguro de compensación para trabajadores usted no es elegible para recibir beneficios de compensación bajo la Ley de Compensación para Trabajadores de Texas. Sin embargo, un empleador sin cobertura puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener información acerca de la disponibilidad de otros beneficios o compensación por una lesión o enfermedad relacionada con el trabajo. Además, usted puede tener derechos bajo la ley de “Derecho Común” de Texas, si usted ha sufrido una lesión o enfermedad relacionada con su trabajo. Es requerido que su empleador le proporcione información acerca de la cobertura, por escrito, cuando es contratado o cuando su empleador obtiene o deje de tener cobertura de seguros de compensación para trabajadores.

LÍNEA DIRECTA PARA REPORTAR CONDICIONES INSEGURAS: La División ha establecido una línea telefónica gratuita las 24 horas, para reportar condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen contra un empleado o empleada porque él o

ella, de buena fe, reporta una presunta violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al teléfono 1-800-452-9595.

Your Injury Benefit Program: The Company **DOES PROVIDE** to all Texas associates, without cost, the Program 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 manager first** of any unsafe working condition, safety violation or on-the-job 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 working condition, on-the-job injury or potential occupational health or safety violation.

ELIGIBILITY

You automatically become a participant in the Program if you are an associate of the Company and your employment with the Company is principally located within the State of Texas. You must be a person who is employed in the regular business of, and receive your pay by means of a salary, wage or commission directly from, the Company and for whom the Company files a Form W-2 with the Internal Revenue Service. This Program does not cover an independent contractor or third-party agent.

HOW THE PROGRAM WORKS

Medical Determinations and Treatment

As explained further below, in order to receive any benefits under this Program, all medical care must be **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 their license)**, unless provided in connection with Emergency Care as described below.

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 list of Approved Physicians or Approved Facilities at any time. **No Approved Physician or Approved Facility is an agent of the Company. Although benefits under this Program 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 Program is not intended to affect your relationship with your health care 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 health care providers based on their independent judgment for the provision of health care.**

For purposes of this Program, 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 Program.

Procedure In Event Of Injury

- **You must notify your manager immediately after being injured at work, no matter how minor the Injury appears to be (including any disease exposure). For an Injury due to an Accident or for a known exposure to an Occupational Disease, verbal notice must be provided by the end of the next business day following the date of the Injury.** For an actual Injury due to Occupational Disease, verbal notice must be provided 24 hours after being medically diagnosed with a work-related Injury, or within 30 days after you should have known of the work-related Injury,

whichever is earlier. You must also submit a written incident report to your manager within 24 hours after the Injury is reported.

- **For purposes of an Injury that involves an Accident, the date of the Injury shall be the date of the Accident resulting in the Injury.** For purposes of an Injury that involves an Occupational Disease,, the date of the Injury shall be the earlier of (1) the date that the damage, harm or symptoms of the Occupational Disease were first known (or should have been known) to you, or (2) the date that an Approved Physician medically diagnosed you with an Occupational Disease.

- With respect to an Injury due to Occupational Disease, if the Company has purchased an insurance policy, the purpose of which (in whole or in part) is to pay Program benefits to a participant or reimburse the Company for Program benefits, then the notice of Injury from Occupational Disease must in all events be provided not later than 35 months after the end of the policy period.

➢ **You must receive medical care from an Approved Physician or Approved Facility.** You may use a non-approved physician or facility (and still be eligible to receive benefits under this Program) only if the following requirements are satisfied:

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

- **Second,** 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

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

➢ **You must receive your first medical treatment from an Approved Physician or Approved Facility within 14 days after the date of your Injury.** If necessary, the Claims Administrator will assist you in arranging for appropriate treatment.

➢ **You must submit to alcohol and/or drug testing, in accordance with the Company's substance abuse policy, if you require offsite medical treatment.** You must either provide the Company with this alcohol and drug testing information or authorize the Company to gain access to this information.

➢ **You must obtain pre-approval for all medical care from the Program's Claims Administrator.** You do not have the right to select and have the Program 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.

➢ **You must also follow the procedures described below in the REQUESTING BENEFITS section and comply with the requirements of the CONTINUING BENEFITS section of this booklet.**

Funding

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

- **benefit payments under this Program shall not be payable or shall immediately cease in the event that benefits coverage is not available to the Company 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 Company. Any such insurance policy shall be owned by, and all amounts under the policy shall be payable to the Company, 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 Program may relate to requirements of such insurance policy).

COVERED AND NON-COVERED INJURIES

Covered Injuries

The Program pays benefits only on account of an **"Injury."** An "Injury" means damage or harm to the physical structure of the body resulting from either:

- an **"Accident"** (which means an event that --
  - was unforeseen, unplanned, and unexpected;
  - occurred at a specifically identifiable time and place;
  - occurred by chance or from unknown causes; and
  - resulted in physical injury to you); or
- an **"Occupational Disease"** (which means a condition marked by a pronounced deviation from your normal healthy state arising out of your assigned duties in your Course and Scope of Employment. Occupational Disease includes other diseases or infections that naturally result from the work-related disease. Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of your assigned duties in your Course and Scope of Employment).

Any such damage or harm must occur or arise during, and directly and solely result from, the Course and Scope of Employment by the Company (see the DEFINITIONS section of this booklet). In order to be subject to the provisions of this booklet, **the date of the Injury must be on or after January 31, 2010.**

Any provision of this Program to the contrary notwithstanding, if the Company has purchased an insurance policy as described above, the purpose of which (in whole or in part) is to pay Program benefits to a participant or reimburse the Company for Program benefits, then:

- the Accident must have occurred during the policy period; or
- your last day of last exposure to the condition causing or aggravating any Occupational Disease must have taken place during the policy period.

All injuries relating to (1) an Accident or related series of Accidents, or (2) exposure to an environmental or physical hazard that causes Occupational Disease, 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;
- poor or inappropriate posture;
- the natural results of aging;
- osteoarthritis, arthritis, or degenerative process (including, but not limited to, degenerative joint disease, degenerative disc disease, degenerative spondylosis/spondylolisthesis and spinal stenosis), or;
- other circumstances prescribed by the Claims Administrator which do not directly and solely result from your Course and Scope of Employment;

➢ Damage or harm to the physical structure of the body occurring (or alleged to have occurred) as a result of repetitious, physically traumatic activities that occur over time (including, but not limited to, carpal tunnel syndrome). However, a carpal tunnel injury that solely and directly results from an Accident incurred in your Course and Scope of Employment may be eligible for Program benefits if such injury otherwise meets Program requirements;

➢ Damage or harm resulting from factors to which the general public is exposed;

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

➢ Except to the limited extent provided under the section of this booklet entitled "Medical Services and Supplies Requiring Specific Approval in Writing or by Electronic Notice," any mental injury, emotional distress, mental trauma or similar injury to your mental or emotional state, 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 resulting from airborne contaminants not commonly found in the Company's normal working environment, including, but not limited to, pollen, fungi, and mold;

➢ Damage or harm resulting from job stress;

➢ Any heart attack, stroke, or aneurysm (an "attack"), unless --

- the attack can be identified as –
  - ➢ occurring at a definite time and place at the work site; and
  - ➢ caused solely by a specific event related to and occurring in the Course and Scope of Employment and independent of any other cause or condition;
- the preponderance of the medical evidence regarding the attack indicates that your work rather than the natural progression of a preexisting heart condition or disease was a substantial contributing factor of the attack; and
- the attack was not triggered solely by emotional or mental stress factors, unless it was precipitated by a sudden work-related stimulus that was above and beyond normal workplace stress factors;

➢ Hernia, unless inguinal and/or umbilical hernia that -

- appeared suddenly and immediately following the Injury;

- did not exist in any degree prior to the Injury; and
- was accompanied by pain; or

- 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 Program if:

- the Injury did not occur as a result of your Course and Scope of Employment, including but not limited to (1) injuries or ordinary diseases of life that are not solely and directly related to your Company work activities or your Company work environment, or (2) injuries caused solely and directly as a result of an ordinary function of life, such as walking, standing or sitting.

- you are not an associate of the Company or your employment is not principally located in the State of Texas;

- the Injury occurred while you were in a state of intoxication or had otherwise lost the normal use of your mental or physical faculties as a result of the use of a drug or alcohol. For this purpose, you will be considered to have been in a state intoxication at the time of the Injury if the drug or alcohol test required by the Company finds a violation of the Company's substance abuse policy;

- the Injury 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 or 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;

- your long-term cell phone use, or second-hand smoke was a proximate cause of the Injury;

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

- 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 associate or because of your employment;

- the Injury arose out of your 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 the Company (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 Company;

- the Injury arose out of your participation in:

  - a riot or act of civil disturbance;
  - a war, declared or undeclared;
  - any act of war or terrorism;
  - any illegal act;
  - a felony or an assault, except an assault committed in defense of the Company's business or property; or
  - service in the military of any country or any civilian non-combatant unit serving with such forces;

- any damage or harm arising out of the use of or caused by --

  - asbestos, asbestos fibers or asbestos products; or
  - the hazardous properties of nuclear material or biological contaminants.

- 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 Company;

- the Injury did not occur during your Course and Scope of Employment; or

- the Injury was not timely reported (or requested information was not timely provided) in accordance with the timeframes specified in the REQUESTING BENEFITS section of this booklet.

WAGE REPLACEMENT BENEFITS

When Wage Replacement Benefits Begin

- **Total Disability.** From the first full day that you become Totally Disabled due to a covered Injury, the Program shall pay Wage Replacement Benefits equal to 85% of your Pre-Injury Pay.

- **Partial Disability.** From the first full day you become Partially Disabled, the Program shall pay Wage Replacement Benefits equal to 85% of the portion of your Pre-Injury Pay that you are unable to earn (due to the Approved Physician's restrictions) while working Modified Duty.

- If you have a Partial Disability and are released to Modified Duty, but (i) the Company has no Modified Duty position available, and (ii) an Approved Physician has not assigned permanent restrictions and has not released you to any other gainful employment, then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."

- If you have a Partial Disability and 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, but you are either:

  - again determined by an Approved Physician to be Totally Disabled, or
  - the Modified Duty position ceases to be available (for example, the position reaches its maximum duration) and an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment;

  then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."

The Company's ability to provide a Modified Duty position while you are under work restrictions determined by the Approved Physician does not imply or create a permanent Modified Duty position for the purposes of the Americans with Disabilities Act ("ADA").

- **Payment Terms and Other Limitations.** An Approved Physician must make the determination regarding whether you are Totally Disabled or Partially Disabled, except to the extent that such determination is made in conjunction with Emergency Care as determined by the Claims Administrator. Wage Replacement Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week shall be prorated. Only your normal, scheduled workdays shall be considered in calculating benefits (based upon your employment status as of the date of Injury). Wage Replacement Benefit payments shall be reduced as described in the "Offset For Other Benefits" section of this booklet. **Wage Replacement Benefit payments will not exceed $1,000 per week.**

When Wage Replacement Benefits Cease

Wage Replacement Benefits will continue until the earliest of:

- the expiration of 120 weeks from the date of the Injury. This 120-week maximum period for Wage Replacement Benefits is calculated continuously from the date of the Injury, regardless of whether or not you qualify as Disabled at all times during such period or receive Wage Replacement Benefits continuously throughout such period;

- the date you are determined by the treating Approved Physician to no longer be Disabled, without regard to whether you return to regular or Modified Duty on that date;

- the date that the Maximum Benefit Limit is met;

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

  - application of a duration limit in the Company's leave of absence policy, or

  - 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;

- as otherwise provided under the CONTINUING BENEFITS section below; or

- the date on which you are determined to have reached **Maximum Rehabilitative Capacity** by an Approved Physician.

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.

DEATH BENEFITS

If you die as the direct and sole result of, and within 365 days of, an Injury, then the Program will pay your Beneficiary a Death Benefit equal to $250,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Program's Maximum Benefit Limit.

The Death Benefit will be paid to your Beneficiary as follows: (1) 20% will be paid in a lump sum cash payment as soon as administratively possible following your death; and (2) the remainder will be paid in 35 equal monthly installments (without interest) commencing on the first day of the month following the initial lump sum payment. Death Benefits will be in addition to Dismemberment Benefits, Wage Replacement Benefits, and Medical Benefits payable with respect to any one Injury; provided, however, that no interest in future Dismemberment Benefits survives after your death if your Beneficiary then becomes entitled to Death Benefits under this Program. In addition to the Death Benefits set forth above, the Program shall reimburse reasonable burial expenses to any person who incurs liability therefore, up to $6,000.

DISMEMBERMENT BENEFITS

If you suffer a loss described in the Schedule of Losses below as the direct and sole result of, and within 365 days of, an Injury, then the Program will pay you an amount equal to the applicable percentage from the schedule below times $250,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Program's Maximum Benefit Limit. For example, if you suffer an Injury resulting in the loss of sight in one of your eyes (as described below), you would generally be entitled to a Dismemberment Benefit of $125,000 (50% x $250,000).

The Dismemberment Benefit will be paid as follows: (1) 20% will be paid in a lump sum cash payment as soon as administratively possible following the date of loss; and (2) the remainder will be paid in 35 equal monthly installments (without interest) commencing on the first day of the month following the initial lump sum payment.

SCHEDULE OF LOSSES

Loss of:	**Benefit Amount:**
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%

Speech	50%
Hearing	50%
Finger or Toe (two joints)	10%
Finger or Toe (one joint)	5%

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

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

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

- The above-described loss of "Finger or Toe (two joints)" must be at or above the joint at the proximal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the metacarpophalangeal joint. The above-described loss of "Finger or Toe (one joint)" must be at or above the joint at the distal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the joint at the distal end of the proximal phalanx. (If you have any questions regarding a loss of "Finger or Toe (two joints)" or a loss of "Finger or Toe (one joint)," you should consult an Approved Physician or contact the Claims Administrator.)

- Dismemberment Benefits will be in addition to Wage Replacement Benefits and Medical Benefits; provided, however, that payment of Dismemberment Benefits will cease in the event of death that results in the payment of Death Benefits.

MEDICAL BENEFITS

Subject to the medical management and other provisions of this Program, medical services and supplies that are approved by the Claims Administrator (referred to below as "Covered Charges") are covered at 100%, with no co-pays, deductibles or other out-of-pocket expense to you, provided that all applicable Program 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 Program. Coverage also requires satisfaction of the following requirements:

First and Continuing Treatment

- The first Covered Charge must be received from an Approved Physician and incurred within 14 days following the date of your Injury (unless the Claims Administrator determines that good cause exists); and

- No further amount shall be considered a Covered Charge if you do not receive medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days. This section, however, shall not apply to any Covered Charge for testing and any follow up vaccination with respect to an Injury that involves a potential occupational exposure to a bloodborne pathogen.

Approved Provider and Pre-Authorization Requirements

The cost of a service or supply shall be a Covered Charge only if:

- **Treatment is (1) 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, and (2) pre-approved by the Claims Administrator (except when the Claims Administrator determines that prior approval was impossible under the circumstances).** Such pre-approval may include authorization for multiple visits to an Approved Physician or Approved Facility, and must be in writing, or by electronic notice (except as otherwise specified below or in the Program's claims procedures); or

- **Treatment is provided as Emergency Care** and (1) 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 (2) 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.

  An Emergency Care determination solely relates to consideration of an exception to the Program's approved medical provider requirements. "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. An Emergency Care determination shall be made within the sole administrative discretion of the Claims Administrator or Appeals Committee, with such advice and consultation from an Approved Physician as the Claims Administrator or Appeals Committee deems appropriate. If you obtain treatment from a non-approved health care provider and the Claims Administrator or Appeals Committee determines that your situation has not satisfied all of the above requirements, your claim for benefits will be denied.

Covered Medical Services and Supplies

Medical Services and Supplies That Can Be Verbally Authorized. Subject to the restrictions and limitations set out elsewhere in this booklet, Covered Charges that can be verbally authorized will include the cost of the following:

- Approved Physician visits - at an Approved Facility (including charges for an 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 treating 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;

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

- Eyeglasses or contact lenses - one pair per Injury up to $200, inclusive of professional office visit charges, but excluding routine eye examinations; and

- External hearing aid - up to $600, inclusive of professional office visit charges.

Medical Services and Supplies Requiring Specific Approval in Writing or by Electronic Notice. Subject to the restrictions and limitations set out elsewhere in this Program, 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 on an inpatient or outpatient basis, including semi-private room and board, ambulatory day surgery, anesthesia and its administration, and similar services;

- Diagnostic testing, including x-ray examinations, laboratory tests, MRI, CAT Scan, nuclear medicine, radiology and pathology (including interpretive services) and similar testing;

- Speech, occupational and physical therapy provided by an Approved Physician or a licensed speech therapist, 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;

- Limited or temporary pain management services (for example, epidural steroid injections), but not including pain management programs;

- 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 teeth (excluding temporomandibular junction dysfunction services) when you seek treatment as soon as possible after the Injury;

- Home health care (with respect to physical needs only) up to 75 visits per Program 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 Representative, Approved Physicians or other health care providers;

- Mental health services (to the extent not otherwise covered by the Company's Associate 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 such services shall not exceed five visits with an

Approved Physician or Approved Facility. This coverage applies solely to Medical Benefits coverage and will not result in any payment of Wage Replacement Benefits or other benefits under this Program;

- 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 usual place of employment (one way) as interpreted by the Claims Administrator for application under this Program and approved by the attending Approved Physician.

Non-Covered Medical Services and Supplies

While the Program provides benefits for many medical expenses, the following expenses are **not** covered by the Program:

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

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

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

- Charges incurred more than 60 days after the date of the last Covered Charge (except as otherwise specified in this booklet);

- Expenses that exceed any fee schedule adopted by the Claims Administrator or the usual and customary 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 Food and 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 physician'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 Program;

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

- 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;

- Canceled appointment charges;

- Self-administered services;

- Services or supplies to which your condition is persistently nonresponsive;

- Services or supplies relating to Preexisting 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 programs, hypnosis, biofeedback, other forms of self-care or self-help training or any related diagnostic testing, or any service or supply ancillary to any of these treatments;

- 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 assist 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 your spouse;
    - a child of you or your spouse; or
    - a brother or sister of you or your spouse; and

- The cost of any other service or supply not specified above as a Covered Charge.

Initial Treatment and Denial

Any provision of this Program to the contrary notwithstanding, the Company may render first aid, or the Program may pay for Emergency Care, pay Wage Replacement Benefits or pay for a medical evaluation or treatment, and the Program 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 Program. The payment of benefits under the Program shall not constitute a waiver of the right to later determine that the Participant has not suffered a covered Injury, nor shall the Program be prevented from making such a determination.

Medical Provider Referrals

If the treating Approved Physician finds it necessary to refer you to another health care 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 Program. **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 Program 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. **However, any medical expenses for this medical care will not be payable under this Program and your use of a non-approved physician or facility may result in a complete denial or termination of benefits under this Program.** The Company, Claims Administrator, Appeals Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other health care services provided by any Approved Physician, Approved Facility or other designated health care service provider. Health care providers are not agents of the Program, Company, Claims Administrator, or Appeals Committee. The Program, Company, Claims Administrator, and Appeals Committee 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 health care providers based on their independent judgment for the provision of health care.

Second Medical Opinions

The Program reserves the right to require a second medical opinion from an Approved Physician selected by the Claims Administrator for purposes of obtaining an Independent Medical Evaluation (IME) or for any other reason relating to the payment of Medical Benefits, Wage Replacement Benefits, or any other benefits under this Program. If you refuse to be examined by an Approved Physician selected by the Claims Administrator for the second opinion, all benefits under the Program will be suspended.

The Claims Administrator will weigh the findings of the treating Approved Physician and the Approved Physician providing the second opinion and make a benefit determination under the Program. However, if you disagree with the diagnosis or treatment recommended by the Approved Physician whose opinion is accepted by the Claims Administrator ("Physician A"), then you may request a second medical opinion. **You must notify the Claims Administrator in advance of receiving any second medical opinion in order for this opinion to be considered by the Program.** If you provide advance notice to the Claims Administrator, then you shall have the right to a one-time examination at your own expense by another physician ("Physician B"). This examination by Physician B will be solely for the purpose of evaluating your condition and making a treatment recommendation.

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

Use and Disclosure of Protected Health Information

See Appendix A located at the back of this booklet.

When Medical Benefits Cease

Medical Benefits will cease upon the earliest of:

- the expiration of 120 weeks from the date of the Injury;
- reaching the Maximum Benefit Limit;
- involuntary termination of your employment with the Company for gross misconduct;
- the date that you do not receive medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days;
- your failure to comply with the requirements specified under the CONTINUING BENEFITS section of this booklet; or
- the date on which you are determined to have reached **Maximum Rehabilitative Capacity** by an Approved Physician.

REQUESTING BENEFITS

The following is a summary of the procedures for requesting benefits under this Program. Also see the DETAILED CLAIM PROCEDURES in the next section of this booklet.

Notice of Injury

You (or your Representative) must provide verbal notice of an Injury **immediately** to your manager then on duty. **For an Injury due to an Accident, or known exposure to an Occupational Disease, this verbal notice must be provided by the end of the next business day following the date of the Injury. For an actual Injury due to Occupational Disease, this verbal notice must be provided by the earlier of the following: (1) within 24 hours after being medically diagnosed with a work-related Injury, or (2) within 30 days after you should have known of the work-related Injury.**

With respect to reporting an Injury due to Occupational Disease, if the Company has purchased an insurance policy as described above, the purpose of which (in whole or in part) is to pay Program benefits to a participant or reimburse the Company for Program benefits, then the notice of Injury from Occupational Disease must in all events be provided not later than 35 months after the end of the policy period.

You must also notify your manager (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 your Representative) and your manager (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.**

An immediate incident report to your manager is essential so that the Claims Administrator can promptly verify the facts regarding your Injury and pay appropriate benefits. No benefits will be payable under the Program if:

- notice of Injury is not provided as specified above, unless the Claims Administrator determines that good cause exists for failure to give notice in a timely manner; or

- all required information is not provided as specified above, unless the Claims Administrator determines that good cause exists for failure to provide such information in a timely manner.

Medical Examination

You must submit to medical examinations or evaluations as often as the Claims Administrator determines to be reasonably necessary or appropriate.

CONTINUING BENEFITS

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

- submit to any requested drug and/or alcohol testing in accordance with the Company's substance abuse policy, and provide the Company with this alcohol and/or drug testing information or authorize the Company to gain access to this information;

- receive prior approval for all medical care (except in the case of Emergency Care, as explained in the MEDICAL BENEFITS sections of this booklet);

- utilize only Approved Physicians and Approved Facilities (except in the case of Emergency Care, as explained in the 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;

- do not reach Maximum Rehabilitative Capacity or are otherwise responsive to treatment. Nonresponsiveness would include, but not be limited to, nonresponsiveness due to the need for participant behavioral modification recommended by the treating Approved Physician;

- provide accurate information to, and follow the directions of, a treating Approved Physician. Following the directions of a treating Approved Physician includes, but is not limited to, any recommended treatment, therapy, course of action, abstinence or rehabilitation program;

- allow an authorized representative of the Company to go with you to appointments with health care providers;

- keep and be on time for all scheduled appointments with health care providers. Except in extraordinary circumstances as determined by the Claims Administrator, a first missed appointment will result in a warning and/or suspension of benefits and a second missed appointment will result in a termination of benefits;

- do not engage in conduct which hinders your recovery;

- report in to your manager periodically as directed until you are able to return to work, including providing your manager a completed Physician's Report form (or similar work status report form) within 24 hours after each appointment with the treating Approved Physician;

- immediately inform your manager 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;

- do not receive benefits with respect to the Injury from, and the incident does not create any liability for the Company under, any workers' compensation law (regardless of whether or not any coverage for benefits is actually in force under such law);

- are truthful and do not demonstrate bad faith in connection with administration of the Program, including, but not limited to, any aspect of the required information supplied as part of the Injury reporting or employment process;

- fully cooperate with the Claims Administrator (including, but not limited to, the requirements on providing information) in connection with the administration of the Program, including, but not limited to, subrogation or coordination of benefits procedures; and

- comply with the provisions of this summary plan description, the Program, and the rules and procedures adopted by the Claims Administrator for the administration of the Program.

DETAILED CLAIM PROCEDURES

Filing a Claim for Benefits

A claim for Medical Benefits, Wage Replacement Benefits, or Dismemberment Benefits under the Program will be initiated by you (or your Representative) by complying with the injury notice and medical treatment requirements found in the REQUESTING BENEFITS section and other parts of this booklet. A claim for Death Benefits under the Program shall be initiated by a Beneficiary providing notice of entitlement thereto to the Claims Administrator within 90 days after the date of the participant's death. If, within two years after any amount becomes payable under this Program to an individual, but the individual fails to claim such amount and the Claims Administrator has exercised reasonable diligence in attempting to make such payment, the amount shall be forfeited and shall cease to be a liability of this Program.

- **What is a Claim** -- Each (1) medical service or supply for which payment is requested, (2) Wage Replacement Benefit for a particular payroll period, or (3) claim for Death Benefits or Dismemberment Benefits, will be deemed a separate "claim" for benefits that is subject to a determination under the Program. The Program's payment of a particular claim (for example, payment for an initial medical evaluation, even on a claim that may have been reported late) does not waive or otherwise prejudice the Claims Administrator's or Appeals Committee's right to deny another particular claim or all future claims for benefits under the Program. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Program to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter.

- **Who is a Claimant** -- A claimant or a claimant's Representative may file a claim for benefits under the Program, as well as an appeal of an Adverse Benefit Determination. References in this DETAILED CLAIMS PROCEDURES section to "claimant" may include you, a medical provider seeking payment for a service or supply, or a claimant's authorized Representative, as applicable.

- **Information to Submit** -- Claims must include the information required by the REQUESTING BENEFITS section above and such other reasonable information requested by the Claims Administrator, such as medical records or a written statement from an independent service provider evidencing the date, type of services rendered, and the total cost of such services. In addition, the Claims Administrator may require the claimant to provide a written and signed statement that provides that the amounts requested for payment under this Program have not been reimbursed, or is not reimbursable under any other plan or program. Further, the Claims Administrator may also request that the claimant file all appropriate claims and requests for payment from any other plan or program maintained by the claimant prior to making any payments under this Program. See the OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFITS section of this booklet.

- **Submission of Medical Bills for Payment** -- Approved Physicians and Approved Facilities will be requested to invoice all health care-related charges directly to the Claims Administrator (or the Company, which will immediately transmit such invoice to the Claims Administrator). However, in the event that you receive such an invoice or pay such a charge, you must file all requests for payment or reimbursement of covered charges with the Claims Administrator within 30 days from the date such expenses are incurred or, if later, the date you receive an invoice from an Approved Physician, Approved Facility, or other health care provider (in the case of Emergency Care) for such expenses.

- **Incomplete Claim Submissions** -- If a claim, as originally submitted, is not complete, the Claims Administrator will notify the claimant in the manner described below, and the claimant will have the responsibility for providing the missing information. Subject to the applicable provisions of this DETAILED CLAIMS PROCEDURES, if the period of time for a particular claim is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination will be suspended from the date on which the notification of the extension is sent to the claimant until the date on which the Claims Administrator receives the claimant's response to the request for additional information.

Claims Review Procedures

- **Notice of Initial Benefit Determination** - The Claims Administrator will provide notice to the claimant of its initial benefit determination as follows:

  - **Urgent Care, Pre-Service Medical Claims** - In the case of an Urgent Care Claim for Medical Benefits, the Claims Administrator will notify the claimant of the Program's initial benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies of the particular claim, but not later than 72 hours after receipt of the claim. However, if the claimant (1) fails to follow the Program's procedures for filing an Urgent Care Claim, or (2) otherwise fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Program on an Urgent Care Claim, then:

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

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

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

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

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

    - Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Program that is an Urgent Care

Claim will be decided as soon as possible, taking into account the medical exigencies of the claim. The Claims Administrator will make an initial benefit determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to the Program at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If such claim is not made to the Program within such 24-hour period, the request will be treated as an Urgent Care Claim and be decided within the normal Urgent Care Claim timeframes (in other words, as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after receipt).

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

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

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

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

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

- **Post-Service Medical Benefit, Wage Replacement Benefit, Death Benefit, and Dismemberment Benefit Claims** - In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, Death Benefits or Dismemberment Benefits, the Claims Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after its receipt of the claim. The Claims Administrator may extend this period up to an additional 15 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Program. Notice of such extension must be provided to the claimant prior to the expiration of the initial 30-day period and state (1) the special circumstances requiring the extension, and (2) the date by which the Program expects to render a decision. If the extension relates to a claim for Wage Replacement Benefits, such notice will also state (1) the standards on which entitlement to benefits is based, and (2) unresolved issues that prevent a benefit determination on the claim and what additional information is needed to resolve those issues. If additional information is requested with the extension notice, the claimant will have 45 days from the date of the notice of extension to provide the specified information. However, the Claims Administrator's timeframe for making a benefit determination shall be suspended until the date upon which the claimant responds to the request for additional information.

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

  - Any electronic notice will satisfy ERISA regulations that specify the standards for electronic disclosure of benefit plan information;

  - The notice will be written in a manner calculated to be understood by the claimant;

  - The notice will set forth the specific reason or reasons for the Adverse Benefit Determination, making reference to the specific Program provisions on which the Adverse Benefit Determination is based;

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

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

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

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

  - The notice will describe any additional materials or information necessary for the claimant to perfect the claim and explain why such material or information is necessary; and

  - The notice will provide a description of the Program's review procedures (including the time limits applicable to these review procedures).

- **Appeal of Adverse Benefit Determinations** -- The claimant may appeal in writing an Adverse Benefit Determination to the Appeals Committee within the following number of days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator:

  - 180 days for a Medical Benefits or Wage Replacement Benefits claim; or

  - 60 days for a Death Benefit or Dismemberment Benefit claim.

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

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

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

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

- The Appeals Committee review of an Adverse Benefit Determination on a claim for Medical Benefits or Wage Replacement Benefits will not give any deference to the claimant's initial Adverse Benefit Determination.

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

- Upon request of a claimant, the Appeals Committee will identify the individual names of any medical or vocational experts whose advice was obtained in connection with an initial Adverse Benefit Determination of a Medical Benefits or Wage Replacement Benefits claim, without regard to whether the advice of such experts was relied upon in making the benefit determination.

➢ **Timing of Notice of Benefit Determination on Review** - The Appeals Committee will provide notice to the claimant, as described below, of the Program's benefit determination on review in accordance with the following timeframes:

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

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

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

- **Manner and Content of Benefit Determination on Review** - The Appeals Committee will provide a claimant with written or electronic notification of the Program's benefit determination on review. If the decision on review is an Adverse Benefit Determination, the notice must satisfy all the requirements set forth in the first six bullets under the "Manner and Content of Adverse Benefit Determination" section above, and also state that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for Program benefits.

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

- **Exhaustion of Administrative Remedies**: No legal action can be brought by or with respect to you to recover benefits under the Program before the foregoing claim procedures have been exhausted. Every ERISA right of action by you, your Representative, Beneficiary or estate against the Program, or any Program fiduciary, must be brought no later than one (1) year from the date that the foregoing claim procedures have been exhausted (due to claimant inaction, claimant receipt of a final Adverse Benefit Determination on appeal, or otherwise). Unless contrary to applicable law, any ERISA right of action or other legal action challenging a Program decision shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

FINAL COMPROMISE AND SETTLEMENT

At the Claims Administrator's option within 120 weeks after the date of Injury, and at any time if the Claims Administrator elects to extend such 120-week period after the date of Injury, the Claims Administrator may notify you of the Program's intention to be released from any further known and unknown benefit and all other injury-related claims by you and pay a final claim settlement to, or with respect to, you in exchange for your agreement to a release of liability in favor of the Program, Company, Claims Administrator, Appeals Committee and other interested parties with respect to such claims. In that event, the Claims Administrator may appoint an actuary, appraiser, and/or Approved Physician to investigate, determine, and capitalize such claims, or use such other valuation method as the Claims Administrator may specify. The payment by the Program and/or Company of the value of such claims (as finally determined by the Claims Administrator) will be made in such manner as the Claims Administrator may determine. No additional claims will be subsequently accepted with respect to such Injury. Any actuary or appraiser will apply such rules, standards, and assumptions (present value discount, inflation, and mortality rates, etc.) as the Claims Administrator may determine. You must cooperate and provide all information, sign such forms and agreements, and submit to all medical examinations as may be requested by the Claims Administrator to arrive at a valuation and settlement of your claims. No further benefits will be payable to, or with respect to, you if you fail or refuse to accept the Claims Administrator's claim valuation, sign the release agreement presented by the Claims Administrator, or otherwise comply with the requirements of this section or other provisions of the Program. Prior or subsequent to the Claims Administrator's evaluation and determination of the value of your claims, the Claims Administrator may determine to not capitalize and satisfy any such claim as described above and to instead continue eligibility for benefit payments and defer the above valuation and settlement.

OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFIT

Offset For Other Benefits

Benefit payments under this Program shall be reduced by:

- the amount of any applicable federal or state income, employment, or other taxes that are required by law to be withheld;

- your earnings from any employer after disability begins, amounts legally garnished, and your contributions (through salary reduction or otherwise) to a 401(k) or a 403(b) plan, cafeteria plan, or other pre-tax salary deferral employee benefit plan; and

- except as otherwise specified in the Program's "Coordination of Benefits" section, any amount paid or available with respect to your Injury under the following: Social Security Act, the Railroad Retirement Act, workers' compensation law, unemployment compensation law, occupational disease law or any other government program or similar law. The Program shall deduct from Program benefits the estimated benefit amounts for which you are likely to be eligible under such other deductible sources of income, regardless of whether you actually apply for such other deductible source of income.

All benefits paid under this Program shall be offset against any alleged liability of the Company, its officers, directors, or agents to you or your Beneficiaries, heirs, or assigns due to an Injury.

Coordination Of Benefits

If you are covered under this Program and one or more other benefit plans, then (unless otherwise subject to the "Subrogation and Reimbursement Rights" section) any Medical Benefits and Wage Replacement Benefits payable under this Program will be either regular benefits or reduced benefits that, when added to the benefits of the other plan(s), will not exceed 100% of the amount described herein. The purpose of this provision is to prevent duplicate payments under plans that would exceed 100% of the benefits described in this Program. In the coordination of benefits, one of the plans will be designated as the primary plan and the other plans will be designated as secondary. The primary plan will pay its full benefits first, then the secondary plan(s) will pay, but payments will be coordinated so that the total from all plans will not be more than the benefits described in this Program.

- For purposes of this section, "other benefit plans" shall mean any health or disability-type benefits provided under (1) any individual, group, blanket or franchise plan, (2) other prepaid coverage under service plan contracts, or under group or individual plans, policies or a practice, (3) uninsured arrangements of group or group-type coverage, (4) labor-management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans, (5) benefits coverage in a group, group-type and individual policy or policies of automobile coverage (including, but not limited to medical payment coverage, personal injury protection coverage, uninsured motorists coverage and underinsured motorists coverage, and (6) any other group-type contracts – that is, those contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

- Except as specified below, if a person is covered by more than one plan to which this coordination of benefits provision applies, then the following rules will determine which plan will be primary:

    - With respect to health benefits only, when only one of the plans has a coordination of benefits provision, then the plan without such a provision will be the primary plan;

    - The plan under which the person is covered other than as a dependent (for example, active associate, former associate, inactive associate, COBRA participant or retiree) will be the primary plan over a plan which covers the person as a dependent;

    - The plan under which the person is covered as an active associate will be the primary plan over a plan which covers the person as former associate, inactive associate, COBRA participant or retiree;

    - If none of these rules establish an order of benefit determination, then the plan that has covered the person for the longer period of time will be the primary plan.

- Any provision herein to the contrary notwithstanding, Medical Benefits payable under this Program to or with respect to any person who is in "current employment status" as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be primary and shall not be reduced by the amount of benefits payable to or with respect to such person under Medicare, which will be considered the secondary plan. However, Medical Benefits payable under this Program to or with respect to any person who is not in "current employment status," as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be secondary and reduced by the amount of all benefits payable to or with respect to such person under Medicare, which will be the primary plan. In addition, the fact that a person is eligible for or provided medical assistance under a state plan will not be taken into account in making payments under the Program.

- You must notify the Claims Administrator of such other benefit plans and cooperate with the Claims Administrator in (1) furnishing copies of other policies, coverages or plans which may be applicable to the Injury, and in (2) completing and returning to such Claims Administrator 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.

Subrogation and Reimbursement Rights

For purposes of "Subrogation and Reimbursement Rights", the "Notice of Legal Proceedings," and "Assignment of Rights" sections of this Program, the term "Payee" means you or your Beneficiary or your respective family members, heirs, estate, or other Representative (in their individual or representative capacity), singularly or collectively as the context may require to give the Program the broadest possible rights of recovery.

- **Right of Subrogation - -** If a Payee becomes entitled to or directly or indirectly receives Program benefits for any Injury caused by the negligence or other act or omission of any person or organization (including, but not limited to, the Company), the Payee shall automatically be required to (i) subrogate his, her or its right to said damages or other compensation to the extent of the Program benefits paid to, or with respect to, the Payee and (ii) allow the Program to institute a lawsuit in his, her or its name to recover said damages or other compensation to the extent of the Program benefits paid to, or with respect to, the Payee.

- **Written Confirmation -** Upon request of the Program, the Payee shall provide the Program written confirmation of this subrogation right, including execution of any assignment, lien form or other document requested by the Claims Administrator to enable the Program to recover such Program benefits and related expenses. Any failure of a Payee to give written confirmation of the Program's subrogation rights does not adversely affect its rights of subrogation because the Program's right of subrogation arises automatically once payment under this Program is made to or on behalf of the Payee.

- **Right to Reimbursement -** If (i) a Payee fails, refuses or neglects to reimburse the Program or otherwise comply with the provisions of this section, or (ii) payments are made under the Program based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the Program, then the Program shall still have all remedies and rights of recovery specified herein. The Program shall also have the right to terminate or suspend benefit payments and/or recover the reimbursement of all amounts above due to the Program by withholding, offsetting and recovering such amounts out of any future Program benefits or amounts otherwise due from the Program to or with respect to such Payee.

- **Right of Recovery From Third Parties-** If a Payee becomes entitled to or directly or indirectly receives Program benefits for any Injury caused by the negligence or other act or omission of any person or organization (including, but not limited to, the Company), and is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury (including, but not limited to, damages for negligence, survival, wrongful death or other legal or equitable action), whether by insurance, litigation, settlement or other proceeding, the Program shall have the first lien recovery against any benefits paid or to be paid by the Program. A Payee must reimburse the

Program out of said damages or other compensation for all benefits paid under the Program, medical management, investigation, attorneys' fees, costs of recovery, and other expenses related to the claim for benefits (including costs and fees associated with any proceeding required to obtain reimbursement). The Program shall also have the right to bring a lawsuit and assert a constructive trust or other interest against any and all persons that have assets to which the Program can claim rights. The Program has the right of first recovery from any judgment, settlement or other payment, regardless of whether the Payee has been "made whole." This right of recovery applies to the claims of a Payee which are derivative of or dependent upon an Injury for which benefits are paid under the Program.

- **Attorney's Fees and Expenses -** The Program's subrogation rights and right of recovery from third parties will not be reduced by attorneys' fees or expenses incurred by any party in pursuing recovery against a third party and the "common fund" doctrine shall not apply. Any attorneys' fees and/or expenses incurred by or at the request of the Payee or his, her or its attorneys in a third party or other action shall be the sole responsibility of such party.

Notice of Legal Proceedings

A Payee (whether or not such person has received or may in the future directly or indirectly receive Program benefits) shall provide the Claims Administrator with prior written notice of the involvement of such party in any lawsuit, settlement discussion or other proceeding (for negligence, wrongful death, survival or other cause of action), one of the principal purposes of which is recovering, from any person or organization, damages or other compensation in any way related to any Injury for which Program benefits have been or may in the future be paid. The Program shall have the right to intervene for itself and on behalf of a Payee in any such lawsuit, settlement discussion or other proceeding. If a Payee neglects, fails or refuses to seek a recovery from any person or organization for any Injury caused by the negligence or other act or omission of such person or organization, the Program shall have the right to institute a lawsuit or other proceeding or do any other act that in the opinion of the Claims Administrator may be necessary or desirable to recover the Program benefits paid (and to be paid in the future), plus all medical management, investigation, attorneys' fees, costs of recovery, and other expenses incurred by the Program.

Assignment of Rights

By participating in this Program, a participant obligates himself or herself, as well as all other Payees (in both their individual and representative capacities), to the provisions of this Program, including, without limitation, the "Subrogation and Reimbursement Rights, "Notice of Legal Proceedings," and "Assignment of Rights" sections hereof. Upon the request of the Claims Administrator, a Payee shall assign to the Program the right to intervene in or institute any lawsuit, settlement discussion, or other proceeding described in the "Subrogation and Reimbursement Rights, and "Notice of Legal Proceedings," sections, and to use the name of such party for such purpose. The Program shall have the right to select legal counsel of its own choice and such counsel shall have complete control over the conduct of any such lawsuit, settlement discussion, or other proceeding without the consent or participation of any such Payee. Whenever the Program shall intervene in or institute any lawsuit or other proceeding as permitted by the provisions of this section, the Program may pursue same to a final determination and the Program expressly reserves the right to appeal from any adverse judgment or decision. The Payee shall give the Program all reasonable aid in any such lawsuit, settlement discussion, or other proceeding in effecting settlement, in securing evidence, in obtaining witnesses, or as may otherwise be requested by the Claims Administrator. The Payee shall release the Program, the Company, the Plan Administrator, the Claims Administrator, the Appeals Committee, and their respective directors, officers, agents, consultants, attorneys, and associates from all claims, causes of action, damages and liabilities of whatever kind or character that may directly or indirectly arise out of the pursuit or handling by the Program of any such lawsuit, settlement discussion or other proceeding.

Right To Receive And Release Necessary Information

Subject to Appendix A herein, 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.

ARBITRATION OF CERTAIN INJURY-RELATED DISPUTES

The Company has adopted a **mandatory company policy** requiring that you comply with the following arbitration requirements.

This arbitration requirement does not apply to any legal or equitable claim under ERISA for benefits, fiduciary breach, or other problem or relief solely relating to benefits payable under this Program. If you wish to appeal a denial of benefits under the Program, you must follow the process described in the "Detailed Claims Procedures" section of this booklet. After exhausting the appeal process outlined in the "Detailed Claims Procedures" section, any action challenging a Program decision, or any other ERISA right of action, must be brought in the United States District Court for the Northern District of Texas, Dallas Division.

Arbitration Requirement

All claims or disputes described below that cannot otherwise be resolved between the Company and you are subject to **final and binding** arbitration. **This binding arbitration is the only method for resolving any such claim or dispute**.

Claims Covered By This Arbitration Requirement

This arbitration requirement applies to:

- any legal or equitable claim or dispute relating to enforcement or interpretation of the arbitration provisions in a Receipt, Safety Pledge and Arbitration Acknowledgement form or this arbitration requirement; and

- 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; and claims for assault, battery, negligent hiring/training/supervision/retention, emotional distress, retaliatory discharge, or violation of any other noncriminal 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 booklet).

This includes all claims listed above that you have now or in the future against the Company, its officers, directors, owners, associates, representatives, agents, subsidiaries, affiliates, successors, or assigns.

The determination of whether a claim is covered by these provisions will also be subject to arbitration under this arbitration requirement. **Neither you nor the Company will be entitled to a bench or jury trial on any claim covered by this arbitration requirement. This arbitration requirement applies to you without regard to whether you have completed and signed a Receipt, Safety Pledge and Arbitration Acknowledgement or similar written receipt**. These provisions also apply to any claims that may be brought by your spouse, children, parents, beneficiaries, Representatives, executors, administrators, guardians, heirs or assigns (including, but not limited to, any survival or wrongful-death claim). This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.

Required Notice of All Claims

When you seek arbitration, you must give written notice of any claim to the American Arbitration Association **and** the other party within the applicable statute of limitations. The day upon which the act complained of occurred will 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 written notice in triplicate to the American Arbitration Association, Attention: Regional Claims Administrator, at 13455 Noel Road, Two Galleria Tower, Suite 1750, Dallas, Texas, 75240-6620. You must also send written notice to the Company, in care of the TAAP Administrator, Kohl's Department Stores, Inc., N56 W17000 Ridgewood Drive, Menomonee Falls, Wisconsin 53051. If the Company wishes to invoke arbitration, it will give notice to you at the last address recorded in your personnel file. The party requesting arbitration must specifically identify and describe in the written notice all claims asserted and the facts on which the claims are based. This written notice shall be sent certified or registered mail, return receipt requested. The responding party shall have the ability to file special exceptions with the arbitrator on the basis that the written notice does not satisfy the requirements of this arbitration requirement.

If after expiration of the applicable statute of limitation (1) a court has ordered the parties to arbitrate, and (2) such court or arbitrator for whatever reason has determined that the claim is not barred by the applicable statute of limitations, then the party that is compelled to arbitrate must give notice of such claim to AAA and the other party within 10 days of such order or the party's claim shall be barred by limitations. Such notice must be given in the manner described above.

Arbitration Procedures

Except as otherwise provided below, any arbitration under this arbitration requirement will be administered in accordance with the rules of procedure published by the American Arbitration Association ("AAA") under its then-current Employment Arbitration Rules and Mediation Procedures.

- Unless otherwise agreed to in writing by the parties, the arbitrator selected by the parties in accordance with those rules (1) shall be an attorney licensed to practice in the State of Texas with experience in personal injury litigation, and (2) shall be selected from an AAA approved panel of arbitrators located in Dallas County, Texas, and 3) shall remain on AAA's approved panel throughout the proceedings. If the arbitrator so selected becomes unable to serve for any reason, the parties shall again go through the same selection process.

- The arbitrator will apply the substantive law of Texas (other than the Texas General Arbitration Act), or federal law, or both, depending upon the law applicable to the claims asserted. The arbitrator will provide brief findings of fact and conclusions of law. The arbitrator will have the authority to consider and grant motions consistent with the Texas Rules of Civil Procedure (or Federal Rules of Civil Procedure, if applicable), including, but not limited to, motions for summary judgment. The arbitrator is authorized only to rule on the claims set forth in the original written notice, 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 arbitration requirement or to make any award merely on the basis of what he or she determined to be just or fair. **The arbitrator shall also not commingle the standards for state law determinations and remedies (for example negligence claims and special damage awards) with the standards for federal law determinations and remedies that may or may not be subject to this arbitration requirement (for example, ERISA benefit eligibility and ERISA damage awards are not subject to arbitration).**

- The final decision and the arbitration award, if any, shall be made consistent with the remedies available under the state or federal statute, common law, code or regulation that is the subject of the claim. All decisions rendered by an arbitrator under this arbitration requirement will be kept confidential by all parties, and will not serve as binding, legal precedent with respect to subsequent claims or disputes brought under this arbitration requirement. **An arbitrator's decision can be**

challenged in a state or federal court of law only on such basis as are available under the Federal Arbitration Act.

Payment of Fees and Expenses

- You shall pay a nonrefundable arbitration filing fee equal to the standard employee filing fee specified under then-current AAA Employment Arbitration Rules and Mediation Procedures. Your filing fee 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 Company shall pay a nonrefundable arbitration filing fee equal to the standard employer filing fee specified under then-current AAA Employment Arbitration Rules and Mediation Procedures. The Company 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 the arbitrator finds completely in your favor on all claims, the Company will reimburse you for your share of the filing fee.

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

- Either party may arrange for and pay the cost of a court reporter to provide a stenographic record of the proceedings;

- Each party will 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 such fees, the arbitrator may award reasonable attorney's fees to the prevailing party;

- Notwithstanding the above provisions, the arbitrator will assess the AAA filing fee, arbitrator fees and expenses, and attorney's fees against a party upon a showing by the other party that the first party's claim is frivolous, or unreasonable, or factually or legally groundless; and

- If either party pursues a claim covered by this arbitration requirement by any means other than arbitration, the responding party will be entitled to dismissal of such action, and the recovery of all costs and attorney's fees and expenses related to such action.

Three Panel Arbitrations

Notwithstanding the foregoing, if the amount in controversy exceeds $250,000 the arbitration shall be held before a panel of three arbitrators. Any arbitration held before a panel of three arbitrators shall also be administered in accordance with the rules of procedure published by the AAA and in accordance with this arbitration policy, except as follows:

- Unless both parties agree otherwise, the determination regarding whether a claim is covered by this three-panel arbitration requirement shall be subject to arbitration in accordance with the provisions of this arbitration policy.

- One arbitrator shall be named by each party within ten days after notice of arbitration is served by either party upon the other, and a third arbitrator shall be selected by these two arbitrators within fifteen days after notice of arbitration. If the arbitrators are unable to agree on a third arbitrator, then the third arbitrator will be chosen by AAA in accordance with its then-current AAA Rules.

- Each party will pay for the arbitrator that they selected and both parties will share equally in the expenses of the third arbitrator.

Interstate Commerce

The Company is engaged in transactions involving interstate commerce (for example, purchasing goods and services from outside Texas which are shipped to Texas, and providing goods and services to customers from other states) and your employment involves such commerce. The Federal Arbitration Act will govern the interpretation, enforcement, and proceedings under this arbitration requirement. Unless contrary to applicable law, any lawsuits seeking to enforce or vacate an arbitration award shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

Binding Effect of Arbitration

This arbitration requirement for resolving claims by final and binding arbitration is equally binding upon, and applies to any such covered claims that may be brought by, the Company and all associates, including you and your spouse, children, parents, beneficiaries, Representatives, executors, administrators, guardians, heirs or assigns (including, but not limited to, any survival or wrongful-death claim). This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.

- **This arbitration requirement applies to all associates without regard to whether they have completed and signed a Receipt, Safety Pledge and Arbitration Acknowledgement form or similar written receipt.** Adequate consideration for this arbitration requirement is represented by, among other things, your eligibility for (and not necessarily any receipt of) benefits under this Program, becoming employed (or continuing employment) with the Company and the fact that it is mutually binding on both the Company and you. Any actual payment of benefits under this Program to or with respect to you will serve as further consideration for and represent your further agreement to the provisions of this arbitration requirement. This arbitration requirement will remain in effect with respect to the Company and you even if you refuse benefits under this Program, you return Program benefit payments to the Company, you become ineligible for benefits or benefits cease under this Program in accordance with its terms, or your employment with the Company is voluntarily or involuntarily terminated.

- **This arbitration provision is not subject to ERISA requirements or otherwise dependent upon the benefit provisions of this Program in any way, and is included in this booklet strictly as a matter of convenience in documentation.** This Program and arbitration requirement also in no way changes the "at will" employment status of any associate not covered by a collective bargaining agreement.

AMENDMENT OR TERMINATION OF PROGRAM

The Company presently intends to continue the Program indefinitely, but the Company reserves the right to amend, modify, or terminate the Program at any time; provided, however, that no such amendment or termination will alter the arbitration provisions incorporated into this booklet with respect to, or reduce the amount of any benefit payable to or with respect to you under the Program in connection with, an Injury occurring prior to the date of such amendment or termination. In addition, any such amendment or termination of the arbitration provisions incorporated into this booklet shall not be effective until at least 14 days after written notice has been provided to you. Any such amendment or termination will be adopted pursuant to formal written action of a representative authorized to act on behalf of the Company.

This summary plan description is intended to summarize the contents of the official plan document for the Program. The official plan document contains additional terms and conditions which are not contained in this summary plan description. The official plan document controls over the summary plan description with respect to such terms and conditions. If you would like to review the official plan document, you may ask your manager for a copy.

DEFINITIONS

This section defines specific terms used in this booklet. These definitions should not be interpreted to extend coverage unless specifically provided for in the other sections of this booklet and the plan document for the Program.

Adverse Benefit Determination

A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Program benefit. For example, this includes denial, reduction or termination of benefits based upon (1) your ineligibility to participate in the Program, (2) application of any utilization review, (3) a medical service being considered experimental, investigational or not medical necessary, or (4) you no longer being Disabled.

Appeals Committee

The individual or individuals appointed by the Company to make determinations on appeal of benefit claims and otherwise administer the Program on behalf of the Company.

Approved Facility

A hospital, other medical care facility or other 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 Program participant.

Approved Physician

A person duly licensed under applicable state law as a Medical Doctor or Doctor of Osteopathy and either expressly approved by the Claims Administrator, included in an approved list of physicians adopted by the Claims Administrator, or otherwise approved in writing by the Claims Administrator upon the request of a Program participant.

Beneficiary

The person or persons determined in the following priority:

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

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

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

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

- For purposes of this Section:

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

- "Eligible Child" means a surviving child of the deceased participant, whether by blood, marriage, or legal adoption, if the child is:

  - under 18 years of age;

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

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

Claims Administrator

The individual, individuals or entity appointed by the Company to make initial determinations of benefit claims under this Program on behalf of the Company.

Course and Scope of Employment

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 Company, and that is performed by you in the furtherance of the affairs or business of the Company. The term includes activities conducted on the premises of the Company or at other locations designated by the Company. This term does not include:

- transportation to and from your place of employment, unless:

  - the transportation is furnished as part of your employment arrangement or is paid for by the Company; provided, however, that this exception does not include commuting to or from your usual place of employment;

  - the means of the transportation are under the control of the Company; or

  - you are directed in your employment to proceed from one place to another place. Commuting to the place where you begin Company business and commuting away from the place where you cease Company business will not be covered if such transportation is not paid for by the Company or otherwise under Company control.

- travel by you in furtherance of the affairs or business of the Company 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 Company to be furthered by the travel.

- any injury occurring before you clock in or otherwise begin work for the Company, or after you clock out or otherwise cease work for the Company, unless the Injury occurs in parking lot, common area or other area owned by the Company (or for which the Company is responsible for maintenance).

- any injury occurring while you are on a work break, unless (1) the injury occurs while you are on a work break inside the Company's facility (for purposes other than eating or smoking), (2) such work break was authorized by your manager (or was otherwise permitted consistent with your job description), (3) you are scheduled to return to work that same day following such work break, and (4) you have not clocked out or otherwise ceased work for the Company.

Disabled or Disability

A Total Disability or a Partial Disability:

- A "Total Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury, and commencing within six months from the date of Injury, which -

  - causes you to be unable to perform the normal duties for which you were employed;
  - causes you to be under the regular care of an Approved Physician; and
  - causes you to be unable to engage in Modified Duty or any other occupation for wage or profit.

- A "Partial Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury that results in you being –

  - unable to fully perform the normal duties for which you were employed;
  - under the regular care of an Approved Physician;
  - released to Modified Duty by such Approved Physician; and
  - working for the Company in a Modified Duty position approved by the Company.

Emergency Care

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.

Maximum Benefit Limit

The maximum amount of all benefits payable to you under the Program with respect to an Injury. Payments made for each form of benefit will be counted towards the Maximum Benefit Limit amount. The Maximum Benefit Limit for this Program is $250,000; provided, however, that the aggregate amount of the Maximum Benefit Limits with respect to claims of all participants arising out of a single Accident, or related series of Accidents, or Occupational Disease exposure, will not exceed $750,000. This aggregate amount may proportionally reduce the Maximum Benefit Limit applicable to each participant involved in such Accident, related series of Accidents, or exposure, in such manner as the Claims Administrator or Appeals Committee may determine.

Maximum Rehabilitative Capacity

The earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Modified Duty

A temporary accommodation that allows you to perform your regular job, or an alternate, temporary job that complies with your work restrictions and the Company's needs.

Plan Administrator

The Company is the plan administrator of the Program for purposes of ERISA. The Program is administered on behalf of the Company by the Claims Administrator and Appeals Committee.

Subject to the Program claim procedures, both the Claims Administrator and the Appeals Committee have discretionary authority to interpret and implement the provisions of the Program. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Program to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter. Every interpretation, choice, determination, or other exercise of authority by the Claims Administrator or Appeals Committee will be binding upon all affected parties, without restriction, however, on the right of the Claims Administrator or Appeals Committee to reconsider and redetermine such action. There shall be no de novo review by any arbitrator or court of any decision rendered by the Appeals Committee and any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion. The Claims Administrator or Appeals Committee may adopt any rules and procedures it considers necessary or appropriate for the administration of the Program. The Claims Administrator or Appeals Committee may deny a claim for or suspend the payment of Program benefits otherwise payable to you if you do not comply with any provision of the Program or the rules and procedures adopted by the Claims Administrator or Appeals Committee. **Notwithstanding the foregoing, the Appeals Committee shall have final authority regarding any decision made with respect to the administration of the Program.**

Post-Service Claim

Any claim for a Medical Benefit that is not a Pre-Service Claim.

Preexisting Condition

Any associate illness, injury, disease, impairment or other physical or mental condition, whether or not work-related, which originated or existed prior to the date of the Injury.

Pre-Injury Pay

- For a salaried participant, regular bi-monthly salary from the Company at the time of the Injury; and

- For an hourly participant, the average earnings from the Company for the 14 consecutive weeks immediately preceding the date of Injury; provided, however, that if such a participant has been employed for less than 14 consecutive weeks, or if his or her earnings as of such date cannot be reasonably determined (in the judgment of the Claims Administrator), such 14-week average will be based upon the earnings received over such period by a similar associate of the Company.

"Pre-Injury Pay" **will include** pay for overtime and participant contributions (through salary reduction or otherwise) to a 401(k) arrangement, cafeteria plan, or other pre-tax salary deferral employee benefit plan. "Pre-Injury Pay" **will not include** any bonuses, benefits (including, but not limited to, Company contributions to any employee benefit plans or matching contributions to a retirement plan) or other extraordinary remuneration.

Pre-Service Claim

Any claim for Medical Benefits with respect to which this Program requires Claims Administrator approval in advance of obtaining medical care.

Program

Kohl's Texas Associate Accident Program

Representative

A person that a participant authorizes in writing to act on his/her behalf. The Program will also recognize a legally valid power of attorney or a court or administrative agency order giving a person authority to take an

act on a participant's behalf. In the case of an Urgent Care Claim, a physician with knowledge of the participant's condition may act as the participant's Representative.

Receipt, Safety Pledge and Arbitration Acknowledgement

The form attached to the back of this SPD booklet.

Urgent Care Claim

Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent Pre-Service Claim determinations (generally, 15 days after the Claims Administrator's receipt of the claim):

- could seriously jeopardize your life or health or your ability to regain maximum function; or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim as described above shall be made by the Claims Administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the claimant's medical condition determines that a claim is an Urgent Care Claim and clearly communicates such determination to the Claims Administrator, the Program shall treat the claim as an Urgent Care Claim.

The characterization of a claim as an Urgent Care Claim solely impacts the timeframes and other procedures for processing benefit claims and in no way changes this Program's approved medical provider requirements, pre-authorization requirements, or other medical management requirements. These requirements generally provide that (1) except in the case of Emergency Care, no amount shall be considered a Covered Charge under the Program unless treatment is pre-approved by the Claims Administrator and furnished by or under the direction of an Approved Physician or Approved Facility, and (2) all determinations relating to your physical condition (upon which the payment of benefits is based) must be made by an Approved Physician. Urgent Care Claims may not arise to the level of involving Emergency Care. Your decision to seek treatment from an urgent care clinic or hospital emergency room does not necessarily result in an Urgent Care Claim or involve Emergency Care. See the MEDICAL BENEFITS and DETAILED CLAIM PROCEDURES sections of this booklet for more information.

GENERAL INFORMATION

Type Of Plan and Administration

The Program is a welfare benefit plan providing wage replacement, death, dismemberment and medical benefits (including certain dental and vision benefits) due to an Injury. The Program is administered by the Claims Administrator and Appeals Committee to the extent such duties have been delegated to the Claims Administrator and Appeals Committee by the Plan Administrator.

Name And Address Of Plan Sponsor

Kohl's Department Stores, Inc.
N56 W17000 Ridgewood Drive
Menomonee Falls, Wisconsin 53051

Name and Address Of Plan Administrator

Any questions you may have about the Program may be posed to the Plan Administrator by mail, c/o the Company's TAAP Administrator, Kohl's Department Stores, Inc., N56 W17000 Ridgewood Drive, Menomonee Falls, Wisconsin 53051, or by telephone at (262) 703-3790.

Name And Address Of Person Designated As Agent For Service Of Legal Process

CT Corporation
350 N. St. Paul St.
Dallas, Texas 75201

Service of legal process may also be made upon the Plan Administrator.

Employer And Plan Identification Numbers

The employer identification number assigned by the Internal Revenue Service to Kohl's Department Stores, Inc. is 13-3357362. The plan number of the Program is 512.

Plan Year

The Program operates and keeps its records on the basis of the 12-month period ending each January 30.

ERISA RIGHTS STATEMENT

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

Receive Information About Your Program and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites) all documents governing the Program, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) filed by the Program 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 Program, 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 Program Fiduciaries

In addition to creating rights for Program participants, ERISA imposes duties upon the people who are responsible for the operation of the Program. The people who operate your Program, called "fiduciaries" of the Program, have a duty to do so prudently and in the interest of you and other Program participants and beneficiaries. No one, including the Company, 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 for the Program or the latest annual report from the Program and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court 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 of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Program fiduciaries misuse the Program'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 file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have brought a claim against to pay these costs and fees. If you lose, the court 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 Program, 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.

January 31, 2010

APPENDIX A

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: JANUARY 31, 2010

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. THIS EMPLOYEE INJURY BENEFIT PROGRAM SHALL COMPLY WITH THE "STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION" (THE "HIPAA PRIVACY RULES"), AS OF THE ABOVE DATE WITH RESPECT TO MEDICAL BENEFITS UNDER THIS PROGRAM.

The Program 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 Program.

"Protected Health Information" or "PHI" includes any individually identifiable health information that is transmitted or maintained by the Program, but **does not include** (1) individually identifiable health information contained in education records and employment records held by a 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 Program's uses and disclosures of your PHI, (2) the Program'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 Program.**

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Program 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 Program 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 Program is required to provide you with an accounting of certain disclosures of your PHI that the Program has made.

Treatment, Payment or Health Care Operations

- **General Rule** - The Program may use or disclose your PHI in the following situations that relate to treatment, payment or health care operations:
  - **Treatment - The Program 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 Program may use your PHI and disclose your PHI to another health plan or health care provider in order to pay claims under the Program.** For example, the Program may tell a doctor whether you are eligible for coverage and whether the bill can be paid by the Program. "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.
  - **Program's Health Care Operations - The Program may use your PHI for the Program's health Care operations.** For example, the Program 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 Program 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 Program 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 Program 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 Program 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 Program.)

Uses and Disclosures to Plan Sponsor

The Program may disclose PHI to your Company in its capacity as the plan sponsor for the Program 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 Program only to the extent that the use and disclosure is permitted or required under the HIPAA Privacy Rules.

- The Company shall not use or further disclose PHI other than as permitted or required by the plan documents for the Program or as required by law;
- The Company shall require any agents, including a subcontractor, to whom it provides PHI from the Program 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 Program for employment-related actions and decisions or in connection with any other benefit of the Company;
- The Company shall report to the Program any use or disclosure of PHI provided by the Program 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 HIPAA 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 Program, to extent that these disclosures must be accounted for under the HIPAA Privacy Rules;
- The Company shall make its internal practices, books, and records relating to the use and disclosure of PHI from the Program available to the Department of Health and Human Services to determine Program compliance with the HIPAA Privacy Rules;
- If feasible, the Company shall return or destroy all PHI received from the

Program 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 Program.

➢ **Separation Between Company and the Program** - The Program's designated Claims Administrator, the Program's designated Appeals Committee and their respective representatives whom they have designated to perform Program functions shall be the only associate or other persons under the direct control of the Company that shall be given access to PHI for use and disclosure. Except as specified below, 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 Program. In the event that any of these persons fails to comply with the requirements of the HIPAA Privacy Rules, you may submit a complaint in writing to the Contact Person listed at the end of this Notice.

➢ **Exceptions** - The Program 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 Program, or (2) modifying, amending or terminating the Program; or
- information on whether an individual is participating in the Program.

<u>Uses and Disclosures Requiring An Opportunity for You to Agree or Object</u>

➢ **Permitted Uses and Disclosures -** The Program 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 HIPAA 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 Program 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 Program 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 Program 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 Program, 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 Program must disclose your PHI when requested by the U.S. Department of Health and Human Services in order to investigate or determine whether the Program is in compliance with HIPAA 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 Program reasonably 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 HIPAA 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 HIPAA 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.

PROGRAM RIGHTS AND RESPONSIBILITIES

Authorization

Except as otherwise indicated in this Notice, the Program 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 on the authorization or 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 Program's ability to investigate and evaluate your claim for benefits.

Notice

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

Minimum Necessary

When using or disclosing PHI or when requesting PHI, the Program 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 HIPAA Privacy Rules.

Agreed Restrictions

If you and the Program agree to a restriction of your PHI, the Program 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 Program may not agree to restrictions with respect to:

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

De-Identified Information

The Program 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 Program will use the de-identified information. The HIPAA Privacy Rules do not apply to de-identified information that meets the standard and implementation specifications of the HIPAA Privacy Rules, unless:

- the Program 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 Program (such as claims administration services, billing, legal, actuarial, accounting, consulting, data aggregation, etc.) and the services involve the use or disclosure of PHI. The Program may disclose PHI to a Business Associate and may allow a Business Associate to create or receive PHI on its behalf, if the Program obtains satisfactory assurance that the Business Associate will appropriately safeguard the PHI. The Program 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 HIPAA Privacy Rules that apply to Business Associate communications. However, this requirement shall not apply:

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

Security of Electronic PHI

The Program shall comply with the "Standards for the Protection of Electronic Protected Health Information" ("HIPAA Security Rules"), as specified under 45 CFR Part 164, Subpart C:

- **General Rule -** The Company shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that is created, received, maintained, or transmitted by the Company on behalf of the Program.
- **Adequate Separation –** The Company shall ensure that adequate separation exists between the Company and the Program through the implementation of reasonable and appropriate security measures.
- **Third Parties –** The Company shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to

implement reasonable and appropriate security measures to protect the electronic PHI.

- **Security Incidents –** The Company shall report to the Program any security incident of which it becomes aware.
- **Exceptions –** The Program may disclose to the Company as plan sponsor without complying with the requirements of this section is 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 Program, or (2) modifying, amending or terminating the Program; or
  - Information on whether an individual is participating in the Program.

Personal Representatives

For purposes of using and disclosing PHI, the Program must treat your personal representative as if it were you, in accordance with the HIPAA 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 Program retains discretion to deny access to your PHI to a personal representative.

Other Uses and Disclosures

A workforce member of the Program 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 Program is not required to agree to a restriction.
- **Alternate Communications** - You have the right to request that the Program 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 Program 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 HIPAA Privacy Rules. If you request copies, the Program 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 Program, 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 Program 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 Program 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 Program;
  - 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 Program 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 Program or the Secretary of Health of 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 personal 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 Program 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 or by law.

CONTACT PERSON

For further information regarding privacy rights or this Notice, please call (262) 703-2377 or write the Privacy Officer c/o the Senior Benefits Manager, N56 W17000 Ridgewood Drive, Menomonee Falls, Wisconsin 53051.

Este folleto y forma contiene información importante sobre sus derechos. Si tiene dificultad entendiendo esté folleto ó forma, por favor comuníquese con el TAAP Administrator a (262) 703-3790.

APPENDIX B

RECEIPT, SAFETY PLEDGE AND ARBITRATION ACKNOWLEDGEMENT

RECEIPT OF MATERIALS. By my signature below, I acknowledge that I have received and read (or had the opportunity to read) the Summary Plan Description (the "SPD") for the Kohl's Texas Associate Accident Program, effective January 31, 2010.

INJURY NOTICE AND MEDICAL PROVIDERS. I understand and agree that if I am injured on the job, I must notify my manager by the end of the next business day following the date of the Injury and receive any medical care from a Program-approved physician within 14 days of my injury in order to receive benefits under the Program.

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

ARBITRATION. I also acknowledge that this SPD includes a mandatory company policy requiring that **claims or disputes relating to the cause of an on-the-job injury (that cannot otherwise be resolved between the Company and me) must be submitted to an arbitrator,** rather than a judge and jury in court. I understand that by receiving this SPD and becoming employed (or continuing my employment) with the Company at any time on or after January 31, 2010, I am accepting and agreeing to comply with these arbitration requirements. I understand that the Company is also accepting and agreeing to comply with these arbitration requirements. All covered claims brought by my spouse, children, parents, beneficiaries, Representatives, executors, administrators, guardians, heirs or assigns are also subject to the Company's arbitration policy, and any decision of an arbitrator will be final and binding on such persons and the Company.

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

Este folleto y forma contiene información importante sobre sus derechos. Si tiene dificultad entendiendo esté folleto ó forma, por favor comuníquese con el TAAP Administrator a (262) 703-3790.

Sign and Turn In

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X _____ For the Company	_____ Date