

**AMENDMENT
FOR TTI TRUCKING, INC.**

This Amendment is designed to update TTI Trucking, Inc. Employee Benefit Plan.

Nothing contained in this Amendment shall alter any provision of the Plan other than particularly stated.

Effective August 1, 2009 the Plan is amended in the following manner:

SCHEDULE OF MEDICAL BENEFITS

Important Note: This information is intended as a summary of Plan benefits only. Refer to the detail information within this Summary Plan Description Book for additional coverage descriptions, including limitations and exclusions.

Plan Name: TTI, Incorporated Employee Health & Welfare Plan

Page 35, SCHEDULE OF MEDICAL BENEFITS – The following 2 plans will now be offered:

\$700 Deductible Plan

	In Network	Out of Network
Deductible: Single/Family	\$700/\$1,400	\$1,400/\$2,800
Coinsurance:	80% to \$10,000	50% to \$10,000
Individual Out of Pocket Maximum: <i>(includes deductible)</i> Single/Family	\$2,700/\$5,400	\$6,400/\$12,800
Lifetime Maximum	\$1,000,000	\$1,000,000

NOTE: In and Out of network deductible and coinsurance do NOT apply towards each other

Non-Routine Physician Charges	In Network	Out of Network
Office Examination / Consultation	80% after Deductible	50% after Deductible
Office X-Ray	80% after Deductible	50% after Deductible
Office Laboratory Services	80% after Deductible	50% after Deductible
Non-Routine Injection of Drugs	80% after Deductible	50% after Deductible
Office Surgery/Anesthesia	80% after Deductible	50% after Deductible
Voluntary Second Surgical Opinion	100% to \$100 per opinion, then ded/coins applies, deductible waived	100% to \$100 per opinion, then ded/coins applies, deductible waived

Well Care – Routine Physician Care		
	In Network	Out of Network
Routine Office Examination	\$10 copay then 100% to \$500, then deductible/coinsurance	50% after Deductible
Routine Colonoscopy	Included in routine Wellness Benefit	50% after Deductible
Routine Mammogram Two between ages 45 – 49, One per calendar year for ages 50-65	Included in Wellness Benefit	50% after Deductible
Routine Lab Service	Included in routine wellness visit limit if done in office. If done at other facility then Deductible/Coinsurance applies	50% after Deductible
Routine Pap Smear one per calendar year	Included in Wellness Benefit	50% after Deductible
Immunizations	Included in Wellness Benefit	50% after Deductible
Other Physician/Specialty Services		
	In Network	Out of Network
Chiropractic Care Limited to 12 visits per calendar year	80% after Deductible	50% after Deductible
Surgery / Anesthesia	80% after Deductible	50% after Deductible
Testing/Treatment for Infertility	Not covered	Not covered
TMJ/Jaw Joint Problems Limited to \$1,250 per calendar year	80% after Deductible	50% after Deductible
Physical Therapy	80% after Deductible	50% after Deductible
Chemotherapy / Radiation	80% after Deductible	50% after Deductible
Kidney Disease/Dialysis Limited to \$30,000 per calendar year	80% after Deductible	50% after Deductible
Cardiac Rehabilitation Limited to 36 visits per calendar year	80% after Deductible	50% after Deductible
Pulmonary Rehabilitation Limited to 20 visits per calendar year	80% after Deductible	50% after Deductible
Hospice Care	80% after Deductible	50% after Deductible
Home Health Care Limited to 30 visits per calendar year	80% after Deductible	50% after Deductible
Human Organ and Tissue Transplant – Limited to \$250,000 per transplant, \$500,000 lifetime (for transplants that fall outside of the Organ Transplant policy)	<i>Please see the SPD for a list of Specified Transplant Covered Expenses</i> 80% after Deductible	<i>Please see the SPD for a list of Specified Transplant Covered Expenses</i> 50% after Deductible

Outpatient Hospital/Other Facility		
	In Network	Out of Network
Surgical Center	80% after Deductible	50% after Deductible
Outpatient Physical Therapy	80% after Deductible	50% after Deductible
Pre-Admission Testing	80% after Deductible	50% after Deductible
Outpatient Lab Service	80% after Deductible	50% after Deductible
Outpatient X-Ray Services	80% after Deductible	50% after Deductible
Emergency Room	80% after Deductible	50% after Deductible
Inpatient Hospital/Facility*		
	In Network	Out of Network
Semi-Private Room	80% after Deductible	50% after Deductible
Private Room	<i>Limited to Semi-Private Room Rate</i> 80% after Deductible	<i>Limited to Semi-Private Room Rate</i> 50% after Deductible
ICU/CCU	80% after Deductible	50% after Deductible
Inpatient Physician Consultation	80% after Deductible	50% after Deductible
Miscellaneous Physician Charges	80% after Deductible	50% after Deductible
Supplies / Other Related Services	80% after Deductible	50% after Deductible
<i>Skilled Nursing Facility - Limited to 30 days per Inpatient stay and 60 days per year for Inpatient rehabilitation</i>	<i>80% after Deductible</i>	<i>50% after Deductible</i>
Outpatient Psychiatric Care		
	In Network	Out of Network
Therapy for Mental Health	<i>Limited to 6 visits per calendar year</i> 80% after Deductible	<i>Limited to 6 visits per calendar year</i> 50% after Deductible
Therapy for Substance Abuse	<i>Limited to 6 visits per calendar year</i> 80% after Deductible	<i>Limited to 6 visits per calendar year</i> 50% after Deductible
Transitional Psychiatric Care		
	In Network	Out of Network
Transitional for Mental Health	<i>Limited to 6 visits per calendar year</i> 80% after Deductible	<i>Limited to 6 visits per calendar year</i> 50% after Deductible
Transitional for Substance Abuse	<i>Limited to 6 visits per calendar year</i> 80% after Deductible	<i>Limited to 6 visits per calendar year</i> 50% after Deductible
Inpatient Psychiatric Care		
	In Network	Out of Network
Admission for Mental Health	<i>Limited to 6 visits per calendar year</i> 80% after Deductible	<i>Limited to 6 visits per calendar year</i> 50% after Deductible
Admission for Substance Abuse	<i>Limited to 6 visits per calendar year</i> 80% after Deductible	<i>Limited to 6 visits per calendar year</i> 50% after Deductible

Prescription Drug Card/Retail	
Retail	\$10 Co-Payment Generic 20% Co-Payment Single Source Brand 50% Co-Payment Brand <i>Dispensed as written</i>
Mail Order Prescription Drug	
Mail Order	\$10 Co-Payment Generic 20% Co-Payment Single Source Brand 50% Co-Payment Brand <i>Dispensed as written</i>

This plan has Mandatory Generic Substitution. If a generic is available, and your provider has not specified that a Brand is required due to a medical reason, a Generic substitute will be dispensed. If the member chooses a Brand over a Generic the member will pay the Brand name copay (50%).

\$1,700 Deductible Plan

	In Network	Out of Network
Deductible: Single/Family	\$1,700/\$3,400	\$3,400/\$6,800
Coinsurance:	80% to \$10,000	50% to \$10,000
Individual Out of Pocket Maximum: <i>(includes deductible)</i> Single/Family	\$3,700/\$7,400	\$8,400/\$16,800
Lifetime Maximum	\$1,000,000	\$1,000,000

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BY THIS AGREEMENT, TTI, Inc. is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for TTI, Inc. on or as of the day and year first below written.

By _____

Jeannie Timblin- Human Resource Representative for TTI, Inc.

Witnessed By _____