Execution Version

TEAM, INC. WELFARE BENEFIT PLAN

(Amended and Restated Effective as of January 1, 2020)

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TEAM, INC. WELFARE BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2020)

Team, Inc. (the "**Plan Sponsor**") maintains the Team, Inc. Welfare Benefit Plan (the "**Plan**") for the benefit of the eligible Employees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers. The Plan Sponsor hereby amends and restates the Plan effective as of January 1, 2020.

The Plan is an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"). The Plan provides health and welfare benefits to Participants, in accordance with the terms, conditions and limitations of the Plan. Terms of the Plan pertaining to eligibility, coverage, exclusions and limitations on coverage, and other rules pertaining to the benefits available under the Plan, are set forth in the Wrap-SPD (as defined herein) and the Welfare Program Documents (as defined herein) which are incorporated into the Wrap-SPD in their entirety by reference and, together with the Wrap-SPD, constitute the "**Summary Plan Description**" of the Plan. The Summary Plan Description and the Policies set forth in the Policy Appendix to this Wrap-Plan (as defined herein) are incorporated into this Wrap-Plan in their entirety by reference and, together with this Wrap-Plan, shall together form the complete Plan. In particular, and without limitation, the Summary Plan Description contains the claims review and appeal procedures under the Plan, and those procedures are incorporated in their entirety by reference into the Plan.

The capitalized terms used in this Wrap-Plan shall have the meanings set forth herein; provided, however, the definitions of certain capitalized terms contained in this introduction are provided solely for convenience or reference within this introduction.

ARTICLE I
DEFINITIONS AND INTERPRETATIONS

1.1 **Definitions**. As used in this Wrap-Plan, any capitalized terms not defined herein shall have the meaning ascribed to them in the Wrap-SPD, and the following words and phrases shall have the meanings ascribed to them as follows, unless the context clearly requires a different meaning:

(a) **Affiliate**. A corporation or other entity which is controlled by the Plan Sponsor, or under common control with the Plan Sponsor, as determined by the Plan Sponsor after taking into consideration the common control rules under Section 3(40)(B) of ERISA (*i.e.*, for multiple employer welfare associations).

(b) **Affordable Care Act**. The federal Patient Protection and Affordable Care Act of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010 and subsequent amendments, and the authoritative guidance issued thereunder by the appropriate governmental entities.

(c) **Beneficiary.** A Beneficiary under the Plan as defined under the terms of the respective Welfare Program.

(d) **Board**. The Board of Directors of the Plan Sponsor.

(e) **CEO**. The then current Chief Executive Officer of the Plan Sponsor.

(f) **Claims Administrator**. The insurance company, third party administrator or other entity, as set forth in Appendix D to the Wrap-SPD, as designated by the Plan Administrator to determine eligibility for benefits, process claims and/or perform other administrative duties under the Plan or a Welfare Program.

(g) **Claims Fiduciary**. The person or entity that serves as the named claims fiduciary with respect to reviewing and making final decisions regarding claims under a Welfare Program. The "Claims Fiduciary" shall be the Plan Administrator unless otherwise set forth in Appendix D to the Wrap-SPD.

(h) **Code**. The Internal Revenue Code of 1986, as amended, and the implementing regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of the Code shall also refer to any successor provision thereof.

(i) **Dependent**. An Employee's (a) Spouse, (b) Child under age 26, and (c) unmarried Child age 26 or over who is dependent on the Employee because of a mental or physical handicap rendering the Child medically incapacitated and unable to be self-supportive. For purposes of determining eligibility for Dependent coverage, the term "Child" means a (i) biological child of an Employee, (ii) legally adopted child or a child placed for adoption with the Employee or Spouse, (iii) stepchild of

an Employee, or (iv) child for whom the Employee or Spouse has a court appointed legal guardianship but only if the Employee provides over half (50%) of the child's support and such child lives with the Employee and is a member of the Employee's household.

Notwithstanding the foregoing, if the applicable Welfare Program Document for a Fully-Insured Program provides a definition of "Dependent" that is more restrictive than this definition, the definition in such Welfare Program Document will control for purposes of that Fully-Insured Program.

(j) **Disclosure Administrator**. The individual or entity, as designated in Article XIV of the Wrap-SPD, to whom the Plan Administrator has delegated the authority, duty and discretion to furnish, on its behalf, the disclosures that are required by Section 104(b)(4) of ERISA and which are requested in accordance with Section 2.3 of this Wrap-Plan.

(k) **Effective Date**. The effective date of this amendment and restatement of the Plan, *i.e.*, January 1, 2020.

(l) **Employee**. Unless otherwise expressly stated in a Welfare Program Document for a particular Welfare Program, the term "Employee" means any individual who is considered to be in an employer-employee relationship with the Employer on the payroll records of the Employer for purposes of federal income tax withholding. Except as may otherwise be expressly stated in a Welfare Program Document for a particular Welfare Program, the term "Employee" shall not include any person during any period that such person was classified on the Employer's records as other than an Employee. For example, the term "Employee" shall not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee or similar classification, regardless of any determination by a governmental agency or court that any such person is or was a common law employee of an Employer, even if such determination has a retroactive effect. For purposes of this definition, (a) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Code Section 414(n)(2), whose services are supplied by an employment, leasing, or temporary service agency and who is paid by or through an agency or third-party; and (b) an "independent contractor" means any person rendering service to the Employer and whom the Employer treats as an independent contractor by reporting payments for the person's services on Internal Revenue Service Form 1099 (or its successor), regardless of whether any agency (governmental or otherwise) or court concludes that the person is, or was, a common law employee of the Employer even if such determination has a retroactive effect.

Furthermore, employees who (i) are non-resident aliens and (ii) receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) shall not be considered Employees who are eligible to participate in the Plan.

(m) **Employer**. The Plan Sponsor or any of its Affiliates that have adopted the Plan with the consent of the Plan Sponsor. The adopting Employers of the Plan shall be listed in Appendix A to the Wrap-SPD, as such Appendix may be revised from time to time by the Plan Sponsor without the need for a formal amendment to the Plan.

(n) **ERISA**. The Employee Retirement Income Security Act of 1974, as amended.

(o) **Fiduciary**. The Plan Administrator, the Claims Fiduciary and any other person or entity who exercises fiduciary authority under the Plan as prescribed in Section 3(21) of ERISA, but only with respect to their specific fiduciary responsibilities. Any person or entity may serve in more than one fiduciary capacity with respect to the Plan.

(p) **Fully-Insured Program**. The following Welfare Programs that are fully-insured: Team, Inc. Vision Program; Team, Inc. Long Term Disability Insurance Program; Team, Inc. Life and AD&D Insurance Program; Team, Inc. Critical Illness Insurance Program; Team, Inc. Group Legal Services Program; Team, Inc. Employee Assistance Program; Team, Inc. Blanket Accident Insurance Program; Team, Inc. Hawaii Employee Benefits Program; and Team, Inc. Puerto Rico Employee Benefits Program.

(q) **Participant**. An Employee of the Employer who meets the requirements for eligibility as set forth in the Wrap-SPD and who properly enrolls for coverage under the Plan. The term "Participant" also includes any Dependent of a person specified in the previous sentence who is properly enrolled for coverage under the Plan. A person shall cease to be a Participant when he no longer meets the requirements for eligibility as set forth in applicable provisions of the Plan.

(r) **Participant Contribution**. The pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" includes contributions used to purchase coverage under insurance contracts or policies, as well as contributions used for the provision of benefits under a self-funded arrangement, if any, of the Plan Sponsor or an Employer.

(s) **Plan**. The Team, Inc. Welfare Benefit Plan (which consists of (i) this Wrap-Plan, (ii) the Policies set forth in the Policy Appendix and incorporated herein by reference, (iii) the Wrap-SPD as incorporated herein by reference, and (iv) each Welfare Program Document as incorporated hereunder by reference), as amended from time to time. The Wrap-Plan, Policies, Wrap-SPD and Welfare Program Documents each contain the terms of the Plan and together constitute the complete Plan.

(t) **Plan Administrator**. The person or entity which has the authority and responsibility to manage and direct the operation of the Plan in its discretion. However, the Plan Administrator may assign or delegate duties to third parties, such

as the Claims Administrator or the Claims Fiduciary, under the terms of either the Plan or any Welfare Program, or by means of a separate written agreement. The Plan Administrator is the "plan administrator" for purposes of Section 3(16)(A) of ERISA. The "Plan Administrator" shall be the Plan Sponsor. References herein to the "Plan Administrator" shall include, when appropriate, any Employee, Claims Administrator, or other person or entity who has been delegated the appropriate authority by the Plan Administrator in accordance with Section 2.10.

(u) **Plan Sponsor**. Team, Inc., or its successor in interest.

(v) **Plan Year**. Each twelve (12) month calendar year commencing January 1st and ending on December 31st.

(w) **Policy**. A group insurance policy issued by an insurance carrier to the Plan Sponsor (or other Employer), pursuant to which certain benefits under the Plan are provided to Participants, including any amendments, endorsements or riders thereto and which is incorporated, in its entirety, into the Plan document by reference.

(x) **Spouse**. A person to whom an Employee is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable Federal law (including, but not limited to, the Code and ERISA), and any regulations promulgated under such applicable Federal law, but will not include an individual separated from the Employee under a legal separation or divorce decree. The term "Spouse" shall also include a common law spouse if the Employee and spouse became common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. The Employee must provide proof of a ceremonial or common law marriage acceptable to the Plan Administrator if requested, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state.

(y) **Summary Plan Description**. The Summary Plan Description of the Plan, which consists of (i) the Wrap-SPD, including any appendices attached thereto, and (ii) each Welfare Program Document incorporated thereunder by reference, as all such documents may be amended from time to time (including, without limitation, by distribution of a summary of material modification), and all of which are incorporated into this Wrap-Plan by reference and contain certain terms of the Plan.

(z) **Welfare Program**. A program of benefits that is offered by the Plan Sponsor (and/or another Employer) under the Plan to provide certain employee welfare benefits coverage to eligible Employees and their eligible Dependents, which would be an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately. The Welfare Programs are incorporated into the Wrap-SPD, which is, in turn, incorporated into the Wrap-Plan. Each Welfare Program under

the Plan is identified in Appendix B of the Wrap-SPD. The Plan Sponsor may add or delete a Welfare Program from the Plan by amending Appendix B of the Wrap-SPD.

(aa) **Welfare Program Document**. A written arrangement, including (i) any insurance contract between an Employer and an insurance company or other similar organization to provide certain employee welfare benefits to Participants, including any amendments, endorsements or riders thereto, (ii) a benefits booklet, schedule of specifications or summary plan description, including any amendments or attachments thereto, or (iii) a certificate of coverage, schedule of benefits, notice or other instrument under which a Welfare Program is established, operated or maintained. Each of the documents referenced in items (i), (ii) and (iii) (above) is attached to the Wrap-SPD as part of Appendix C thereto, and incorporated, in its entirety, therein by reference. A Welfare Program Document (or any portion thereof) shall not, in and of itself, constitute either the written "Plan document" or the "summary plan description" of the Plan, as required by ERISA, notwithstanding any references in any Welfare Program Document to the contrary; however, such Welfare Program Document does contain the terms of the Plan. Any reference to a Welfare Program Document also refers to any amendment, endorsement, rider, exhibit or attachment thereto.

(bb) **Wrap-Plan**. This wrap-around Plan document (including any appendices attached hereto), as may be amended from time to time, into which the Policies, the Wrap-SPD and the Welfare Program Documents are incorporated by reference to form the Plan.

(cc) **Wrap-SPD**. The document entitled "Summary Plan Description of the Team, Inc. Welfare Benefit Plan", which is the wrap-around summary plan description document (including the appendices attached thereto), as may be amended from time to time, into which the Welfare Program Documents are incorporated by reference to form the Summary Plan Description.

1.2 **Interpretation**. Notwithstanding any reference in a Welfare Program Document that such Welfare Program Document, in and of itself (or any portion thereof), constitutes a written "Plan document" as required by ERISA, the Plan shall consist of this Wrap-Plan, the Policies as set forth in the Policy Appendix hereto, the Wrap-SPD, including all appendices thereto, and the Welfare Program Documents for the Welfare Programs as identified in Appendix B of the Wrap-SPD. If a term or provision of this Wrap-Plan or the Wrap-SPD directly conflicts with a term or provision of a Welfare Program Document or Policy, the term or provision of the relevant Welfare Program Document or Policy, as applicable, shall control unless specifically stated otherwise herein or in the Wrap-SPD. Further, if a term or provision of this Wrap-Plan document directly conflicts with any term or provision of the Wrap-SPD, then the term or provision of the Wrap-SPD shall control.

Notwithstanding the foregoing, if there is a conflict between a term or provision of this Wrap-Plan, a Welfare Program Document, a Policy or the Wrap-SPD, and such conflict involves a term or provision required by ERISA, the Code or other controlling law, on the

one hand, and a term or provision not so required on the other, the term or provision required by controlling law shall control. This determination shall be made by the Plan Administrator. The terms and provisions of this Wrap-Plan shall not enlarge the rights of a Participant or Beneficiary to any benefits available under a Welfare Program.

The terms and provisions of the Plan include the terms and provisions of this Wrap-Plan, the Policies listed in the Policy Appendix to this Wrap-Plan, the Wrap-SPD, and the Welfare Program Documents.

ARTICLE II
ADMINISTRATION OF THE PLAN

2.1 Controlling Provisions. The provisions of this Article II shall supersede any provisions of a Welfare Program Document for a Welfare Program that is not a Fully-Insured Program regarding the subject matter hereof and shall govern and control.

With respect to a Fully-Insured Program, to the extent a provision of this Article II conflicts with, or is inconsistent with, a provision of the Welfare Program Document regarding the same subject matter, the provision of the Welfare Program Document will control, unless such conflict involves a term or provision required by ERISA, the Code or other controlling law, in which case the term or provision required by controlling law will control. This determination will be made by the Plan Administrator.

2.2 Reporting Responsibilities. The Plan Administrator shall be responsible for filing all reports, returns and notices required by ERISA or the Code.

2.3 Disclosure Responsibility.

(a) *General.* The Disclosure Administrator shall, in response to a written request by a Participant or Beneficiary, furnish a copy of the documents and instruments specified in Section 104(b)(4) of ERISA ("**Plan Disclosures**") as required by ERISA. A Participant's or Beneficiary's request for Plan Disclosures must be submitted to the Disclosure Administrator in writing, at the address listed in Article XIV of the Wrap-SPD, and must identify the particular Plan Disclosures that are being requested. The Disclosure Administrator may, in its discretion, impose a reasonable charge to cover the cost of copying and furnishing the requested Plan Disclosures to the extent permitted by ERISA.

(b) *Requests by an Authorized Representative.* A request for Plan Disclosures may be submitted to the Disclosure Administrator by an authorized representative of the Participant or Beneficiary, provided that (i) the authorization of such representative is designated in writing by the Participant or Beneficiary in a manner that is sufficiently clear and conspicuous, as determined by the Disclosure Administrator in its discretion, to enable the Disclosure Administrator to reasonably verify the status of the authorized representative and the scope of such authorization, and (ii) a copy of the signed authorization is submitted to the Disclosure Administrator with the request for Plan Disclosures. The Disclosure Administrator will not make any

Plan Disclosures to a person or entity claiming to be an authorized representative prior to receipt of an authorization that meets the criteria in clauses (i) and (ii), as determined by the Disclosure Administrator. The Disclosure Administrator may disregard any designation of an authorized representative that it deems to be defective or otherwise improper or invalid hereunder. In particular, and without limitation, the Disclosure Administrator reserves the right and discretion to refuse to honor a Participant's or Beneficiary's designation of an authorized representative if the Disclosure Administrator determines that such designation is fraudulent; such as, for example, when the Disclosure Administrator determines that the signature of approval on the designation does not belong to Participant or Beneficiary.

(c) *Examination of Records*. Participants and Beneficiaries shall have the right to examine such records, documents and other data as required by ERISA at reasonable times during regular business hours. Nothing contained in the Plan shall give any Participant the right to examine any data or records with respect to any other Participant except as required by applicable law which cannot be waived.

2.4 **Fiduciaries**. The Plan Administrator and the Claims Fiduciary are named Fiduciaries. Any person or group of persons may serve in more than one Fiduciary capacity with respect to the Plan. The Plan Administrator may designate persons or agents (including third party administrators) to carry out Fiduciary responsibilities under the Plan.

2.5 **Complete and Separate Allocation of Fiduciary Responsibilities**. It is intended that this Article II shall allocate to each named Fiduciary the individual responsibility for the prudent execution of the actions assigned to each named Fiduciary. The performance of such responsibilities shall be deemed a several assignment and not a joint assignment. None of such responsibilities, nor any other responsibility, is intended to be shared by two or more of such fiduciaries unless such sharing is provided by a specific provision of this Wrap-Plan, the Wrap-SPD or any Welfare Program Document. Whenever one named Fiduciary is required by the Plan to follow the directions of another, the two shall not be deemed to have been assigned a shared responsibility, but the responsibility of the one giving the direction shall be deemed the named Fiduciary with regard to said responsibility to be its sole responsibility, and the responsibility of the one receiving such direction shall be to follow it insofar as such direction is on its face proper under the Plan and applicable law.

2.6 **Disclaimer of Liability**. Except as otherwise required by Sections 404 through 409 of ERISA, neither any Employer nor the Plan Administrator shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of the Plan.

2.7 **Indemnification**. To the full extent permitted by law, the Plan Sponsor and each other Employer (collectively, in this Section 2.7, the "**Employer**") jointly and severally shall indemnify each past, present and future Employee who acts in the capacity of an agent, delegate or representative of the Plan Administrator (including any benefits committee) or the Plan Sponsor, under the Plan (collectively, each such Employee shall be referred to in this Section 2.7 as a "**Plan Administration Employee**") against, and each Plan Administration Employee shall be entitled without further act on his part to indemnity from

the Employer for, any and all losses, liabilities, costs and expenses (including the amount of judgments, court costs, attorneys' fees and the amount of approved settlements made with a view to the curtailment of costs of litigation, other than amounts paid to an Employer) incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened or anticipated possible action, suit, or other proceeding, including any investigation that might lead to such a proceeding, in which he is or may be involved by reason of, or in connection with, his being or having been a Plan Administration Employee. **This indemnity obligation is intended to indemnify the Plan Administration Employee against the consequences of his active, passive, concurrent or partial negligence; provided, however, such indemnity shall not include any and all losses, liabilities, costs and expenses incurred by any such Plan Administration Employee (a) with respect to any matters as to which he is finally adjudged in any such action, suit or proceeding to have been guilty of gross negligence or willful misconduct in the performance of his duties as a Plan Administration Employee, or (b) with respect to any matter to the extent that a settlement thereof is effected in an amount in excess of the amount approved by the Plan Sponsor (which approval shall not be unreasonably withheld).**

No right of indemnification hereunder shall be available to, or enforceable by, any such Plan Administration Employee unless, within twenty (20) days after his actual receipt of service of process in any such action, suit or other proceeding (or such longer period as may be accepted by the Plan Sponsor), he shall have offered the Plan Sponsor, in writing, the opportunity to handle and defend same at its sole expense, and the decision by the Plan Sponsor to handle the proceeding shall conclusively determine that the Plan Administration Employee is entitled to the indemnity provided herein unless he then expressly agrees otherwise.

Until and unless a final judicial determination has been made that indemnity is not applicable, all the costs and expenses of the Plan Administration Employee shall be promptly and fully paid or reimbursed by the Employer upon demand.

The foregoing right of indemnification shall inure to the benefit of the heirs, executors, administrators and personal representatives of each Plan Administration Employee, and shall be in addition to all other rights to which he may be entitled as a matter of law, contract, or otherwise.

2.8 Allocation of Authority. The Plan Administrator shall control and manage the operation and administration of the Plan, except to the extent such duties have been delegated to other persons or entities as provided in this Wrap-Plan, the Wrap-SPD or a Welfare Program Document. Any decisions made by the Plan Administrator or Claims Fiduciary (or any other person or entity delegated authority by the Plan Administrator or Claims Fiduciary, as applicable, to determine benefits in accordance with the Plan) shall be final and conclusive on all Participants, Beneficiaries and all other persons and entities, subject only to the claims appeal provisions of the Plan. Neither the Plan Administrator nor any Employee shall receive any compensation from the Plan with respect to services provided under the Plan, except as an Employee may be entitled to benefits hereunder.

2.9 Powers and Duties of Plan Administrator. The Plan Administrator (and the Claims Fiduciary, but only with respect to reviewing and making decisions regarding claims under a Welfare Program) will each have such duties and powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to have final discretionary authority to (i) administer, enforce, construe, and construct the Plan, including the Welfare Program Documents, (ii) make decisions relating to all questions of eligibility to participate, and (iii) make a determination of benefits including, without limitation, reconciling any inconsistency, correcting any defect supplying any omission, and making all findings of fact;

(b) to prescribe procedures to be followed by Participants filing application for benefits;

(c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, any information that explains the Plan and benefits thereunder;

(d) to receive from the Employer and from Participants such information as necessary for the proper administration of the Plan;

(e) to furnish the Employer and the Participants such annual reports with respect to the administration of the Plan as necessary;

(f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses;

(g) to exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of Participants, including an examination at the Employer's expense of the records of the Plan to be made by such attorneys, accountants, auditors or other agents as it may select, in its discretion, for that purpose; and

(h) to appoint persons or entities to assist in the administration as it deems advisable; and the Plan Administrator may delegate thereto any power or duty imposed upon or granted to it under the Plan.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision will be considered ambiguous and will be interpreted by the Plan Administrator (or the Claims Fiduciary) in a fashion consistent with its intent, as determined by the Plan Administrator (or the Claims Fiduciary). The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The Plan Administrator (or Claims Fiduciary) may rely upon the direction or information from a Participant relating to such Participant's entitlement to benefits

hereunder as being proper under the Plan, and will not be responsible for any act or failure to act. Neither the Plan Administrator nor the Employer makes any guarantee to any Employee in any manner for any loss that may result because of the Employee's participation in the Plan.

All decisions, interpretations, determinations and actions in the exercise of the powers and duties described in this Section will be final and conclusive on all persons and entities subject only to the claims appeal provisions of the Plan. Benefits under the Plan will be paid only if the Plan Administrator (or Claims Fiduciary) determines in its discretion that the Participant is entitled to them. There will be no *de novo* review of any such decision, interpretation, determination or action by any court. Any review of any such decision, interpretation, determination or action will be limited to determining whether the decision, interpretation, determination or action in question was so arbitrary and capricious as to be an abuse of discretion under ERISA standards.

2.10 Delegation by the Plan Administrator. The Plan Administrator may delegate to other persons or entities any of the administrative functions relating to the Plan, together with all powers necessary to enable its designee(s) to properly carry out such duties hereunder, including, without limitation, delegation to the Claims Administrator and the Claims Fiduciary. The Plan Administrator may employ such counsel, accountants, Claims Administrators, Claims Fiduciaries, consultants, actuaries and such other persons or entities as it deems advisable in its discretion. The Plan Administrator, as well as any person to whom any duty or power in connection with the operation of the Plan is delegated, may rely upon all valuations, reports, and opinions furnished by any accountant, consultant, third-party administration service provider, legal counsel, or other specialist. Moreover, the Plan Administrator or such delegate who is also an Employee will be fully protected in respect to any action taken or permitted in good faith in reliance on such information.

2.11 Rules and Decisions. The Plan Administrator may adopt such rules and procedures, as it deems necessary or appropriate for the proper administration of the Plan. The Plan Administrator will be entitled to rely upon information furnished to it which appears proper without the necessity of any independent verification or investigation.

2.12 Facility of Payment for Incapacitated Participant. Whenever, in the Claims Fiduciary's opinion, a Participant is entitled to receive any payment of a benefit hereunder and is under a legal disability or is incapacitated in any way so as to be unable to manage his own financial affairs (including physical and mental incompetence or status as a minor), the Claims Fiduciary may direct payments to such person or to the person's legal representative (such as a guardian or conservator, upon proper proof of appointment furnished to the Claims Fiduciary), Dependent, or relative of such person for such person's benefit, or the Claims Fiduciary may direct payment for the benefit of such person in such manner as the Claims Fiduciary considers advisable in its discretion. Any payment of a benefit, to the full extent thereof, in accordance with the provisions of this Section 2.12 will be a complete discharge of any liability for the making of such payment under the Plan.

ARTICLE III

BENEFITS

The actual terms and conditions of eligibility, coverage, exclusions and limitations on coverage, and the additional rules pertaining to the benefits of Participants under the Plan, are set forth in the Wrap-SPD and the Welfare Program Documents. Any maximum benefit amounts, deductibles, copayments, out-of-pocket maximum amounts, and the reimbursement percentages for eligible charges under the Plan, are also contained in the Wrap-SPD and the Welfare Program Documents, as they may be amended from time to time. The Welfare Program Documents, as then currently in effect, are incorporated in their entirety by reference into the Wrap-SPD which, in turn, is incorporated by reference into the Wrap-Plan.

Notwithstanding anything to the contrary contained herein, benefits under a Fully-Insured Program will be paid solely in the form and amount specified in the relevant Welfare Program Document for the Fully-Insured Program, and pursuant to the terms and conditions of such Fully-Insured Program, except as otherwise required by ERISA, the Code or other applicable law, regulation, or other authority issued by a governmental entity.

ARTICLE IV
ADOPTION OF THE PLAN BY OTHER ENTITIES

4.1 **Adoption Procedure**. With the approval of the Plan Sponsor, any Affiliate of the Plan Sponsor may adopt and become an Employer under the Plan by executing and delivering to the Plan Sponsor an adoption instrument stating that the Affiliate intends to adopt the Plan and to be bound as an Employer by all the terms and conditions of the Plan with respect to its eligible Employees and their Dependents. The adoption instrument shall specify the effective date of such adoption of the Plan and shall become, as to such Affiliate and its Employees, a part of the Plan.

4.2 **Administration**. Any Affiliate which adopts the Plan shall designate the Plan Sponsor as its agent to act for it in all transactions affecting the administration of the Plan, and shall designate the Plan Administrator to act for such Affiliate and its Participants in the same manner in which the Plan Administrator may act for the Plan Sponsor and its Participants hereunder.

4.3 **Termination of Participation**. Any Employer may cease to participate in the Plan with respect to its Employees, provided the Employer is authorized to do so by the Plan Administrator. The Plan Sponsor may amend Appendix A to the Wrap-SPD, as needed, to reflect an Employer's withdrawal of the Plan, without regard to the formal amendment provisions of the Plan.

ARTICLE V
FUNDING

Notwithstanding anything to the contrary contained herein or in a Welfare Program Document, participation in the Plan by a Participant and the payment of Plan benefits shall be conditioned on such Participant Contributions towards the cost of coverage under the Plan at such

time and in such amounts as the Plan Administrator shall establish from time to time. The Plan Administrator shall designate the applicable method by which the Participant must make any Participant Contributions, and the Participant must consent in writing to such payment method to remain covered under the Plan. Nothing herein requires an Employer or the Plan Administrator to contribute to or under the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant or Beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant, Employee, Dependent or Beneficiary shall have any right to, or interest in, the assets of any Employer as the result of coverage under the Plan until actually paid. The Plan shall not be "funded" for purposes of ERISA.

Benefits or premiums for the Plan shall be provided through insurance contracts or through the general assets of the Employer in accordance with the terms of the relevant Welfare Program. An Employer shall have no obligation, but shall have the right, to insure or reinsure or to purchase stop loss coverage, where applicable, with respect to any Welfare Program under the Plan. To the extent that the Plan is provided through an Employer's purchase of insurance, payment of any benefits under such Welfare Program shall be the sole responsibility of the insurer, and the Employer shall have no responsibility for such payment.

ARTICLE VI
RIGHT OF SUBROGATION AND REIMBURSEMENT

The provisions of this Article VI will govern and control the Plan's rights to subrogation and reimbursement, and will supersede any subrogation and reimbursement provisions set forth in any Welfare Program Document (other than a Welfare Program Document for a Fully-Insured Program) to the extent that such other provisions are more restrictive or limited regarding the rights of the Plan than are these provisions. The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law as determined by the Plan Administrator.

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this Article VI on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this Article VI on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

6.1 Benefits Subject to this Provision.

This Article VI will apply to all benefits provided under the Plan, except for those provided under a Fully-Insured Program. For purposes of this Article, certain terms are defined as follows:

(a) "**Recovery**" means any and all monies and property paid by a Third Party to (i) the Participant, (ii) the Participant's attorney, assign, legal representative, or Beneficiary, (iii) a trust of which the Participant is a beneficiary, or (iv) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault

is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the injury or illness.

(b) "**Reimbursement**" means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Participant toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.

(c) "**Subrogation**" means the Plan's right to pursue the Participant's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.

(d) "**Third Party**" means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Participant's injury or illness.

The term "Third Party" will include the party or parties who caused the injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the injury or illness; a Participant's own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the injury or illness.

6.2 When this Provision Applies.

A Participant may incur medical or other charges related to any injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the injury or illness. If so, the Participant may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VI (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant's attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant. This right of Reimbursement enforceable by an equitable lien is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA, and will be construed accordingly.

As a condition to receiving benefits under the Plan, the Participant hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any injury or illness that provides, or may provide, the Plan with Subrogation

and/or Reimbursement rights under this Article VI.

The Plan's equitable lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures, or may be entitled to procure, regardless of whether the Participant has received compensation for any or all of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Participant's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Participant agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this Article VI, and Participant hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Participant:

(a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this Article VI apply;

(b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

(c) Must cooperate fully with the Plan in its exercise of its rights under this Article VI, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Participant who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to Section 6.5, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's rights of full Subrogation and Reimbursement, as provided in this Article VI ("**S&R Agreement**").

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injury or illness. The Plan may file a copy of an S&R

Agreement signed by the Participant and his attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any medical or other benefits for any injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Participant, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Participant's claim for benefits for the injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made-whole" and "common-fund" doctrines. A Participant who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VI, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this Article VI. A Participant who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Participant automatically agrees, without further notice, to all the terms and conditions of this Article VI and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this Article VI and to make changes in its interpretation as it deems necessary or appropriate.

6.3 Amount Subject to Subrogation or Reimbursement.

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Participant receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this

amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

6.4 When Recovery Includes the Cost of Past or Future Expenses.

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made-whole" and "common-fund" doctrines in applying the provisions of this Article VI.

It is the responsibility of the Participant to inform the Plan Administrator when expenses incurred are related to an illness or injury for which a Recovery has been made. Acceptance of benefits under the Plan for which the Participant has already received a Recovery will be considered fraud, and the Participant will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Participant is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

6.5 When a Participant Retains an Attorney.

If the Participant retains an attorney, the Plan will not pay any portion of the Participant's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Participant's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Participant's attorney must acknowledge and consent to the fact that the "made-whole" and "common fund" doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his pursuit of Recovery.

Any Recovery paid to the Participant's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VI, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this Article VI. A Participant's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

6.6 When the Participant is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent.

The provisions of this Article VI will apply to the parents, trustee, guardian or other representatives of a minor Participant and to the heirs or personal representatives of the estate of a deceased Participant, regardless of applicable law and whether or not the representative has access to or control of the Recovery. For purposes of this Article VI, the term "Participant" will also include a COBRA qualified beneficiary who has elected COBRA Continuation Coverage under the Plan. If a covered Dependent is the Participant whose benefits under the Plan are subject to the Plan's Subrogation and Reimbursement rights, the covered Employee who enrolled such Dependent under the Plan will also be required to execute the S&R Agreement, upon request, even if the Dependent is not a minor and, in such event, the Employee will be liable for any breach of this Article VI by the Employee or such Dependent.

6.7 When a Participant Does Not Comply.

When a Participant does not comply with the provisions of this Article VI, the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Participant and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce the provisions of this Article VI, the Participant will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

ARTICLE VII
AMENDMENT OR TERMINATION

The provisions of this Article VII shall govern and control amendment and termination of the Plan, and will supersede any conflicting or inconsistent provisions set forth in a Welfare Program Document.

7.1 Right to Amend.

The Board (or a committee of the Board), the CEO and any Senior Vice President of the Plan Sponsor, shall each have the right, authority and power to make, at any time, and from time to time, any amendment to the Plan; provided, however, no amendment shall prejudice any claim under the Plan that was incurred but not paid prior to the effective date of the amendment, unless the person or entity responsible for the amendment, as applicable, determines that such amendment is necessary or desirable to comply with applicable law or is required under the terms of a particular Welfare Program. Moreover, if the Plan is amended, a Participant's right to receive coverage for expenses incurred for supplies or services that were actually received or actually rendered on his behalf before the effective date of such amendment shall not be reduced or eliminated. However, an amendment may reduce or eliminate a Participant's right to receive coverage for expenses that are or will be incurred for supplies or services that are received or rendered on or after the effective

date of the amendment, even if such supplies or services were approved or are part of a series of treatments or services that began prior to such effective date.

7.2 Right to Terminate.

The Board (or a committee of the Board), the CEO and any Senior Vice President of the Plan Sponsor shall each have the right, authority, power and discretion to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its or his discretion; provided, however, such termination shall not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the Board (or such committee), the CEO or the Senior Vice President, as applicable, determines it is necessary or desirable to comply with applicable law. An Employer, by action of its board of directors (or equivalent governing body) or chief executive officer, may terminate the Plan with respect to its Employees only, at any time with at least thirty (30) days prior notice to the Plan Administrator; provided, however, the Plan Administrator, in its discretion, may limit such termination to the end of a Plan Year.

ARTICLE VIII
MISCELLANEOUS PROVISIONS

8.1 Governing Law; Jurisdiction. Except as otherwise required by the Welfare Program Document or Policy for a Fully-Insured Program, all matters or issues relating to the interpretation, construction, validity, and enforcement of the Plan shall be governed by the laws of the State of Texas, without giving effect to any choice-of-law principle that would cause the application of the laws of any jurisdiction other than Texas, except to the extent such laws are preempted by ERISA or other controlling federal law. As the Plan is administered in Fort Bend County, Texas, mandatory venue for any claim, legal suit, action or other proceeding arising out of, or relating to, the Plan, other than an interpleader action under the Plan that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof, shall be the Federal District Court for the Southern District of Texas—Houston Division or any judicial district court that is situated in either Fort Bend County, Texas, or Harris County, Texas subject to removal of any such action under ERISA (under 28 U.S.C. §§ 1441 et seq. or any successor provision). Venue for an interpleader action under the Plan that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof shall be, as decided by the Plan Administrator in its discretion, in (a) the state where the deceased Participant resided at his death (if the benefits which are the subject of the interpleader action are those of a deceased Participant), (b) the state in which at least one defendant in the interpleader action resides, or (c) the Federal District Court for the Southern District of Texas—Houston Division or any judicial district court that is situated in either Fort Bend County, Texas, or Harris County, Texas.

Each Participant, as the result of, and in consideration for, participation in the Plan, and his designated representative, with respect to any claim or dispute relating in any way to, or arising out of, the Plan, consents and agrees to such jurisdiction and venue as described in this Section 8.1 and waives any objection to such jurisdiction or venue including, without limitation, that it is inconvenient. Such parties shall not commence any legal action other than before the above-named courts. Notwithstanding the previous sentence, a party may commence any legal action in a court other than the above-named courts solely for the

purpose of enforcing an order or judgment issued by one of the above-named courts..

8.2 **Invalidity of Particular Provision**. If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, and the Plan shall be construed and enforced as if the invalid or illegal provision had not been inserted herein.

8.3 **Acceptance of Terms and Conditions of the Plan by Participants**. Each Participant, by making application to become a Participant under the Plan or by the execution of any form authorized under the terms of the Plan for himself or his Beneficiaries or legal representatives, approves and agrees to be bound by the terms and provisions of the Plan (including the incorporated Wrap-SPD and Welfare Programs) and by the actions of the Plan Administrator and the Claims Fiduciary taken in accordance with the Plan.

8.4 **Construction**. Words used in the Plan in the singular shall include the plural and vice-versa. The gender of words used herein shall be construed to include whichever may be appropriate under particular circumstances of the masculine, feminine or neuter genders. Headings of articles and sections used herein are inserted for convenience of reference and shall not create any inference or presumption concerning the construction of the Plan.

8.5 **Non-Alienation of Benefits**. No benefit, right or interest of any Participant or Beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law. The Employer shall not be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any Participant or Beneficiary entitled to benefits hereunder.

8.6 **Limitation of Rights**. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed so as to:

(a) give any person any legal or equitable right against the Plan (including any assets of the Plan), the Plan Sponsor, an Employer or the Plan Administrator, except as required by controlling law which cannot be waived; or

(b) create a contract of employment with any Employee, obligate an Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way, including the right of the Employer to discharge any Employee, with or without cause, at any time.

8.7 **Costs and Expenses**. Any costs and expenses incurred in the administration of the Plan shall be paid by the Plan, the Plan Sponsor and/or one or more Employers, as determined by the Plan Sponsor.

8.8 **Assignment and Payment of Benefits**. The provisions of this Section 8.8 shall supersede any provisions of a Welfare Program Document (other than the Welfare Program Document(s) of a Fully-Insured Program) regarding the subject matter hereof and shall

govern and control.

Except as otherwise expressly provided under the terms of a written agreement with a provider of healthcare services or supplies to which the Plan Administrator, the Claims Fiduciary, or other delegate of the Plan Administrator is a named party (a "**Plan Agreement**"), no rights, causes of action and benefits under the Plan can be assigned or transferred to any person or entity, including, but not limited to, an out-of-network healthcare provider (or any representative or agent with respect to such provider), either before or after healthcare services or supplies are provided to or on behalf of a Participant. For purposes of clarification and not limitation, such rights and causes of action shall include any administrative, statutory, or legal right or cause of action that a Participant or other individual may have under ERISA, including, but not limited to, any right to (a) make a claim for Plan benefits, (b) request the Plan or other documents related to the Plan or a claim for benefits, (c) file an appeal of a denied claim for Plan benefits, or (d) file a lawsuit under ERISA or other applicable law.

In the absence of a Plan Agreement which specifically provides for assignment of the Participant's benefits and/or rights under the Plan (*i.e.*, is not merely an agreement between the Participant and the provider or its representative or agent), the Plan Administrator and Claims Fiduciary, as applicable, each reserve the unilateral right and discretion to elect to make any benefit payment under the Plan directly to the provider, the Participant, or to another designated person or entity, with or without the Participant's authorization, with each such payment being made on behalf of the Participant, and not to such payment recipient in its, his or her own right. Moreover, if the Plan Administrator or Claims Fiduciary, as applicable, elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator or Claims Fiduciary of the anti-assignment provisions of this Section 8.8. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to the Participant for benefits under the Plan to the full extent of such payment. Accordingly, if a provider is overpaid as the result of accepting a payment for the same covered service from the Participant and from the Plan, the provider, and not the Plan, shall be responsible for reimbursing the Participant for such overpayment.

Disclosures of information about the Participant can only be made to a Participant or a Participant's authorized representative and in accordance with applicable law and the terms of the Plan.

8.9 **Overpayments**. If, for any reason, any benefit, premium or fee under the Plan is erroneously paid or reimbursed by the Plan Administrator, Claims Fiduciary or other person or entity to a Participant or to an insurance company, a healthcare or other services provider (including an assignee of the Participant as described in Section 8.8), or other person or entity for the benefit of a Participant (collectively, a "**Third-Party Payee**"), such erroneously-paid amount shall constitute an "**Overpayment**" under the Plan, with respect to which the Plan shall have a right of first and primary reimbursement from such Participant or Third-Party Payee that is enforceable by an equitable lien equal to 100% of the Overpayment amount ("**Overpayment Reimbursement**"). Without limitation, the Plan's right to Overpayment Reimbursement is intended to entitle the Plan to equitable

relief under Section 502(a)(3) of ERISA and shall be construed accordingly. By accepting a benefit, premium or fee under the Plan, each Participant and Third-Party Payee automatically acknowledges and agrees that the Plan has the right to pursue Overpayment Reimbursement from the general assets of the Participant or Third-Party Payee to whom the Overpayment was made, to the full extent permitted by ERISA.

If such Overpayment is not refunded to the Plan within a reasonable time period as determined by the Plan Administrator or Claims Fiduciary, the Overpayment shall be (a) charged directly to the Participant (including, without limitation, to a covered Employee on behalf of any of his or her Dependents or Beneficiaries) or to a Third-Party Payee as a reduction of the amount of future benefits otherwise payable by the Plan on behalf of the Participant, or (b) recouped by any other method which the Plan Administrator or Claims Fiduciary, as applicable, deems to be appropriate in its discretion, to the extent permitted by applicable law. For example, the selected repayment method may include, without limitation, (i) payroll deductions in the case of an Employee or his Dependent or Beneficiary (in which case the Employee must execute such forms authorizing payroll deduction as the Plan Administrator shall require as a mandatory condition of his participation, or continued participation, in the Plan) or (ii) offsetting other payments made by the Plan to the Participant, or to the same Third-Party Payee on the Participant's behalf, as permitted by applicable law (in which case, such payment offset to a Third-Party Payee shall not constitute an adverse benefit determination that is subject to the ERISA claims and appeals procedures of the Plan). For purposes of clarity and not limitation, in the event of the application of any Overpayment Reimbursement to a Third-Party Payee pursuant to the foregoing provisions of this Section 8.9, the offset of the Overpayment hereunder is simply an adjustment to the amount payable to the Third-Party Payee to reflect the Overpayment and shall not be considered to be the denial or partial denial of any benefit claim under the Plan.

8.10 **Entire Plan**. The Wrap-Plan, Policies, Wrap-SPD, Welfare Program Documents, and any appendices or exhibits attached thereto, together set forth the entire Plan, and fully supersede any and all prior plans, summary plan description documents, agreements, representations, promises or understandings, written or oral, pertaining to the subject matter hereof. Any amendment to the Plan must be in writing and in accordance with the applicable requirements of the Plan.

[*Signature page follows*]

IN WITNESS WHEREOF, the undersigned, being duly authorized to act on behalf of the Plan Sponsor, has approved and executed this amended and restated Plan on this 11th day of December, 2020, effective as of January 1, 2020.

ATTEST:

By:_____

Name:_____

Title:_____

TEAM, INC.

By: [signature]

Name: André C. Bouchard

Title: EVP, Chief Legal Officer

TEAM, INC. WELFARE BENEFIT PLAN

POLICY APPENDIX

The following group insurance policies issued by the insurance carrier to the Plan Sponsor (or other Employer), pursuant to which certain employee welfare benefits under the Plan are provided to Participants, including any amendments, endorsements or riders thereto (each individually a "**Policy**" and collectively, the "**Policies**"), are attached hereto and incorporated, in their entirety, into this Plan document by reference:

- Vision Insurance Policy #F023170 between Team, Inc. and Dearborn National Life Insurance Company;
- Life and Accidental Death and Dismemberment Insurance Policy #52630 between Team, Inc. and Prudential;
- Long Term Disability Insurance Policy #GF3-890-466197-01 between Team, Inc. and Liberty Life Assurance Company of Boston;
- Employee Assistance Program Contract #230539 between Team, Inc. and Optum;
- Critical Illness Insurance Policy # 216626 between Team, Inc. and MetLife; and
- Blanket Accident Insurance Policy #ADD N04158489R between Team, Inc. and ACE American Insurance Company.

Hawaii Employees Only

- Health, Prescription, Dental, and Vision Insurance Policy #13977, between Team, Inc. and Hawaii Medical Services Association.

Puerto Rico Employees Only

- Health, Prescription, and Dental Insurance Policy # SP0001477 between Team, Inc. and Triple-S Salud, Inc.

TEAM, INC. WELFARE BENEFIT PLAN

HIPAA PRIVACY EMPLOYEE DESIGNATION APPENDIX

The following employees are hereby designated as being entitled to receive Protected Health Information subject to HIPAA from the Plan:

- General Counsel;
- Director Corporate Benefits;
- Sr. Director HRMS/Payroll;
- Sr. Director HR;
- Employee Benefits Administrators;
- Employee Benefits Manager; and
- Chief Human Resources Officer.