Cypress BENEFIT ADMINISTRATORS

Master Plan Document

TTI, Incorporated
Flatbed Division

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IMPORTANT INFORMATION ABOUT YOUR PLAN

This document is a description of the TTI, Incorporated Employee Health and Welfare Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

TTI, Incorporated reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. Changes in the Plan may occur in any or all parts of the Plan including but not limited to the coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, and eligibility requirements.

As a Plan Participant, it is your responsibility to read and understand this plan document. It is also your responsibility to maintain and amend your copy of this plan document as instructed by Cypress Benefit Administrators, or your employer.

This document summarizes the Plan rights and benefits for covered Employees and is divided into the following parts:

- ***Section 1: Definitions***
- ***Section 2: Eligibility***
- ***Section 3: Covered Expenses***
- ***Section 4: Medical Limitations and Exclusions***
- ***Section 5: Prescription Drug Coverage***
- ***Section 6: General Plan Provisions***

INFORMATION REGARDING PPO NETWORK AND NON-PPO NETWORK PROVIDERS:

The Plan Sponsor has entered in agreements with one or more PPO Network Providers. The Plan Sponsor has contracted with certain medical providers who agree to provide pre-determined medical services or supplies at prices that are typically less than the prices charged to individuals who are not covered by a PPO Network Agreement. To determine if a particular medical provider participates in the local PPO Network with which the Plan Sponsor has contracted, please contact the PPO Medical Services Facilitator.

It is the choice of the covered person whether or not to use an PPO Network Provider. The Plan, Plan Sponsor and Third Party Administrator make no representations or warranties regarding the qualifications or the care provided by any provider, including those providers who participate in the PPO Network. Covered persons should make their own decisions concerning the qualifications of the providers they select to provide them with medical services or supplies.

SECTION 1

DEFINITIONS

DEFINITIONS

The following terms have specific meanings when used in this Plan.

Accident: A happening by chance and without intention or design. A happening that is unforeseen, unexpected and unusual at the time it occurs, causing bodily injury.

Actively at Work: An employee is performing, on a regular basis, all customary occupational duties at the employer's usual business establishment or another location of business when required to travel on the job. Each day of regular paid vacation and any regular non-working day will be considered actively at work if you are actively at work on your last regular working day; any day an employee is covered under the Plan by virtue of a leave as described in the Plan (other than an FMLA leave); or, any day an employee is on an FMLA leave.

Affiliation Period: A period of time that must expire before health insurance coverage provided by an HMO becomes effective and during which time the HMO is not required to provide benefits.

Ambulatory Surgical Center: A licensed center that has permanent facilities and equipment primarily for performing outpatient surgery. An Ambulatory Surgical Center must have a staff of Physicians, must offer continuous Physician and nursing care by registered nurses (RNs). An Ambulatory Surgical Center is not a General Hospital, a Skilled Nursing Facility or a facility used primarily as an office or clinic for the private practice of a Physician.

Amendment: A formal document duly authorized and signed by the person or persons designated by the Plan Administrator that changes the provisions of the Plan.

Benefit Maximums: The Plan limits an amount payable by the Plan for a service or supply. The limitation may be based, for example, on the number of services provided while the person is covered by the Plan or it may be determined on a periodic basis such as a set period of time or per occurrence of an illness or injury. These limitations may also be expressed in other terms, for example, a number of days, visits or confinements. (See the Schedule of Benefits section of the Plan for additional information.)

Birthing Center: A licensed facility that provides prenatal care, delivery and immediate postpartum care as well as the care of a child born at the Birthing Center. A Birthing Center must:

1. Be directed by a Physician;
2. Have a Physician or a Certified Nurse Midwife present at all births and during the immediate postpartum period;
3. Extend staff privileges to Qualified Practitioners who practice obstetrics and gynecology in the geographic area around the Birthing Center;
4. Have at least two beds or birthing rooms for use by patients during labor and delivery;
5. Provide full-time nursing services directed by a registered nurse (RN) or Certified Nurse Midwife;
6. Provide diagnostic x-ray and laboratory services for the mother and newborn;
7. Have the capacity to administer anesthesia and perform minor surgical procedures including but not limited to an episiotomy or the repair of a perineal tear;
8. Be equipped and staffed to handle medical emergencies and provide immediate life support measures;

9. Accept only low risk pregnancies;

10. Have admitting privileges to one or more area Hospitals for the transfer of patients; and

11. Maintain medical records on each patient and provide an ongoing quality assurance program.

Calculation of Plan Maximum Amounts: Amounts paid by the Plan shall be used in calculating any Plan Maximum amounts under the Plan.

Calendar Year: January 1st through December 31st of the same year.

Certified Nurse Midwife: An individual who provides obstetrical care and treatment, who is licensed by the state in which he or she resides, and who practices under the supervision of a Physician.

Chiropractic Care: Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the spine or other areas of the human body. Chiropractic Care is done by a Physician to remove nerve interference resulting from or related to distortion, misalignment or subluxation of or in the vertebral column.

Claims Administrator: Cypress Benefit Administrators is the firm employed by the Plan Sponsor to provide clerical services in connection with the operation of the Plan and any other functions including the processing of claims. In the event that no Claims Administrator is employed by the Plan Sponsor at any particular point in time, Claims Administrator will mean the Plan Sponsor.

Clinical Psychologist: A licensed person or practitioner who treats patients with emotional and mental problems. When there is no licensure law, the psychologist must be certified by the appropriate professional body. Clinical Psychologist does not include licensed clinical social workers.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance: The percentage of the eligible charges for covered services and supplies, which the Plan will pay – subject to all of the provisions of the Plan. It is the responsibility of the covered person to pay for the percentage of coinsurance not payable by the Plan.

Complications of Pregnancy: A complication of pregnancy is a condition whose diagnosis is distinct from Pregnancy, but must be caused by, related to, or adversely affected by Pregnancy. Complications of pregnancy include such conditions as acute nephritis, nephrosis, cardiac decompensation, puerpural infection, eclampsia, toxemia and missed abortion. Complications of Pregnancy do not include: False labor, occasional spotting, Physician prescribed rest, morning Illness, or similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct complication of pregnancy.

Spontaneous abortions, non-elective caesarean section deliveries, and terminated ectopic pregnancies are also considered Complications of Pregnancy.

Confinement: means being a resident patient in a hospital for at least 15 consecutive hours per day or being a resident bed patient in a convalescent or skilled nursing home or other qualified treatment facility 24 hours a day. Successive confinements are considered one confinement if they are:

1. due to the same injury or illness; and

2. separated by fewer than 90 consecutive days when you are not confined.

Convalescent Nursing Home (Skilled Nursing Facility or Extended Care Facility): An institution, or distinct part thereof, which is licensed and lawfully run in the jurisdiction where it is located and maintains and provides:

1. Permanent and full-time bed care facilities for resident patients;
2. A qualified practitioner's services available at all times;
3. A registered nurse (R.N.) or qualified practitioner in charge and on full-time duty and one or more registered nurses (RN's) or licensed vocational or practical nurses on full-time duty;
4. A daily record for each patient;
5. Continuous skilled nursing care for sick or injured persons during their convalescence from Illness or injury; and
6. Referral to one or more Hospitals for the transfer of patients.

A convalescent nursing home is not solely a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Copayment:. The amount of a Covered Service, that is not payable by this Plan and that must be paid by the participant directly to the provider of medical or pharmaceutical services at the time of the service. A copayment will not apply towards satisfying the Deductible or coinsurance amount

Covered Person: An Employee or eligible Dependent who is covered under this Plan, who has satisfied any applicable waiting period and who is properly enrolled in the Plan..

Covered Service: A service or supply not excluded by the Plan and incurred by a Covered Person due to an Injury or Illness. A participant incurs a charge for a Covered Service on the date the service or supply is provided to the participant. Covered Service does not include any service or supply if that service or supply is not documented in provider records.

Creditable Coverage: Includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care: Care (including room and board needed to provide that care) that is given principally for assistance in daily activities and can, according to generally accepted medical standards, be performed by non-professional, non-medical or non-licensed persons with training. Examples of Custodial Care are help with personal hygiene, walking, getting in and out of bed, or assistance with bathing, dressing, feeding. Custodial Care includes Respite Care that is care requested to give temporary relief to persons who normally assist with the care of the Covered Person.

Deductible: Means a specified dollar amount that a Covered Person must pay to their health care provider prior to receiving coverage for a Covered Service under the Plan. A deductible applies to all covered services as described in the Schedule of Medical Benefits in this plan.

Dependent: A person other than the employee, who meets the requirements for eligibility of a Dependent according to the Plan. A dependent includes but is not limited to a lawful spouse, a natural born child, an adopted child, or a child legally placed in your custody for which you provide primary care and financial support. A complete definition of eligibility for Dependents is located in the Eligibility section of this Plan.

Diagnostic Service: A test or procedure that is performed to determine a definite condition or disease. A diagnostic service must be ordered by a Physician or other Qualified Practitioner. Diagnostic Services include but are not limited to x-rays, radiology services, laboratory and pathology services, cardiography, encephalography, and radioisotope tests.

Durable Medical Equipment: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally safe, and is not useful to a person in the absence of a covered Illness or Injury.

Effective Date: The first day of coverage following enrollment in the Plan.

Effective Date of The Plan: July 1, 1997

Emergency: An injury or illness that, in the opinion of a prudent layperson, requires immediate treatment and that if not immediately treated would jeopardize or impair the health or the covered participant. An emergency may or may not be life threatening.

Employee: A full-time employee actively at work and working 40 or more hours per week on a regular basis for the employer and retired employees as specified under the Retired Employee Coverage Continuation Provision. Temporary, part-time, seasonal, leased (even if determined to be common-law employees) and retired employees not meeting the requirements of the Retired Employee Coverage Continuation Provision are not eligible for coverage and therefore are not considered employees for purposes of the Plan.

Employer: TTI, Incorporated.

Enrollment Date: The first day of your eligibility period as defined by the plan if you are a timely enrollee to the plan. If you are a late enrollee to the plan, your Enrollment Date is the Effective Date of your coverage under this plan.

ERISA: Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational: Services, supplies, care and treatment which does not constitute accepted medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical or dental community or appropriate government oversight agencies at the time services were rendered. The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

3. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase l or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated

dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

4. If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use, for a particular medical condition.

Family Member: A lawful spouse, child, parent, brother or sister, or any person related in the same way to your covered dependent.

Formulary Drug: When a generic is not available, there may be more than one brand name drug that may be appropriate for you. That is why this formulary was developed. The brand name medications listed on the Formulary are those that have been deemed preferred and were selected based on their ability to meet patient needs at a lower cost.

Full Time Student: An unmarried child Dependent within the age specified in the Eligibility provisions of the plan, who is enrolled in an accredited secondary school, university or college for the minimum number of credits defined by that school, university or college to establish full-time status.

Generic Drug: A Prescription Drug that contains the same active ingredients as Prescription Drug currently marketed under a Brand Name. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist or an applicable plan formulary as being Generic.

Genetic Information: Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency: An organization whose main function is to provide Home Health Care Services and Supplies. A qualified Home Health Care Agency must:

1. Be primarily engaged in and duly licensed to provide skilled nursing services and other therapeutic services, if such licensing is required by the appropriate authority where services are provided;

2. Have policies established by a professional group associated with the agency or organization. This professional group must include at least one registered nurse (RN) to govern the services provided and it must provide for full-time supervision of such services by a Qualified Practitioner or registered nurse;

3. Maintain a complete medical record and Home Care Plan of Treatment for each patient;

4. Have a full-time administrator; and

5. Be approved by Medicare.

Home Health Care Plan of Treatment: A Home Health Care Plan of Treatment must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days, it must state the diagnosis, it must certify that the Home Health Care is in lieu of Hospital confinement, and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies: Part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency; physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital. Home Health Care Services do not include general housekeeping services.

Hospice Agency: An agency which has the primary purpose of providing hospice care to terminally ill patients. Hospice Agencies must be licensed and operated according to the laws of the state in which it is located and it must:

1. Provide 24 hour a day, seven day a week service, supervised by a qualified practitioner;

2. Have a full-time coordinator;

3. Keep written records of services provided to each patient;

4. Have a nurse coordinator who is a registered nurse (R.N.) with at least four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and

5. Have a licensed social service coordinator.

A hospice agency must establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It must provide an on-going quality assurance program, permit area medical personnel to use its services for their patients and may use volunteers trained in care of and services for non-medical needs.

Hospice Care: Palliative and supportive care to terminally ill patients. It offers supportive care to the families of the terminally ill, an assessment of the hospice patient's medical and social needs and a description of the care necessary to meet those needs. Hospice care must be provided under a written plan of hospice care which is established and reviewed by the attending Qualified Practitioner of the Covered Person and the Hospice Care Agency.

Hospice Care Plan: A plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Unit: A facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital: An institution which is engaged primarily in providing medical care and treatment of sick and injured persons and that fully meets these tests:

1. It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations;

2. It is approved by Medicare as a Hospital;

3. It maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians;

4. It continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (RNs); and

5. It is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

1. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates; or

2. A facility operating primarily for the treatment of Substance Abuse if it maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients, has a Physician in regular attendance, if it continuously provides 24-hour a day nursing service by a registered nurse (R.N.), and if it has a full-time psychiatrist or psychologist on the staff.

Illness: A pregnancy or a disease or disturbance in the function or structure of the body which causes physical signs and/or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or systems of the body.

Infertility: The condition of a person who is unable to conceive or produce conception.

Infertility Treatment: Services, tests, supplies, devices, and drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat the cause of infertility when such treatment is done with the intent to bring about pregnancy. Infertility Treatments include, but are not limited to fertility tests and drugs, tests and exams done to prepare for or follow through with induced conception, surgical reversal of a sterilized state which was the result of a previous surgery, sperm enhancement procedures, and direct attempts to cause pregnancy such as hormone therapy or drugs, artificial insemination, in-vitro fertilization, and embryo transfer.

Injury: Accidental physical damage to the body caused by unexpected and external means.

Intensive Care Unit: A separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." An Intensive Care Unit has facilities for special nursing care not available in regular rooms and wards of the Hospital, special life saving equipment which is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee: A Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period as defined by the plan.

Legend Drug: This is a medication that requires a prescription in order to be dispensed.

Legal Guardian: A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime: A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Master Plan Document: The document signed by the Plan Sponsor and all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto which set forth the terms of the Plan.

Maximum Benefit: The total eligible charges that the Plan will pay per covered person while that person is covered under the Plan.

Medical Care Facility: A Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medically Necessary: Care and treatment is recommended or approved by a Physician or other Qualified Practitioner that is consistent with the patient's condition or diagnosis, is generally accepted as a form of treatment according to standards of accepted medical and practice, is medically proven to be effective treatment of the condition, is not performed mainly for the convenience of the patient or provider of medical services, is not conducted for research purposes and is the most appropriate, least costly level of care which can be safely provided to the patient. All of these criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare: The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder/Illness: Any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of The International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. (Note: Substance Abuse shall not be deemed a Mental Health condition for purposes of this Plan.)

Morbid Obesity: Morbid Obesity is defined as excessive obesity to the extent that respiration or circulation are significantly impaired. In order for the Plan to provide coverage for Obesity, the Covered Person must be at least 100% or 100 pounds over the normal body weight for a person of similar height, age and build, whichever is less. In the case of covered Dependent children, a child must be at least 50% above the normal weight for a child of similar height, and stage of development.

No-Fault Auto Insurance: The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-compliance Penalty: An amount that is reduced from eligible charges due to a failure to comply with specified provision requirements of the Plan. Any amount not covered by the Plan due to a non-compliance penalty is the responsibility of the covered person.

Non-Formulary: Brand medications not on the formulary listing.

Outpatient Care: Treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient, or services rendered in a Physician's office, laboratory or radiology facility, an Ambulatory Surgical Center, or the patient's home.

Participant: Each covered Employee and Dependent.

Pharmacy: A licensed establishment where Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician: A legally licensed person who holds a Doctorate designation in Medicine, Osteopathy, Dentistry, Optometry, Podiatry or Chiropractic Medicine who is not specifically excluded by the plan. For purposes of mental health and substance abuse charges, “Physician” shall also include any provider approved or licensed by the state in which services are rendered for treatment of such conditions.

Plan: TTI, Incorporated, Master Plan Document and all of its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto.

Plan Administrator: TTI, Incorporated

Plan Maximums: The total amount the Plan will pay for any covered person while he or she is a participant in the Plan, regardless of whether such coverage is continuous. (See the Schedule of Benefits section of the Plan for additional information.)

Plan Sponsor: TTI, Incorporated

Plan Participant: Any Employee or eligible dependent, who is covered under this Plan.

Plan Year: The period beginning July 1 and ending June 30 of the following year.

Pre-Admission Testing: Tests and studies performed prior to a participant's inpatient hospital admission for surgery. Pre-Admission testing does not include tests and studies done to make a diagnosis.

A Pre-Existing Condition: A condition for which medical advice, diagnosis, care or treatment was recommended or received from a Qualified Practitioner within 6 months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes prescribed medicines.

The Pre-Existing Condition limitation does not apply to pregnancy, to a newborn child who is added to this Plan's coverage within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

Pregnancy: Childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug: Any of the following:

1. A Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription";

2. Injectable insulin;

3. Hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

Provider: A Hospital, Physician or other Qualified Practitioner licensed where required and performing within the scope of the license.

Qualified Practitioner: A person who has earned the designation of a Physician, Physical, Speech, or Occupational Therapist, Anesthesiologist, Registered Nurse Practitioner, Registered Nurse Anesthetist in the absence of a billing from an Anesthesiologist, a Pathologist, Radiologist, and other duly licensed Practitioners of diagnostic care who are practicing within the scope of their license. A Qualified Practitioner may not include a Family Member. Physician Assistants assisting a Physician with a medical service or surgical procedure in the absence of another qualified physician or resident physician are not considered Qualified Practitioners by the Plan.

Service in the Uniformed Services: The performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from

a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Sickness: A bodily disorder, disease, physical illness or Mental Disorder. Sickness includes Pregnancy, childbirth, miscarriage and Complications of Pregnancy.

Skilled Nursing Facility: A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

2. Its services are provided for compensation and under the full-time supervision of a Physician.

3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

4. It maintains a complete medical record on each patient.

5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

7. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

Substance Abuse: Regular, excessive compulsive use of alcohol and/or prescribed or non-prescribed drugs, whether legal or illegal. Substance Abuse does not include nicotine addiction or caffeine over-use.

Terminally Ill: A Plan Participant who has an incurable diagnosis and a medical prognosis of a life expectancy of 6 months or less.

Third Party Administrator (TPA): Cypress Benefit Administrators

Totally Disabled: An Employee is prevented at all times from engaging in regular and customary duties of his or her job, and who is unable to engage in the regular and customary activities of a person of the same age and sex who is in good health. For a Covered dependent, "totally disabled" means that the Covered dependent cannot perform the normal activities of a person of like age and sex who is in good health. This includes attending an accredited school, university or institution as a Full-Time Student.

Uniformed Services: The Armed Forces, Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in the time of war or emergency.

Usual and Reasonable Charge: A charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same geographic area. The Plan Administrator will utilize subscribed geographic data, standard Current Procedural Terminology coding practices and data provided by the practitioner of services to determine the appropriate Usual and Reasonable Charge. In circumstances where a charge from a Qualified Practitioner is found to be

in excess of the Usual and Reasonable Charge, the Plan Administrator will consider the nature and severity of the condition being treated, and will make reasonable adjustments to the allowed amount due to medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse up to the actual charge billed if it is lesser than the Usual and Reasonable Charge. The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

In the case of a PPO Provider, Usual and Customary is the negotiated PPO discount rate for the service or procedure performed.

Waiting Period: The period of time that must pass before an individual is eligible to be covered for benefits under the provisions of the Plan.

SECTION 2

ELIGIBILITY

ELIGIBILITY

Important Notice: *Any change of eligibility for an employee or dependent must be reported to TTI, Incorporated as soon as possible following the change. Changes of eligibility include marriage, divorce, death of any person covered by the plan, birth of a child, dependent children reaching the limiting age, IRS ineligible children, total disability of any individual covered by the plan, retirement, or Medicare eligibility.*

Eligible Classes of Employees Include: All full-time employees actively at work and working 40 or more hours per week on a regular basis for the employer. Temporary, seasonal, part-time, leased (even if determined to be common-law employees) are not eligible for coverage.

Eligibility Requirements for Employee Coverage: An Employee is eligible for coverage if they:

1. Are a regular Active Employee of the Employer. An Employee is considered to be an Active Employee if he or she normally works at least 40 hours per week and is on the regular payroll of the Employer for that work; and

2. Are in a class eligible for coverage; and

3. Complete the employment Waiting Period. A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan.

Dependent Eligibility: On the date an Employee meets the Eligibility Requirements for Employee Coverage and elects to participate in the Plan, Dependents will also be eligible for coverage. The following are considered Dependents:

1. A covered employee's lawful spouse.

Working Spouse Provision – If a spouse's employer offers a medical plan for which the spouse is eligible (other than as a COBRA participant), the spouse must elect to be covered under that plan (the primary plan). This Plan will be the secondary Plan. If the spouse elects not to participate in the spouse's employer's plan even though the spouse was eligible to do so, the spouse will not be eligible for dependent coverage under this Plan. If the spouse's employer does not offer a medical plan or if the spouse is not eligible for coverage under the spouse's employer's plan, the spouse will be eligible to be covered under this Plan.

2. A covered employee's unmarried, natural born child; step-child; legally adopted child; child placed in the Employee's legal guardianship by court order; or child placed with the Employee for the purpose of adoption and for which the Employee has a legal obligation to provide full or partial support; whose age is less than the limiting age.

Children must be unable to provide their own support, or live with the covered Employee. If the covered Employee is required by court order or divorce decree to provide coverage for a child not dependent on the employee for support and maintenance, this requirement is waived for that child.

The limiting age for each Dependent child is:

1. The date the member turns 19 years of age, or

2. The date the member turns 23 years of age, if such child is in regular full-time attendance, as determined by the school, at an accredited secondary school, college or university;

Dependent children who drop below full-time student status as a result of injury or Illness will be covered through the end of the current term (semester, quarter, trimester). Dependent children will be covered for up to 120 days following the close of a school term.

If, on the date a Dependent child reaches a limiting age, all of the following conditions exist:

1. The child is mentally retarded or physically handicapped; and
2. The child is incapable of self-sustaining employment due to mental retardation or physical handicap;
3. The child is dependent on the covered employee for at least 50% support and maintenance; and
4. The child is unmarried,
5. The child is covered on the Plan on the day immediately prior to the date on which the child would lose coverage as a result of having attained a limiting age of the Plan.

The Dependent child will remain an eligible Dependent of a covered Employee. If, at any time after reaching the limiting age that Dependent child no longer continuously satisfies all of the defined conditions since reaching the limiting age, the child will not be eligible for coverage under the plan.

You must provide satisfactory proof that the above conditions exist on and after the date the limiting age is reached. Such proof may not be requested more often than annually following a period of two years from the date the first proof was first provided. You must provide the proof at no cost to the Plan. If satisfactory proof is not submitted, the child's coverage will cease as of the date the proof was due.

In any event, no person may be covered as both an Employee and a Dependent at the same time. If both parents are eligible for coverage under this plan, only one may enroll for Dependent coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Plan shall provide benefits in accordance with the applicable requirement of any Qualified Medical Child Support Order provided that such order does not require the Plan to provide any type or form of benefit, or any option under the Plan, not otherwise provided under the Plan, except to the extent necessary to meet the requirement of a law relating to medical child support described in section 1908 of the Social Security Act(as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

Any payment of benefits made by the Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient’s custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient’s custodial parent or legal guardian.

The terms “Qualified Medical Child Support Order” and “Medical Child Support Order” shall have the meanings given to them in Section 609 of the Employee Retirement Income Security Act.

An “Alternate Recipient” shall mean any child of a covered person who is recognized under a Medical Child Support Order as having a right to enroll under the Plan with respect to such covered person.

A copy of the Qualified Medical Child Support Order procedures may be obtained without charge from the employer.

PRE-EXISTING CONDITION LIMITATION

Important Notice: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan. An eligible person can prove Creditable Coverage exists by obtaining a Certificate of Creditable Coverage from his or her prior plan. Your Employer can assist any eligible person in obtaining a Certificate of Creditable Coverage from a prior plan. If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be duly notified.

As defined by the Plan, a Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received from a Qualified Practitioner within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes prescribed medicines.

Expenses for any Pre-Existing Condition incurred by an Employee or Dependent covered by the Plan will not be eligible for benefits after the effective date of coverage until the earlier of:

1. The date a covered Employee or Dependent has been continuously covered under the Plan for 12 consecutive months after his/her Effective Date of Coverage; or

2. If the Employee or Dependent is a Late Enrollee as defined by the Plan, the date the covered Employee or Dependent has been continuously covered under the Plan for 18 consecutive months.

The Pre-Existing Condition limitation does not apply to pregnancy, to a newborn child who is added to this Plan's coverage within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

ENROLLMENT

Enrollment Requirements: An Employee must enroll for coverage by filling out and signing an enrollment application.

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered *Nursery* and/or *Physician* care will be applied toward the Plan of the newborn child. If the newborn child is not considered a Timely Enrollment, there will be no payment from the Plan and the covered parent will be responsible for all costs.

***Timely Enrollment*:** An enrollment will be considered a Timely Enrollment if a completed and signed enrollment form is received by the Plan Administrator no later than 31 days after the person first becomes eligible for the coverage, either initially or under any Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

***Late Enrollment*:** An enrollment received by the Employer or Plan Administrator more than 31 days after the applicant first becomes eligible for coverage either initially or following any Special Enrollment Period is defined as Late Enrollment. Late Enrollee's will not be considered eligible and therefore will not be allowed coverage under the plan until newly eligible under a "Special Enrollment Provision".

***Special Enrollment Periods*:** The first date of coverage for anyone enrolling for coverage during a Special Enrollment Period is the Enrollment Date. Thus, there is no waiting period during Special Enrollment Periods. A Special Enrollment Period is provided for any Employee who is eligible, but not enrolled in this Plan, if each of the following conditions is met:

1. The Employee was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously

2. If required by the Employer or Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

3. The coverage of the Employee who had lost the coverage was covered under a COBRA continuation provision and the coverage under such provision terminated for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan;

   Or;

   The employee was not covered under a COBRA continuation provision and either the coverage under the other group health plan or health insurance coverage was terminated as a result of loss of eligibility for coverage (including loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; and,

4. The Employee requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above provided the Waiting Period for coverage under the Plan has been satisfied by the employee and provided acceptable written evidence that health coverage under the other group health plan did exist, the names of the individuals who were covered under such group health plan, the level of coverage

under the other group health plan (individual or family), type of coverage (medical, dental, etc.) and the date the coverage terminated.

In such instances, coverage may become effective on the day after coverage under the other previous group health plan or health insurance coverage terminated and such person will not be considered a Late Enrollee as specified in the Pre-existing Condition Limitation section of the Plan. If coverage under the Plan is elected after the time period specified in paragraph 3 above, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

FAMILY STATUS CHANGE:

An eligible dependent of a covered employee or an employee who is eligible for coverage under the Plan, may be permitted to enroll for coverage under the Plan if:

1. the employee is a covered person or the employee has met any waiting period applicable to becoming covered under the Plan and is eligible to be enrolled in the Plan, but when previously eligible, had declined enrollment for coverage under the Plan; and

2. a person becomes a dependent of the employee through marriage, birth, adoption or placement for adoption.

The dependent acquired through marriage, birth, adoption or placement for adoption (and, if not otherwise enrolled, the employee) may be covered under the Plan as a dependent of the employee.

Upon the birth, placement or adoption or adoption of a child, a covered employee may elect coverage under the Plan for his/her spouse, if the spouse is otherwise eligible for coverage.

In these instances, written application to elect coverage under the Plan must be made within 31 days after the date of marriage, birth, adoption or placement for adoption. If coverage under the Plan is elected within this time period, coverage may become effective on the date of such marriage, birth, adoption or placement for adoption and such person will not be considered a late enrollee as specified in the Pre-existing Condition Limitation section of the Plan. If the employee has family coverage in effect on the date of birth of the employee's natural child, then such child may become effective for coverage on the date of birth and the requirement to make written application for coverage for the newborn child shall not apply. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

MISCELLANEOUS ENROLLMENT PROVISIONS

Paternity: Children born outside of marriage may become eligible dependents of a covered employee who is the father. The employee must make written application to elect coverage under the Plan within 31 days of:

1) The date of a court order declaring paternity; or

2) The date the acknowledgment of paternity is filed with the Department of Health and Social Services or its equivalent is filed with the equivalent agency in another state.

If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll such child for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

EFFECTIVE DATE

Effective Date of Employee Coverage: An Employee will be covered under this Plan on the first day of the month coinciding with or following 90 days of continuous employment for the employer as an eligible employee if employee satisfies all of the following:

1. The Eligibility Requirement;
2. The Active Employee Requirement; and
3. The Enrollment Requirements of the Plan.

In certain circumstances, an Employee may become covered without completing the waiting period. In order for this to be allowed by the Plan, the waiver of this portion of the Eligibility Requirement must be made as a condition of an employment offer, and there must be a signed and dated agreement to this in writing between the Employer and the Employee. The written agreement must be dated within 10 business days of the date the Employee started work.

Effective Date of Dependent Coverage: Each dependent is *eligible* for coverage on:

1. The date the employee is eligible for coverage, if he has eligible dependents on that date;
2. The date of the employee's marriage for any dependent acquired on that date;
3. The date of birth of the employee’s natural born child;
4. The date a child is placed by a court order in the employee's home and under the employee's legal guardianship;
5. The date a child is placed in the employee's home for the purpose of adoption or is legally adopted; or
6. The date a valid court order is issued that, by federal law or plan provision, requires the plan to provide coverage for a dependent.

Dependents are covered only if the employee is also covered by the plan. If both parents are eligible for coverage under this plan, only one may enroll for dependent coverage.

An Employee’s Dependent shall become *effective* on the date a Dependent’s completed enrollment forms are received by the plan administrator, if received within 31 days of the date the Dependent first becomes eligible.

If your dependent spouse previously declined coverage under this plan and now wishes to enroll due to the birth of a dependent child or the adoption or placement for adoption of a dependent child, an additional eligibility date will be provided to allow your dependent spouse to enroll in the plan.

If your spouse applies more than 30 days after the date of birth, adoption or placement of the child, your spouse will be considered a Late Enrollee and will be subject to the same restrictions as an Employee who is considered a Late Enrollee as defined by this plan. Any other dependents that were not previously covered under the plan will also be considered Late Enrollees .

Dependent coverage will begin at 12:01 AM, Standard Time, on the dependent's effective date of coverage under the plan.

If your dependent child becomes an eligible employee of the employer, he or she is no longer eligible as your dependent and must make application as an eligible employee.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a Certificate of Creditable coverage that will provide the participant with proof of coverage under this plan.

When Employee Coverage Terminates: coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The date the Employee terminates employment.
2. The date the Employee ceases to be in a class of Employees eligible for coverage.
3. The end of the period for which a contribution for coverage has been paid if the contribution for the next period is not paid when due.
4. The date the Plan is terminated; or with respect to any Employee benefit of the Plan, the date of termination of such benefit.
5. The date the Employee enters military duty on an active duty basis, other than for scheduled drills or other training of less than 31 days, unless coverage continuation has been elected under the Uniformed Services Continuation and Reinstatement;
6. The date of the Employee's death.
7. Extension of Active Service Provisions of the Plan expires; or for any extensions of coverage (including a leave of absence) as described in the Plan which runs concurrently with the Continuation of Coverage (COBRA) provision, coverage will end on the date the extension of coverage (including a leave of absence) begins, unless otherwise specified in such provision.
8. The date on which the employee designates to terminate coverage under the plan.
9. The effective date on which a modification of the Plan terminates coverage for the class of employees or dependents to which the employee or dependent belongs.

When Dependent Coverage Terminates: Dependent coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The date the Employee terminates employment.
2. The date the Dependent ceases to be in a class of Employees eligible for coverage.
3. The end of the period for which a contribution for coverage has been paid if the contribution for the next period is not paid when due.
4. The date the Plan is terminated; or with respect to any Dependent benefit of the Plan, the date of termination of such benefit.
5. The date the Dependent enters military duty on an active duty basis, other than for scheduled drills or other training of less than 31 days, unless coverage continuation has been elected under the Uniformed Services Continuation and Reinstatement.
6. The date of the Employee and/or Dependent's death.

7. The date on which any extension of coverage expires; or for any extensions of coverage as described in the Plan which runs concurrently with the Continuation of Coverage (COBRA) provision, coverage will end on the date the extension of coverage begins, unless otherwise specified in such provision.

8. The date on which a dependent ceases to meet the definition of a dependent.

REINSTATEMENT OF COVERAGE PROVISIONS

Individual Reinstatements: If coverage ends because the employee's employment terminates, the coverage may be reinstated when the employee returns to active regular work.

He or she will be considered to be a new eligible person. All application and effective date provisions will apply.

Full-Time Student Reinstatement of Coverage: A dependent child of a covered employee may be reinstated for coverage under the Plan, if the child's coverage under the Plan terminated because the child ceased to meet the requirements of the Plan's Full-Time Student provision and subsequently the child regains status as an eligible full-time student and satisfies the other eligibility requirements of the Plan. Coverage under the Plan will become effective on the date on which the child is enrolled and accepted as a full-time student. The Pre-Existing Condition Limitation of the Plan will apply. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll the dependent child for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

TRANSFER OF RIGHTS OR BENEFITS

Only the employee and dependents as shown on this Plan's records are entitled to benefits under this Plan. These rights are forfeited if the employee or a dependent:

(1) Transfers those rights; or

(2) Aids any person in fraudulently obtaining benefits under this Plan.

The employee must reimburse the Plan for any benefits that were paid in this context.

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FAMILY AND MEDICAL LEAVE ACT OF 1993

Continuation During Family and Medical Leave: Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

For employees with one to four years of service who are on leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period. During FMLA, the employee will be responsible for any other insurance coverage premiums (i.e, dental, disability).

For employees with five or more consecutive years of service, who are on leave taken under the Family and Medical Leave Act, the Employer will maintain and pay the employee's entire health insurance contribution for the entire twelve-week leave period. During FMLA, the employee will be responsible for any other insurance coverage premiums (i.e, dental, disability).

After the twelve-week Employer Sponsored FMLA period is expired, Cobra insurance would need to be applied for. (Please note: Employees are 100% responsible for Cobra premiums).

In serious cases, twelve weeks may not be enough time to recover from certain surgeries or ailments for the employee's own serious health condition. At TTI''s discretion, the leave could be extended.

TTI's obligation to maintain health benefits under FMLA stop if and when an employee informs the employer (TTI) of an intent not to return to work at the end of the leave period, or if the employee fails to return to work when the FMLA leave is exhausted. TTI's obligation also stops if the employee's premium payment is more than 30 days late.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee when Plan coverage terminated.

UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT CONTINUATION:

A covered person who:

(a) *is employed by the employer;*

(b) *is determined by the employer to be eligible for benefits under the Uniformed Services Employment and Re-employment Rights Act of 1994;*

(c) *is absent from his or her position of employment with the employer by reason of service in the uniformed services; and*

(d) *would otherwise have his or her coverage under the Plan terminated,*

may elect to continue the coverage under the Plan that the covered person and his or her dependents had prior to such absence for a period not to exceed the lesser of:

(e) *the 18 month period beginning on the date on which the covered person's absence begins; or*

(f) *the day after the date on which the covered person fails to apply for or return to a position of employment as specified by the employer.*

The premium payment required for such coverage will not exceed 102% of the applicable premium for the period of coverage. The period of extended coverage provided for here, will run concurrently with and not in addition to, the COBRA Continuation period.

REINSTATEMENT:

Upon re-employment, coverage under the Plan may be reinstated for a person who was absent from his or her position of employment with the employer by reason of service in the uniformed services, as well as for his or her eligible dependents who were covered persons under the Plan at the time the absence began provided that:

(a) *the person was a covered person und employment with the employer commenced by reason of service in the Uniformed Services;*

(b) *the person makes application for re-employment within the time limit specified by the employer; and*

(c) *at the time the person makes application for re-employment, he or she is entitled to benefits under the Uniformed Services Employment and Re-employment Rights Act of 1994.*

In such instances, an exclusion of the Plan, Pre-existing Condition Limitation, or waiting period will not be applied, if that exclusion of the Plan, Pre-existing Condition Limitation, or waiting period would not have been applied had coverage not been terminated as a result of service in the Uniformed Services. This also applies to any eligible dependent of the covered person who becomes covered by the Plan as a result of such reinstatement of coverage.

An exclusion or waiting period may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the Uniformed Services.

COBRA
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

Continuation of Coverage Under COBRA: If you, the employee, terminates or are terminated from your employment (for reasons other than gross misconduct) or your hours are reduced, you can continue your coverage up to 18 months. If the Social Security Administration determines that you were disabled when you lost your job or within 60 days after, you and your Dependents may be eligible for 29 months of continuation. If you have Family Coverage and your Dependents lose coverage because 1) you die or are divorced, or 2) you become eligible for Medicare, your Dependents may continue coverage up to 36 months. A child who is no longer an eligible Dependent may also continue coverage up to 36 months.

Covered retirees and widows or widowers of retirees may have longer continuation rights if the Group files a Chapter 11 bankruptcy petition. You must inform the Plan Administrator if you divorce or legally separate, or if your child is ineligible within 60 days of the date it happens. The person losing coverage will be notified of the right to purchase continued coverage. He or she will then have 60 days to elect the coverage and pay the required premium, and another 45 days to pay the premium covering the time period before the election.

Premium will be no more than 102% of the Group rate (if Your coverage continues beyond 18 months because of a disability, premium in the 19th through 29th months may be 150% of the Group rate). Continued coverage ends earlier if the plan ends or if the person covered:

1. Fails to pay premium timely;
2. Becomes covered under another group health plan which contains no pre-existing condition limitations or exclusions;
3. Becomes covered under another group health plan which contains a pre-existing condition limitation or exclusion which you have satisfied pursuant to the federal Health Insurance Portability and Accountability Act of 1996, as first enacted or later amended; or
4. Becomes entitled to Medicare benefits.

Medicare: Employees aged 65 and over should go to their Personnel Office for a description of insurance options available to them. Three months before your 65th birthday, or if you are disabled upon certification of your doctor, go to the nearest area office of the Social Security Administration to enroll in Medicare. Failure to enroll in Medicare may reduce your benefits. Please see the “General Exclusions” section.

For more detail, please refer to the COBRA Continuation Options heading in the General Plan Information section of this Plan Document.

SECTION 3

COVERED EXPENSES

MEDICAL BENEFITS IMPORTANT INFORMATION

For Verification of Eligibility for Coverage: Please call 920-968-4613 or toll free 1-877-236-0844.

All benefits described in this Schedule are subject to plan Limitations and Exclusions described in detail in the Limitations and Exclusions section of this plan document. Examples of potentially excluded benefits include, but are not limited to care and treatment determined to be not Medically Necessary, charges that may be in excess of Usual and Reasonable charges, or that services, supplies and care that may be Experimental and/or Investigational.

Important Notice: *All Inpatient Hospitalizations and Inpatient Surgeries must be pre-certified or reimbursement from the Plan may be reduced. The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. Please see the Utilization Management information that immediately follows the Schedule of Medical Benefits.*

Benefit Payment: Each Calendar Year, benefits will be paid for the covered charges of a covered Employee or Dependent that are in excess of the deductible. Payment will be made at the applicable rate defined in the Schedule of Medical Benefits. No benefits will be paid in excess of any maximum benefit amount payable as illustrated in the Schedule of Medical Benefits, or elsewhere in this Plan.

Lifetime Maximum Benefit: The lifetime maximum benefit is the total amount of benefits that will be paid for any one Covered Participant during their lifetime and coverage under this Plan. The total lifetime maximum benefit is $1,000,000.

Special Consideration for Pathologists, Anesthesiologists, Radiologists, and Emergency Room Physicians: If an employee seeks care from a PPO facility, all pathologists, anesthesiologists, radiologists and emergency room physicians will be considered in-network providers, regardless of whether they participate in the applicable preferred provider network. This exception only applies when the covered person seeks care from a preferred facility, and when the covered person does not have the ability to choose their own pathologist, anesthesiologist, radiologist or emergency room physician. The exception does not apply to services received in a clinic or office setting. In this setting it is the responsibility of the covered person to ensure their preferred providers utilize preferred pathologists, anesthesiologists, and radiologists to provide diagnostic and other covered services.

Individual Lifetime Maximums on Certain Benefits: Certain benefits under the plan are limited as to the amount the Plan will pay for Covered Persons during their lifetime of coverage under this plan. The following benefits have both calendar year limitations and lifetime maximums:

Inpatient, Outpatient and Transitional Treatment of Substance Abuse / Alcoholism: $7,000 per calendar year, not to exceed a Maximum Benefit of $25,000 while covered by the Plan.

Transitional Care Mental Health / Substance Abuse / Alcoholism: Limited to 6 visits per calendar year. 1 Transitional Day = _ Inpatient Day

Skilled Nursing Facility: Limited to 120 days per calendar year.

Home Health Care: Limited to 30 visits per calendar year.

Chiropractic Care: Limited to 12 visits per calendar year.

Wellness Benefits:

Pap smears and pelvic examinations limited to one per calendar year.

Mammograms limited to two between 45 – 49 years of age; and one per calendar year for ages 50 to 65.

$200 per person Wellness benefit, no deductible. $10 Copay will apply.

INFORMATION REGARDING PPO AND NON-PPO NETWORK PROVIDERS

The Plan Sponsor has entered in agreements with one or more PPO Network Providers. The Plan Sponsor has contracted with certain medical providers who agree to provide pre-determined medical services or supplies at prices that are typically less than the prices charged to individuals who are not covered by an PPO Network Agreement. To determine if a particular medical provider participates in the local PPO Network with which the Plan Sponsor has contracted, please contact the PPO Medical Services Facilitator.

It is the choice of the covered person whether or not to use a PPO Network Provider. The Plan, Plan Sponsor and Third Party Administrator make no representations or warranties regarding the qualifications or the care provided by any provider, including those providers who participate in the PPO Network. Covered persons should make their own decisions concerning the qualifications of the providers they select to provide them with medical services or supplies.

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
Preferred Provider Network: FABOH (Fond du Lac/Milwaukee employees), CCN (Illinois employees)

NOTE:

For current plan details and deductible information, please download the Amendment from the TTI Trucking website at: http://www.ttitrucking.com/employee_info.iml

UTILIZATION MANAGEMENT

This Plan has a utilization management program, which is administered by American Health Holding. Please read this section carefully. Benefits under this Plan may be reduced if the provisions in this section are not followed.

Utilization Management is a program designed to help insure that all Covered Participants receive necessary and appropriate health care while avoiding unnecessary expenses. Utilization Management also reviews the request for a hospital admission and the number of days for the hospital stay to determine whether the admission and the number of days for the hospital stay are within the guideline of the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider. If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

Precertification is required for all inpatient hospitalizations as well as inpatient and outpatient surgeries.

Please Note: Precertification is not required for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

PRECERTIFICATION

The patient, family member, or the patient's attending physician must call the Utilization Manager, American Health Holding, prior to receiving certain scheduled treatment, or after certain emergency treatment has been initiated. The following information will be required at the time of pre-certification.

- The name of the patient
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery and/or proposed rendering of listed medical services

To Precertify a procedure or admission, call:

AMERICAN HEALTH HOLDING

24 HOUR AVAILABILITY

Phone #(888) 236-4021

This telephone number and information is also summarized on the back of your medical identification card.

Please note: If a call is received after 5:00PM there is a person in the Pre-certification department who will take information from the member calling. A Nurse is given the information the following business morning and will follow-up with a phone call to the member or provider to continue the process. The date the member attempts Pre-certification is the date noted in the Pre-Cert so no penalty would apply if done timely.

NON-PRECERTIFICATION PENALTY

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. Charges that are incurred beyond the number of days certified will not be considered eligible charges. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

Penalty. If the Covered Person does not Precertify a procedure as explained in this section, the first $500 of eligible charges for inpatient care will not be payable. The penalty may be taken from either the facility or practitioner charges and is calculated before subtracting any deductible and coinsurance amounts. The penalty will not be applied to the deductible, coinsurance or out-of-pocket maximums.

CONCURRENT REVIEW, DISCHARGE PLANNING

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been Precertified, the attending Physician must request the additional services or days.

If an extension is not certified, benefits for the extension will be payable as described under the penalty for not obtaining pre-admission certification or authorization.

All prior authorizations and Precertifications are valid for 30 days (excluding pregnancies) from the scheduled date of admission. If you are not admitted within 30 days of the scheduled date, or use a different facility, or are admitted for a different reason, another request for prior authorization or Precertification must be made.

CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting--even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

1. personal support to the patient;
2. contacting the family to offer assistance and support; monitoring Hospital or Skilled Nursing Facility;
3. determining alternative care options; and
4. assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan. The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan

Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses would not be normally paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SECOND SURGICAL OPINION

If the Attending Physician recommends elective surgery, the participant may obtain a second or third opinion from another Physician. Covered Services include charges for a consultation and necessary diagnostic services. The benefit payable for a second surgical opinion is 100% limited to a maximum of $100 after which the appropriate deductible and (In-Network or Out-of-Network) coinsurance will apply.

An elective surgery is any non-emergency surgery, which, in the judgment of the Attending Physician, can be scheduled at the participant’s convenience without jeopardizing the participant’s life or causing serious impairment to bodily function.

If the participant elects to have the proposed surgery, Covered Services include the benefits for the surgery according to this Plan, regardless of the opinion given.

APPEAL PROCEDURE

A Covered Participant or Dependent may appeal any decision made during utilization and cost containment review by following the process described in this section. All appeals should be directed to:

UM APPEALS Cypress Benefit Administrators

P. O. Box 7020

Appleton, WI 54912

Written request for an appeal must be made within 60 days of a UM decision. The request should identify the employee, the patient, the health care providers, the reasons for the appeal, applicable dates and any supporting documentation and medical records.

All information on any appeal will be reviewed by one or more UM consultants within the appropriate specialty area. The consultant(s) will review the case individually and ask for additional information if a case is not clear, including possible additional examinations. The reviewing consultant(s) will forward the results of the review to the UM manager within 30 days of receipt of all additional information that may be requested. The recommendation will be reviewed and a final decision will be forwarded in writing to the Plan Participant.

Hospital Bill Audit Incentive Program

This Plan provides incentive for helping locate billing errors on inpatient hospital bills. Examples of which are charges billed but not received and charges incorrectly totaled. If an error is properly verified, benefits are payable as stated on the Schedule of Benefits. The following procedures apply:

1. Before a covered person leaves the hospital, he or she should request an itemized bill from the Patient Accounts Department.

2. Check the bill for charges that reflect treatment or services which were not received, for example:

- verify the number of inpatient days (room and board) for semi-private or intensive care; and
- verify that duplicate charges were not made for the same services.

3. A covered person should notify Cypress Benefit Administrators by phone, within ten days of the discharge, that he/she is reviewing the bill.

4. Cypress Benefit Administrators must receive a copy of the corrected itemized bill within one month after the date of discharge. Cypress Benefit Administrators will then verify the error and reimburse the employee the eligible savings amount, as stated on the Schedule of Benefits; and

5. If Cypress Benefit Administrators personnel initiate the investigation of billing errors, the benefit will not be payable.

COVERED MEDICAL SERVICES

Medical Benefits apply when covered charges are incurred by a Covered Participant for care of an Injury or Illness and while the Participant is covered for these benefits under the Plan. The eligible charges are covered as outlined on the Schedule of Benefits and are subject to the Usual and Customary fee for that type of service. All limitations and exclusions of the Plan apply.

Covered Charges: Covered charges are the Usual and Reasonable Charges that are incurred for the following services and/or supplies: (NOTE: These charges are subject to all benefit limitations, exclusions or other provisions described within this Plan document. A charge is incurred on the date that the service or supply is performed or furnished.)

A. **Hospital Care:** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center.

Inpatient Hospital Care: Benefits are payable as defined in the Schedule of Medical Benefits for covered charges for the average daily semi-private, ward, intensive care, isolation, or coronary care room charges and general nursing services for each day of confinement. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the hospital where you are confined, unless medically necessary. Benefits are also payable for covered charges made by the hospital on its own behalf for services and supplies furnished for treatment during confinement, including charges made by a qualified practitioner for professional services of a radiologist, pathologist, and anesthesiologist, whether billed directly by the hospital or separately. Personal items which are not medically necessary are not covered.

Outpatient Hospital Care: Benefits are payable as defined in the Schedule of Medical Benefits for covered charges provided by an outpatient hospital or other qualified outpatient treatment facility. Outpatient hospital and facility services include the following: Surgical Facility Charges, Treatment or Recovery Room Charges, Urgent Care Room Charges, Hospital Clinic Charges, Diagnostic Laboratory, Radiology and Pathology, and the miscellaneous charges for medical services and supplies of a hospital or qualified facility provided on an outpatient basis. Benefits are also payable for regularly scheduled treatments received at a hospital or facility such as physical therapy, kidney dialysis, chemotherapy, inhalation therapy and radiation therapy when ordered by a qualified practitioner and rendered on an outpatient basis.

Pre-Admission Testing: Benefits are payable at 100%, not subject to deductible for pre-admission testing performed within 7 days prior to a hospital admission. Pre-admission testing is not a covered service if the tests are repeated after the participant is admitted to the hospital. Pre-admission testing services will be covered on an out-patient basis if:

1) The inpatient admission is unexpectedly cancelled; and

2) The pre-admission testing services are properly identified as such on a submitted claim.

Emergency Room Care: Benefits are payable as defined in the Schedule of Medical Benefits for the initial treatment given in a hospital emergency room for the sudden and unexpected onset of an illness or an accident causing injuries which are severe enough that a prudent layperson could reasonably be expected to seek medical attention. Hospital emergency care will be deemed necessary if care could not be safely and adequately provided anywhere other than in a hospital or if adequate care was not available elsewhere in the area at the time and place it was needed.

Important Notice: *Emergency services do not include services obtained for the convenience of, or at the preference of the covered Employee or Dependent.*

B. **Physician Care:** Benefits are payable as defined in the Schedule of Medical Benefits for covered services of a Physician for medical consultation, diagnosis and treatment. This includes services provided in a physician's office or clinic, the participant's home, a hospital, an out-patient treatment

facility or a Skilled Nursing Facility. Covered services include consultation, diagnostic testing, treatment, surgery, anesthesia, professional interpretation of test results and the administration of medication or other covered therapies and or treatments described in this plan.

Surgical Procedures: Eligible charges are covered for surgery when performed in a hospital, outpatient department of a hospital, ambulatory surgical center or clinic. Eligible charges include for example, the following: hospital pre-operative and post-operative care, cosmetic surgery required as a result of an accidental injury, functional repair of any body part to achieve normal body function, charges for an elective sterilization for a covered employee or covered dependent spouse and abortion procedures for a covered employee or covered dependent spouse when the pregnancy is considered a life threatening complication of a non-psychiatric, medical condition.

Charges for multiple surgical procedures will be a covered expense subject to the following provisions:

1) The primary surgical procedure will be compared with and re-priced to the applicable pre-negotiated rate or the Usual and Reasonable charge established for the procedure. Benefits will be reimbursed at the applicable level as defined by the Schedule of Medical Benefits.

2) Additional surgical procedures performed in the same surgical setting, on the same date of treatment, will be compared with and re-priced to the applicable pre-negotiated rate or at a level not to exceed 50% of the Usual and Reasonable charge established by the Plan for the procedure. Benefits will then be reimbursed at the applicable level as defined by the Schedule of Medical Benefits.

3) Assistant Surgeon Charges will be compared with and re-priced to the applicable pre-negotiated rate or at a level not to exceed 20% of the Usual and Reasonable charge established by the plan for the primary or additional surgical procedures. Benefits will then be reimbursed at the applicable level as defined by the Schedule of Medical Benefits.

C. **Home Health Care Services and Supplies:** The treatment must be medically necessary as determined by the Plan Sponsor or the Utilization Manager and care must be provided in lieu of Confinement in a Hospital or Skilled Nursing Facility. The diagnosis, care and treatment must be certified by the attending Physician and the Physician must file a Home Health Care plan of treatment with the Plan Sponsor or Utilization Manager. Home health care services must be provided and coordinated by a state-licensed or Medicare certified home health care agency or rehabilitation agency. Home health care services and supplies include:

1) Nursing services, which are medically necessary as part of the Home Health Care plan of treatment. These services must consist solely of caring for the covered Employee or Dependent;

2) Part-time or intermittent home health aide services which are: medically necessary as part of the Home Health Care plan of treatment, under the supervision of a registered nurse or medical social worker and which consist solely of caring for the covered person.

3) Part-time or intermittent home nursing care rendered by or under the supervision of, a registered nurse

4) Respiratory care and therapy, physical, occupational and speech therapy services;

5) Medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a hospital, if medically necessary under the Home Health Care plan of treatment. These supplies and services are covered to the extent they would have been covered if the participant had been hospitalized;

6) Nutrition counseling provided by a registered dietician where the services are medically necessary as part of the Home Health Care plan of treatment; and

7) Evaluation of the need, and development of a plan of treatment for Home Health Care by the attending Physician or by a registered nurse or medical social worker when approved or requested by the attending physician.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be. A home health provider visit of four hours or less is considered one visit. Each additional four hours of home health care on the same date of treatment will count as an additional visit. If the participant was hospitalized before the start of home care, the Home Health Care plan of treatment must be certified at the start by the Physician who was the primary provider of services during the hospitalization. The maximum weekly allowance for home care coverage will not exceed the usual and customary weekly cost for care in a Skilled Nursing Facility.

Home health care benefits do not include:

1) Food, housing, homemaker services, home-delivered meals;

2) Services of a family member;

3) Services or supplies not included in the Home Health Care plan of treatment established by the attending Physician for the covered Employee or Dependent;

4) Transportation services; or

5) Custodial care

Covered charges for a Covered participant's home health care limited to 40 visits per calendar year.

D. **Skilled Nursing Facility Care:** Benefits are payable as defined in the Schedule of Medical Benefits for room, board and nursing care furnished by a licensed Skilled Nursing Facility when all of the following conditions are met:

1) The confinement begins while the Covered Participant is covered under this Plan;

2) the Covered Participant is hospital confined for at least 3 days;

3) the confinement begins within 7 days after discharge from a hospital confinement and is for the same condition as treated in the hospital or previous Skilled Nursing Facility;

4) the attending Physician files with the Plan Administrator or Utilization Manager a treatment plan that includes diagnosis, the proposed course of treatment, and projected discharge date from the Skilled Nursing Facility;

5) the Covered Employee or Dependent remains under the constant care and supervision of the attending Physician. The attending Physician must provide proof of medical necessity to the Plan Administrator or Utilization Manager on a weekly basis.

Covered charges for a Covered participant's care in these facilities are limited to 120 days per calendar year.

E. **Pregnancy:** Benefits are payable as defined in the Schedule of Medical Benefits for services rendered by a hospital or physician to a covered employee, or covered dependent spouse or daughter for the treatment of normal pregnancy, complications of pregnancy, interruptions of pregnancy and nursery care of a newborn child. Benefits are payable the same as they are for any other covered medical condition.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

F. Inpatient, Transitional and Outpatient Treatment of Mental Health and Substance Abuse:

Inpatient and Transitional Treatment of Mental Health and Substance Abuse: The deductible and coinsurance apply as defined in the Schedule of Benefits section of this document. Transitional is limited to $7,000 per calendar year. Substance Abuse is limited to the maximum benefit amount specified by the plan. One day of Transitional treatment shall count as one-half day of Inpatient Treatment.

Outpatient Treatment of Mental Health and Substance Abuse: The deductible and coinsurance of 80% (in-network) and 60% (out of network) applies as defined in the Schedule of Benefits section of this document. Outpatient treatment is limited to a maximum of $7,000 per calendar year. Substance Abuse is limited to the maximum benefit amount specified by the plan.

When multiple charges and diagnoses are received for outpatient services and supplies that have been provided for either or both Mental Health and Substance Abuse, outpatient benefits under the plan will be determined according to the provider's primary diagnosis listed for that date of service.

The determination of whether a claim for benefits is covered by and subject to the Mental Health benefit shall be made without regard to whether the cause of the condition for which treatment and supplies were provided is, or was, organic in origin.

G. **Other Medical Services and Supplies:** Benefits are payable for the following services and supplies rendered for a covered Employee or Dependent. These services are not otherwise included in the items above. Coverage is subject to the satisfaction of all plan provisions, including but not limited to the Limitations and Exclusions of the Plan:

1) **Ambulance Services:** Local or remote, Medically Necessary, professional land or air ambulance service when the covered Employee or Dependent's covered condition does not permit the use of less costly methods or transportation. Air or ground transportation must be to the nearest hospital qualified to provide treatment for the injury or illness. If the injury or illness requires special treatment which is not available in a local hospital, transportation to the nearest hospital equipped to provide treatment is covered.

2) **Allergy Testing:** Allergy tests for diagnosing disease.

3) **Anesthetics:** Eligible charges are covered for anesthesia and its administration when rendered by a provider who is licensed to perform these services.

4) **Blood and blood derivatives:** Benefits are not available for Blood or Blood derivatives that are donated or replaced other than the covered person's or that which has been donated specifically for the covered person. Administration of Blood or Blood derivatives is included.

5) **Cardiac Rehabilitation:** Medically Necessary Cardiac Rehabilitation services rendered under the supervision of a Physician. Cardiac Rehabilitation must begin within 3 months of hospital confinement for myocardial infarction, coronary artery bypass graft, or coronary angioplasty.

6) **Chemotherapy or Radiation Therapy:** Treatment FDA approved, non-experimental or non-investigational chemical or radioactive treatment. The materials and services of technicians are also included.

7) **Chiropractic Care:** Chiropractic care including x-rays, manipulations and supportive care.

8) **Contact Lenses:** Initial Contact lenses or glasses required for aphakia, keratoconus or following cataract surgery.

9) **Dental Services:** Any medically necessary inpatient hospital charges for dental services including x-rays, lab services and local or general anesthesia. Charges for services rendered by a Dentist for the treatment of, and replacement of, natural teeth or for setting of the jaw, if the dental services are the result of an accidental injury. Services must be performed while covered under the Plan and be within 12 months after the accident. Covered Services do not include dental services to the extent that benefits are provided to the covered Employee or Dependent under a group dental insurance plan.

10) **Diabetic Equipment and Supplies:** Equipment and supplies used in the treatment of diabetes. This includes the installation and use of an insulin infusion pump and diabetes self-management programs if medically necessary and prescribed by a Physician. Insulin pump coverage is limited to the purchase of one pump per calendar year, provided the pump is used for 30 days before purchasing it. Benefits are not payable under the Medical Plan for any Diabetic Equipment and/or Supplies reimbursed by the Prescription Drug Coverage.

11) **Diagnostic Services:** Diagnostic laboratory, pathology and x-ray services by a hospital, physician or other qualified provider.

12) **Hospice:** Covered Services for Hospice care are available for Covered Participants while covered by the Plan and subject to the benefits outlined in the schedule of benefit section of this document. The attending Physician must certify the covered Employee or Dependent is terminally ill and life expectancy is 6 months or less. This Plan shall provide benefits for Hospice care services received in:

    a. A Hospital;

    b. An approved Hospice care facility that operates as an integral part of a Hospice care program; or

    c. The Participant's home for a Participant who is able to remain at home. In such event, the Home Health Care benefits payable under other provisions of this Plan shall apply to Hospice care.

    The following Hospice care customary charges incurred by the Participant are payable:

    a. Room and board charged by the Hospice;

    b. Services and supplies;

    c. Part-time nursing care by or under the supervision of a registered graduate nurse;

    d. Home Health Care services as provided in this Plan; and

    e. Counseling services by a licensed social worker or a licensed pastoral counselor.

    For purposes of these benefits, "Hospice" means a facility that provides counseling, incidental medical services, and room and board to the terminally ill. The Hospice must:

    a. Have obtained approval of any required state or governmental agency;

    b. Provide a certificate of need;

c. Provide 24 hour, 7 days a week service;

d. Have a nurse coordinator who is at least a registered nurse (RN);

e. Have a social service coordinator who is licensed in the area in which the Hospice provider is located;

f. Be established as an agency whose primary purpose is providing Hospice services;

g. Have a full-time administrator;

h. Maintain written records of services provided to the Participants;

i. Be established and operated in accordance with the applicable laws in the area in which it is located.

13) **Injections** of medication when related to a covered illness or injury.

14) **Kidney Dialysis:** Hospital, surgical and other necessary medical charges, including rental of kidney dialysis equipment incurred for kidney dialysis treatment.

15) **Medical Care Provided By The United States:** The Plan will reimburse eligible charges for medical care rendered by the Veteran's Administration for a non-service related illness or injury. The Plan will also reimburse eligible charges for medical care rendered by the United Sates to military retirees and dependents who are covered by this Plan on an inpatient basis

16) **Medical Tests, Devices and Procedures:** Medical tests, devices and procedures are covered as specified in the Schedule of Benefits or other medical services sections of the Plan, provided they are not excluded by any provision of the Plan.

17) **New Drugs:** The Plan does not distinguish between "new" drugs or pharmaceuticals and existing drugs or pharmaceuticals when determining whether the drugs or pharmaceuticals are covered. New and existing drugs and pharmaceuticals are covered as specified in the Schedule of Benefits or other medical services sections of the Plan, provided they are not excluded by any provision of the Plan

18) **Occupational Therapy:** Therapy must be provided by a licensed occupational therapist, must be ordered by a Physician, and must be Medically Necessary treatment of an Injury or Illness. Occupational Therapy must be focused on improving a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

19) **Oral Surgery Services:** Eligible charges are covered for the following oral surgical procedures:

    a. surgical exposure or extraction of impacted teeth

    b. treatment of injuries to natural teeth including replacement of such natural teeth. Eligible charges must be incurred while covered under the Plan and within six months of the accidental injury.

20) **Organ Transplants:** Organ Transplants and implants of non-experimental, non-investigational human-to-human tissue and organ transplants. The procedure must be done at a facility known as having an effective program for performing such a procedure and the Covered Employee or Dependent must be a likely candidate for a successful outcome. Coverage for Organ Transplants is limited to: *skin and bone grafts, vein grafts, heart, heart/lung, liver, lung, pancreas, kidney and bone marrow transplants*.

The attending Physician must certify and it must be determined by the Plan Administrator, Case Manager or Medical Consultant contracted by the plan that the transplant is Medically Necessary in order for coverage to be provided by the Plan. Donor benefits are not available if provided by any other source. Covered services do not include the purchase price of an organ that is sold rather than donated.

When a donor or recipient is involved, charges are covered as follows:

a. When both the recipient and the donor are covered by the Plan, each is entitled to benefits under the Plan.

b. When only the recipient is covered by the Plan, the covered person who is the recipient is entitled to the benefits under the Plan and the donor is entitled to certain limited benefits as specified by the Plan. In this instance, for the donor, only those eligible charges for services to donate the human organ or tissue will be covered. The donor will be eligible for these specified benefits under the Plan only if such charges are not covered for the donor from any other source, including for example, any insurance coverage, employee benefit plan or government program. Eligible donor charges covered by the Plan will accumulate toward any maximum applicable to the covered person who is the recipient.

c. When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan, however, any other source of coverage available to the donor will be considered the primary payor of benefits and this Plan will be the secondary payor of benefits. No benefits are provided to the non-covered transplant recipient.

If any organ or tissue is sold rather than donated to a covered recipient, no benefits are payable for the purchase price of such organ or tissue, however, the costs related to the evaluation and procurement are covered for the recipient.

Eligible charges related to an organ or tissue transplant include, for example, hospitalizations, supplies and medications which are dispensed while either an inpatient or outpatient in a medical facility. Benefits will not be duplicated if they are available from another plan, an organization or Medicare.

Other Covered Services include:

a. Organ/tissue procurement (including typing and acquisition, up to a maximum of $10,000 per procedure;

b. Transportation of the Plan Member and a companion to and from the site of the transplant if the Plan Member's home is located 50 or more miles from the site of the transplant. Transportation charges are limited to: Airline Travel – coach class only, lowest available airfare; car rental – economy class only. If a car is rented no other transportation charges will be covered; and, in lieu of a car rental, taxi service to and from the airport to the hotel and/or transplant facility. If a more economical transportation service such as a hotel shuttle is available, taxi services will not be reimbursed by the Plan;

c. Costs of lodging and meals (excluding alcohol) for the Plan Member and one Companion. The total payable per day shall not exceed $250 per day and a maximum of $8,000 per procedure. *(Although this travel companion benefit does not affect the lifetime maximum benefit under the Plan, benefits may be taxable income to the covered person. Please consult your tax advisor.)*

d. Private duty nursing up to a maximum of $10,000 per procedure;

e. Medical supplies, services and room and board in a Hospital or an alternate treatment setting approved by the Plan; and

f. Drugs and Physician charges.

Pre-authorization of benefits is required for any transplant procedure.

19) **Orthopedic** braces, trusses, crutches, splints, and casts.

20) **Oxygen:** Including the administration and supplies associated to the administration of Oxygen.

21) **Physical Therapy:** Therapy must be provided by a licensed physical therapist in accordance with a Physician's exact orders as to type, frequency and duration of care. Treatment must be medically necessary treatment of a covered illness or injury and must improve a body function.

22) **Prescription Drugs**: Charges for drugs and medicines that are required by law to be obtained on the written prescription of a Qualified Practitioner are payable as described in the Prescription Drugs section of this Plan Document.

23) **Prosthetic Devices:** Prosthetic Devices and supplies which replace all or part of an absent body limbs and/or eyes (including contiguous tissue) or replace the function of a permanently inoperative or malfunctioning bodily limb and/or eye. Only the initial purchase of a Prosthetic Device is a Covered Expense. This Plan does not cover the replacement or prosthetic devices for any reason, other than pathological change due to a disease process. Covered services also include cleaning and repair of prosthetic devices, unless the damage is the result of a covered Employee or Dependent’s negligence or abuse of the prosthesis.

24) **Reconstructive Surgery**: Reconstructive surgery to correct deformity resulting from disease, trauma or a previous therapeutic process covered by this Plan, correction of congenital conditions intended to help the covered Employee or Dependent regain normal body function. This benefit includes coverage for reconstructive mammoplasties.

    In order for coverage to be provided to correct a deformity resulting from disease, trauma, or therapeutic process, it must be determined that the condition occurred while the Employee or Dependent was effective under this Plan and while the Employee or Dependent was continuously covered under this Plan.

    Mammoplasty coverage will include reimbursement for:

    a. Reconstruction of the breast on which a mastectomy has been performed,

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

    Coverage of prostheses and physical complications during all stages of mastectomy, including lymph edemas, in a manner determined in consultation with the attending Physician and the patient

25) **Rental of Durable Medical Equipment:** Rental up to the total purchase price or purchase when approved by the Plan Sponsor or Utilization Manager of durable medical equipment. The equipment must be needed for therapeutic treatment, be able to withstand repeated use, be primarily and customarily used to serve a medical purpose, and not generally useful to a person except for the treatment of an injury or illness. Covered Services also include oxygen and rental of equipment for its administration, rental of equipment to treat respiratory paralysis and rental of radioactive substances. All Durable Medical Equipment must be prescribed by a Physician or other licensed provider, and be

certified by the Plan Sponsor or Utilization Manager as medically necessary. This certification does not in itself entitle the participant to benefits.

Durable medical equipment includes only those items approved as covered items under Medicare Part B. Covered Services also include repair of durable medical equipment, unless damage results from the participant's negligence or abuse of the piece of equipment.

Durable medical equipment does not include self-help devices not chiefly medical in nature, items for comfort or convenience, physician's equipment, disposable supplies unless provided in connection with direct physician care or covered home health care, or exercise and hygienic equipment.

26) **Routine Preventive – Wellness Care**: Preventive/ wellness care is provided in the absence of a physical complaint or diagnosis. Covered Services include routine physical examinations, routine well child examinations, routine mammograms, routine pelvic exams and pap tests, routine prostate and colon cancer screenings, other related x-ray and laboratory services, and routine immunizations.

27) **Special Supplies**: Coverage for supplies such as; catheters, colostomy bags, rings and belts and flotation pads are covered when prescribed by the attending physician.

28) **Speech Therapy**: Services of a Legally Qualified Physician or qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Injury or Illness (other than a functional nervous disorder) or due to Surgery as a result or an Injury or Illness. If the speech loss or impairment is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

29) **Sterilization Procedures:** Vasectomies and tubal ligations, for covered employees and covered dependent spouses only. Reversal of sterilizations is not covered by the plan.

30) **Surgery and Surgical Dressings:** Splints, casts and other devices used in the reduction of fractures and dislocations. Surgical services by a hospital, ambulatory surgical facility, physician or other qualified provider. Covered Services include pre- and post-operative services.

31) **Taxes:** Charges or taxes legally imposed by a governmental entity including those calculated on the amount of eligible charges paid for a covered person under the Plan.

32) **X-ray**: Diagnostic, x-ray, laboratory and related radiology and pathology services when rendered for the diagnosis and treatment of an illness or injury.

SECTION 4

MEDICAL LIMITATIONS AND EXCLUSIONS

PLAN EXCLUSIONS AND LIMITATIONS

Note: In addition to the Exclusions listed below, exclusions related to Prescription Drugs are also shown in the Prescription Drug Plan section of this document.

Charges for the following are not covered:

Abortions, except where the life of the mother would be endangered if the fetus were carried to term.

Acupuncture therapy, except when used as an anesthetic in place of anesthesia services that would have been covered by the Plan.

Services or Supplies received **After the Termination of Coverage.**

Biofeedback Therapy.

Birth control devices, implants and injectables unless described as covered elsewhere in the Summary Plan Document.

Chelation Therapy. Unless care is received for the treatment of heavy metal poisoning.

Chiropractic Care. Charges for care received in excess of any limitation as described in the Schedule of Benefits in the Covered Expenses portion of this Plan Document.

Cochlear implants and all health care services provided in connection with cochlear implants.

Complications. Services, Supplies or Equipment rendered for a **complication resulting from the treatment of a non-covered service**, even though the services, supply or equipment would otherwise be a Covered Expense.

Cosmetic or plastic surgery including any services or supplies related to, resulting from complications of or for reversal of cosmetic surgery, unless for reconstructive surgery due to injury or infection or other disease of the involved part which occurs while covered under the Plan. This exclusion includes breast reduction surgery unless deemed medically necessary. This exclusion does not apply to breast reconstruction following mastectomy.

Court Ordered Treatment or Care. Charges for consultation, treatment, services or supplies ordered by a court of law or performed pursuant to a Federal, State or Local statute or regulation. This includes voluntary or involuntary evaluation for commitment or detention.

Custodial care. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care. Custodial institutions or residential treatment facilities.

Dental Care. Treatment to the teeth, nerves and roots of the teeth, gums or other gingival tissues, or the supporting structures of the teeth (alveolar processes), except as specifically described as a Covered Expense in the Covered Expenses Section of this Plan. Dental Implantology techniques, including prosthetic devices related to such techniques and dental repair of a participant's sound natural teeth due to an accident caused by chewing resulting in damage to a participants sound natural teeth is also excluded.

Dependent Who Does Not Meet the Definition of a Dependent. Charges for a fiancé, companion whether living in your home, child or grandchild who does not meet the definition of a covered dependent as set forth in the Eligibility section of this Plan Document.

Developmental and neuroeducational testing or treatment.

Educational or Vocational Testing. Services for educational and/or vocational testing or training, recreational training and work hardening programs. Except for self-management programs for diabetics.

Exercise programs. Exercise programs *for* treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy as described in the Covered Expenses section of this Plan. Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs and all related material and products for these programs are also excluded.

Expenses reimbursed by a public program, national, state or local government, except Medicare.

Experimental / Investigational. Care and treatment that is Experimental/Investigational, as defined by the Plan in the Definitions Section of this Plan Document.

Extension of Benefits. Expenses for which a Covered Person is entitled to receive benefits during any extension of a prior medical or dental plan.

Eye refractive disorder. Services unless otherwise described as covered in the Covered Expenses of this Plan Document. Radial keratotomy, laser surgery or other eye surgery intended correct refractive disorders of the eye. Also, lenses and contacts for the eyes and exams for their fitting. This exclusion does not apply to aphakic or keratoconus patients and soft lenses or sclera shells intended for use as corneal bandages following cataract surgery.

Charges for **failure to keep a scheduled appointment, phone consultations, completion of claim forms or return to work or school forms;**

Family Counseling or any health care received by a covered person as collateral care to a person not covered by this Plan.

Foot care. Health care services provided: (a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet which are billed as routine and not associated with a medical diagnosis; (b) in the cutting or trimming of toenails which are billed as routine or associated with a medical diagnosis, except for the medical diagnosis of diabetes; and (c) in the non-operative partial removal of toenails which are billed as routine or not associated with a medical diagnosis, and (d) special shoes or devices and charges for orthotics.

Foreign travel. Planned consultation, care, treatment or supplies received outside of the United States.

Genetic testing or counseling, unless medically necessary to treat the illness or injury of a covered Participant or used in the management of a high-risk pregnancy.

Government Provided Care. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician or caused by a covered injury or illness.

Health care services provided while imprisoned. Any health care services received while held imprisoned, or detained in a local, state or Federal penal or other correctional institution, or while in the custody of law enforcement officials, except as specifically stated in Wisconsin Statutes 609.65. Persons on work release are not considered to be held, detained or otherwise imprisoned.

Hearing aids. Charges for services or supplies in connection with hearing aids or their fitting, including internal and external mechanical devices, whether removable or surgically implanted.

Holistic Medicine. Any charges for holistic medicine or other programs with an objective to provide complete personal fulfillment.

Homeopathy. Colon Therapy, Reiki or Visualization Sessions or any other homeopathic treatment is not covered.

Housekeeping, shopping or **meal preparation** services, unless specifically covered elsewhere in the plan**.**

Hypnotism. Charges for hypnotism, any other behavioral modification program.

Illegal acts. Charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior unless the injury or illness results from an act of domestic violence. This exclusion includes the operation of a motor vehicle while legally intoxicated, or any injury or illness sustained as the result of the illegal use of prescription or non-prescription drugs.

Indirect services of a Physician. Including but not limited to creation of lab standards, procedures, and protocols; calibrating equipment; supervising the testing; setting parameters for test results; and reviewing quality assurance data.

Infertility. Any diagnosis, treatment, services, procedures or supplies rendered for the purpose of assisting a covered person with achieving pregnancy. This Plan also does not cover any artificial means of achieving pregnancy including but not limited to artificial insemination, in vitro fertilization, GIFT, treatment to enhance sperm production or motility, and for other infertility treatments and drugs.

Learning Disability. Services for diagnostic evaluations, hearing testing, speech or physical therapy or other treatment or therapy for **learning disabilities, communication delays, perceptual disorders, sensory deficits** when not medically necessary.

Marital Counseling. Charges for marital counseling.

Massage Therapy. Services received from a **Masseur or Massage Therapist.**

Maximum Benefit. Charges in excess of any maximum benefit as shown in the Schedule of Medical Benefits in the Covered Expenses section of this Plan Document.

Medicare is Primary. If a covered person is eligible for Medicare Parts A and B, and Medicare is the primary payor of benefits according to Federal Law, no benefits are available under this Plan for charges, services, supplies, or equipment for which the participant or an assigned provider of care would have been reimbursed under Medicare part A or B. This exclusion applies, regardless of whether the Medicare eligible person actually applies for such coverage. In addition, no coverage is available for services, supplies or equipment Medicare has found to be excluded from coverage or not medically necessary treatment of an illness or injury. The Plan does provide benefits in coordination with Medicare, up to 100% of the eligible charge determined by Medicare. Additional information regarding the coordination of benefits with Medicare is under the heading of Coordination of Benefits in the General Plan Provisions section of this Plan Document.

Military Service Related Injury or Illness. Services, supplies or equipment provided to a Covered Person when such care is related to an injury or illness that is the result of Military Service, whether past or present. The Plan also does not cover care furnished by a Hospital or facility operated by the United States Government, any foreign government, or any authorized agency of the United States Government, to the extent the Plan is legally allowed to exclude these charges.

No charge. Care and treatment for those made by a person, hospital, or entity normally making no charge for medical care, regardless of the patient's financial ability, if the patient has no insurance for medical care. This limitation will not apply where specifically prohibited by applicable statutes;

Non-compliance with Primary Plan. Any charges that would have been paid by a primary insurance plan if the covered person had complied with all the rules established by that plan. This includes but is not limited to penalties for non-precertification. For more information regarding the determination of primary versus secondary insurance plans, refer to the Coordination of Benefits heading in the General Plan Information section of this Plan Document.

No obligation to pay. Charges or expenses for which the covered person (or the covered person's parent or guardian in the stance of a minor dependent) is not legally bound or obligated to pay or which are for medical care furnished without charge, paid for, or reimbursable by or through the government of a nation, state, province, county, municipality or other political subdivision, or instrumentality or agency of such government This limitation will not apply where specifically prohibited by applicable statute.

No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

Non-Compliance with the Precertification requirements of the Plan. Coverage is not available for charges applied towards the satisfaction of the penalty described by the plan for non-precertification. The penalty for non-precertification is defined under the heading of Utilization Management in the Covered Expenses section of this Plan Document.

Charges for services **not documented in provider records**.

Not Medically Necessary. Services and supplies not in connection with a covered Medical Service, or for services deemed not medically necessary treatment of and injury or illness as defined in the Definitions section of this Plan Document.

Not specified as covered. Services, treatments and supplies which are not specified as covered under this Plan.

Nuclear Accident. Explosion, nuclear accident or disaster, nuclear fallout due to actions by armed forces of any country.

Nutritional Supplements, or Nutrition Replacement Formulas regardless of medical necessity.

Occupational. Care and treatment of an Injury or Illness arising from or sustained in the course of any occupation or employment for wage, profit or gain, for which benefits are payable under any Workers' Compensation or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits. In addition, no coverage is payable for care and treatment of an Injury or Illness arising from or sustained in the course of self-employment regardless of the presence of Workers' Compensation or other 24 hour Occupational Injury coverage.

Oral surgery treatment not specified as covered by the plan.

Organ transplants. Services, supplies or equipment for organ transplants other than those transplants specifically defined as covered in the Covered Expenses section of this Plan Document.

Other Insurance. Charges reimbursable under a No-Fault automobile coverage**.** This exclusion also applies to homeowner, boat, recreational vehicle, aircraft and other similar insurance coverages

Over the Counter or non-prescription medications, vitamins and supplements.

Participating in a Riot. Charges for illness or injury resulting from a Covered Person participating in a riot or public disturbance.

Personal comfort items. Charges for the purchase or rental of personal comfort items are not covered by the plan. A personal comfort item is a medical or non-medical item that may be intended for a medical purpose; however, is not specifically designed solely for that medical purpose. A personal convenience item may be useful to other persons who do not suffer from the same illness or injury as the Covered Person receiving the item. Examples of Personal Comfort Items include but are not limited to hygiene items or other equipment, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, physical fitness equipment, whirlpools, first-aid

kits, televisions, telephones, disposable supplies (other than colostomy supplies) and non-hospital adjustable beds.

Pre-Admission or Concurrent stay review. Charges for these services by a provider or facility will not be covered under this Plan.

Pre-existing conditions. Services, supplies or equipment for pre-existing conditions as defined in this Plan Document including treatment for any complications of such pre-existing conditions.

Prescription drugs, except as specified in the Prescription Drug Benefit Section of this Plan Document.

Services or supplies received **Prior to the Effective Date of Coverage.**

Private duty nursing. Charges in connection with care, treatment or services of a private duty nurse while confined in a hospital or other qualified treatment facility, unless otherwise defined as covered in the Covered Expenses section of this Plan Document.

Private Room. Charges for a private room in a Hospital unless otherwise specified as covered in the Covered Expenses section of this Plan Document.

Professional Services from a Hospital. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Reconstructive surgery is excluded from the plan, except for such surgery required: a) to repair a significant defect caused by an injury; or b) to repair a defect caused by a congenital anomaly causing a functional impairment of a dependent child; or c) as a result of a covered mastectomy; or d) due to a physical illness.

Recreational Therapy, Educational Therapy, Physical Fitness or other Health programs, except as specifically stated as covered elsewhere in the Plan.

Relative giving services. Professional services rendered by a family member.

Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change rendering the original device no longer functional.

Reversal of Sterilization. Care and treatment for reversal of a prior vasectomy, tubal ligation or other sterilization procedure.

Rogaine, Minoxidil or their medical equivalent in the topical application form, unless medically necessary.

Rolfing. Or deep tissue massage.

Room, board, and general nursing care for hospital admissions. When provided mainly for physical therapy or for diagnostic studies;

Routine Care. Services and supplies rendered primarily in the absence of a physical diagnosis or complaint, except as otherwise described as covered in the Covered Expenses section of this Plan Document.

Services from an Employer, Mutual Benefit Association, Labor Union, Trust or Academic Institution. Consultation, treatment, services or supplies received from a dental or medical department that is established by or is maintained by your employer, a mutual benefit association, a trust, an academic institution, or a similar person or group. This exclusion of benefits does not include care received from your employer if your employer is a Hospital, Medical or Dental clinic.

Sex changes. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery,

medical or psychiatric treatment, and the treatment of complications suffered as a result of such procedures.

Sexual dysfunction. Health care services including but not limited to surgical services, hormone therapy and devices in connection with sexual dysfunction including but not limited to impotence, or for the purpose of enhancing or affecting sexual performance, regardless of whether the origin of the sexual dysfunction is organic or psychological in nature including but not limited to penile implants and sex therapy. However prescription legend drugs (other than Viagra) used in the treatment of impotency are covered under the plan.

Sleep Disorders. Care, treatment and therapy for sleep disorders unless deemed Medically Necessary for the treatment of a covered illness or injury.

Please note: The testing and treatment of Sleep Apnea will be covered under the standard provisions of the plan. Any DME rental related to the treatment of Sleep Apnea will be covered on a "rent to own" basis.

Smoking Cessation. Charges for smoking cessation, including deterrents.

Stand-by Surgical Team. Charges received from a stand-by surgical team.

Medications, drugs or hormones to **stimulate human biological growth**, unless there is a formal laboratory certified diagnosis of human growth hormone deficiency.

Surrogate mother. Treatment, services or supplies for a surrogate mother or any pregnancy resulting from a participant's services as a surrogate mother.

Telephone, Internet or Computer consultation charges.

Third Party Exams. Charges for third party exams including but not limited to premarital tests or exams; exams or tests for adoption, routine physical exams for travel, employment or purchase of insurance; immunizations required for employment or travel; school sports physicals when other routine care has already been received by the Covered Person during the calendar year.

TMJ Treatment. Surgical and Non-surgical treatment, therapy, supplies and appliances rendered for any condition of the jaw joint or surrounding skeletal structures including temporomandibular joint disorder, craniomaxillary or craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull.

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for services described as covered elsewhere in the plan.

The part of an expense for care and treatment of an Injury or Illness that has been determined is excess of the **Usual Reasonable and Customary Charge** payable by the plan.

Vision therapy.

War. Any loss that is due to a declared or undeclared act of war or service in the armed forces of any country or state.

Weekend Hospital Admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This exclusion does not apply to pregnancy, scheduled surgery that occurs within 24 hours of admission, or emergency admissions.

Weight loss or dietary control programs nutrition counseling, individual or behavior modification therapy, body composition or underwater weighing procedures, exercise therapy, diet supplements or treatment. Surgery including but not limited to stomach stapling, gastric bubble, intestinal or stomach

bypass or liposuction is not covered under this plan, whether or not it is, in any case, a part of the treatment plan for obesity or for another Illness.

SECTION 5

PRESCRIPTION DRUG COVERAGE

PRESCRIPTION DRUG BENEFITS

Retail: Serve You Custom Prescription Management will administer the Prescription Drug Plan. When you have a prescription filled at a participating or network pharmacy, benefits for prescription drugs are payable as described below:

1. When your doctor prescribes prescription drugs for a covered injury or sickness, the Plan will pay benefits after you pay as shown on the Schedule of Benefits and on your member ID card when filled at a member pharmacy.

   For a Generic Drug prescription order or for a Brand Name Drug prescription order, outside databases used by Serve-You to process drug claims shall determine the Brand Name or Generic status of each particular drug. Each designation, as updated from time to time, shall be final as the determination of each drug's brand name/generic status.

2. You must show your ID card to the member pharmacy and sign any required form at the pharmacy in order for benefits to be paid under the program.

3. The covered person is responsible for copay or coinsurance payment of the prescription as specified on the Schedule of Benefits, at the point of service, and when ordering from the mail service.

Prescription Order means each separate written drug or refill for Legend Drugs and Medicines legally requiring a doctor's written prescription, and/or injectable drugs, including but not limited to insulin, prescribed by a doctor; or compounded medications that contain at least one Legend Drug, unless otherwise excluded.

Legend Drugs and Medicines mean covered drugs and medicines which will have the words "Caution: Federal Law Prohibits Dispensing without Prescription" printed on the manufacturer's original label.

Eligible prescription drugs through Retail Pharmacy are as follows:

1. Federal legend drugs;
2. Compounded medication of which at least one ingredient is a prescription legend drug;
3. Anorectics. Prior authorization is required;
4. Retin A; limited to age 35. Over age 35 covered by prior authorization for Medical Necessity;
5. Alcohol dependency therapy;
6. Smoking deterrents, up to 90 days supply per lifetime;
7. Nutritional supplements, including Prenatal vitamins; Note: prescription vitamins other than prenatal are not covered;
8. Insulin;
9. AIDS-related drugs;
10. Hyperactivity drugs (Methylphenidate, Dexedrine, Desoxyn);
11. Human growth hormone, by prior authorization;
12. Schedule V (cough medicines with codeine);
13. Diabetic supplies; and

15. Insulin syringes.

PRESCRIPTION MAIL DELIVERY PROGRAM

Mail Order: Serve-You Prescription Benefits will administer the mail order prescription drug program. All mail order prescription drug claims will be submitted directly to Serve-You. To obtain the appropriate paperwork for submission of the Mail-order Prescription, you may visit your HR Department or contact Serve-You via phone 1(800) 759-3203. Under this benefit, the covered person is responsible for the prescription drug co-payment as specified on the Schedule of Benefits. After satisfaction of the listed co-payment, eligible charges are covered at 100%.

Covered Drugs: Any drug which by Federal law requires a doctor's prescription and is covered by your Plan.

Drugs not Covered: Any drug which can be purchased over the counter without a prescription, or is excluded by your Plan.

Eligible prescription drugs through the Mail Order Program are as follows:

1. Federal legend drugs;
2. Compounded medication of which at least one ingredient is a prescription legend drug;
3. Anorectics. Prior authorization is required;
4. Retin A; limited to age 35;
5. Alcohol dependency therapy;
6. Smoking deterrents, up to 90 days per lifetime;
7. Nutritional supplements;
8. Insulin;
9. Prenatal vitamins;
10. AIDS-related drugs;
11 Hyperactivity drugs (Methylphenidate, Dexedrine, Desoxyn), to age 18;
12 Human growth hormone, by prior authorization;
13. Schedule V (cough medicine with codeine);
14. Diabetic supplies; and
15. Insulin syringes.

Mail Order Prescriptions should be submitted directly to SERVE-YOU at the following address:

SERVE-YOU PRESCRIPTION BENEFITS

P O Box 240034

Milwaukee, WI 53224

(888) 243-6890

LIMITATIONS AND EXCLUSIONS OF THE PRESCRIPTION PLAN

The following charges are not covered and no benefit will be paid with respect to them, except as noted:

1. Any prescription dispensed prior to the covered person's effective date or after the termination date of coverage;
2. Charges for the administration or injection of any drug;
3. Refills of covered drugs which exceed the number that the prescription order specifies or refills of covered drugs after one year from the date of the original prescription;
4. Covered prescription drugs which are not customarily charged for, or for which the provider's charge is less than the required co-payment;
5. Charges arising out of, or in the course of, any occupation or employment for wage or profit, or for which the covered person is entitled to benefits under any Workers' Compensation, Occupational Disease Law or similar laws, regardless of whether such policies are in force and regardless of whether benefits are claimed or not;
6. Charges furnished or covered by, or on behalf of, the United States, or any state, province, or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance;
7. Charges incurred for which the covered person is not, in the absence of this coverage, legally obligated to pay or for which a charge would not ordinarily be made in the absence of this coverage;
8. Covered prescription drugs or medicines covered by Medicare, if you are covered by or are eligible to be covered by either, Part A or B of Medicare, but only to the extent benefits are, or would be, available if you had applied for Medicare;
9. Charges incurred due to an illness or injury which results from war, declared or undeclared, any act incident to war, and any injury or illness occurring, or arising from, service in the armed or military forces of any country;
10. Prescription drugs or medications which are Experimental or Investigational;
11. Prescription drugs or medicines in connection with sex transformation surgery, including sex hormones related to such surgery and prescription drugs or medicines in connection with treatment of sexual dysfunction not related to organic disease;
12. Prescription drugs or medicines for infertility, artificial insemination, in vitro or in vivo fertilization of an ovum, including Pergonal (Menotropins);
13. Non-legend drugs, other than Insulin;
14. Therapeutic devices or appliances, including support garments, and other non-medicinal substances, except those listed herein;
15. Topical Minoxidil preparations, whether commercially prepared or compounded and Rogaine or any other hair replacement or growth product;
16. All drugs which are not self-administered or are administered in a hospital, long-term care facility or other inpatient setting;
17. Oral or other contraceptives. Oral contraceptives are covered under the Mail Order Program.
18. Fluoride preparations;
19. Prescription drugs or medicines which are for cosmetic use;

20. Hyperactivity drugs, unless otherwise specified by the Plan;
21. Insulin devices (except when stated as a covered expense under the Mail Order Program);
22. Medication/vaccines for foreign travel;
23. Oral contraceptives; and
24. Prescription vitamins.

SECTION 7

GENERAL PLAN PROVISIONS

HOW TO SUBMIT A CLAIM

Each Covered Employee and Covered Spouse will receive a Plan identification (ID) card. It will show the Employee's name, identification number and group number. Present the ID card whenever medical, dental or pharmacy services are obtained.

Claims and bills should be sent to the address on the back of the ID card. Complete itemized claims should be submitted on government standardized claim forms whenever possible. Cypress Benefit Administrators does not require special claim forms. You may submit claims directly to:

Cypress Benefit Administrators, LLC
P.O. Box 7020
Appleton, WI 54912-7020

All bills should include:

Employee's name and social security number

Name of patient

Name, address, telephone number of the provider of care

Date of service(s)

Charges

CLAIM FILING LIMITS

Written proof of a claim must be filed with the Claims Administrator within 90 days from the date charges for services were incurred or the date a participant is admitted to a hospital or skilled nursing facility, which ever is earlier. Benefits are based on the Plan's provisions at the time the charges were incurred. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to provide written proof of the claim within the time required, except that no claim shall be eligible for payment if it is submitted more than 15 months from the date the claim was incurred. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Covered Person seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Covered Person with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

1. The specific reason or reasons for the denial;
2. Specific reference to the applicable Plan provisions on which the denial is based;
3. A description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
4. Appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Covered Person will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Plan Administrator shall send written notice of the extension to the Covered Person. The extension notice will indicate the

special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Covered Person may appeal the denial. This appeal provision will allow the Plan Participant to:

1. Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.
2. File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Department within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Covered Person with a written response within 60 days of the date the Plan Administrator receives the Covered Person's written request for review. If not notified, the Covered Person may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Covered Person of the delay within the 60 day period and shall provide a final written response to the request for review within 30 days of the date the Plan Administrator received the Covered Person's written request for review.

The Plan Administrator's written response to the Covered Person shall cite the specific Plan provision(s) upon which the denial is based.

The Plan Administrator shall have the sole discretion to make the determination of all final appeals.

Limitation of Liability. No legal action shall be brought against the Plan prior to the expiration of 60 days after the covered person has filed the proof of claim. A covered person may not bring a legal action against the Plan unless the covered person begins the action within three years from the expiration of the time within which the proof of claim was required by this Plan. Further, a covered person may not bring a legal action on a denied claim until the Appeal Procedures stated above have been resorted to and exhausted.

USUAL, CUSTOMARY AND REASONABLE VERIFICATION

The Claims Administrator may be contacted prior to having a procedure performed to determine if the provider's estimated charge is within the Plan's allowable charge. The following information will need to be provided:

1. Date of service;
2. Place of service and zip code;
3. Valid 5 digit CPT or ADA code; and
4. Provider's estimated charge.

RELEASE OF INFORMATION

Covered Persons must do all things reasonably necessary to help the Plan and Claims Administrator determine if benefits are payable. This includes authorizing the release of medical or dental information, including names of all providers from whom treatment has been received. Charges made by a provider for the copying or furnishing of the information is not a Covered Service or charge. If a Covered Person refuses to assist the Plan or Claims Administrator when asked, the affected claim(s) will be denied.

DETERMINATION OF BENEFITS

1. If benefit levels change under this Plan, participants are entitled to the level of benefits in effect on the date services or supplies were rendered.
2. Participants may request an advance determination as to whether a treatment, service, or supply is a Covered Service. Submit the request in writing to the Claims Administrator.
3. We will consider alternative treatment plans proposed by participants or on participants' behalf. As part of this, benefits may be extended for services which are not Covered Services. The services must be Medically Necessary, cost-effective, and feasible. This is done on a case-by-case basis. Extra benefits may be stopped at any time.

WORKER'S COMPENSATION

The Plan is not issued in lieu of, nor does it affect any requirements for coverage by Workers' Compensation. This Plan contains a limitation which states that health services for bodily injuries or Illness which are job, employment or work related for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, are excluded from coverage. However, if benefits are paid by and it determines Covered Person is eligible to receive Workers' Compensation for the same incident, the Plan has the right to recover any benefits paid as provided in the Section entitled Rights of Recovery. As a condition of receiving benefits on a contested work or occupational claim, Covered Person will consent to reimburse the Plan when considering into any settlement and compromise agreement or at any Workers' Compensation Division Hearing. Plan reserves its right to exercise this right to recover against person even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
2. No final determination is made that the bodily injury or Illness was sustained in the course of or resulted from employment; or
3. The amount of Workers' Compensation due medical or health care is not agreed with or defined by the Covered Person or the Workers' Compensation carrier; or
4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

Covered person will not enter into a compromise or hold harmless agreement relating to any work related claims paid by Plan, whether or not such claims are disputed by the Workers' Compensation insurer, without the express written agreement of the Plan.

COORDINATION OF BENEFITS

This Coordination of Benefits ("COB") provision applies to this Plan when a Covered Person has health coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another plan. The benefits of this Plan:

1. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

2. Maybe reduced when, under the order of benefits determination rules, another plan determines its benefits first. The reduction is described in the Section titled "Effect on the Benefits of This Plan."

Definitions for Coordination of Benefits:

Allowable Expense. The Usual, Customary and Reasonable Charge for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a Semi-Private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

Claim Determination Period. A calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this COB provision or similar provision takes effect.

Plan is any of these that provides benefits or services for, or because of, medical care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured that include 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident type coverage.

2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid {Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance or other non-governmental program.

Each contract or other arrangement for coverage under {a) or {b) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

- o When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

- o When This Plan is a Secondary Plan, the benefits under this plan will be reduced so total benefits payable by all plans will not exceed the total allowable expenses of this plan.

- When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

This Plan. The part of the Certificate that provides benefits for health care expenses.

ORDER OF BENEFIT DETERMINATION RULES

General. When there is a basis for a claim under This Plan and another plan, This Plan is the Secondary payor, unless:

1. The other plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules, in subparagraph 2 below, require that This Plan's benefits be determined before those of the other plan.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

1. Employee/Dependent. The benefits of the plan, which covers the person as an employee (that is, other than as a Dependent) are determined before those of the plan, which Covers the person as a Dependent.
2. Dependent Child/Parents not Separated or Divorced. Except as stated in Rule (c.) below, when This Plan and another plan cover the same child as a Dependent:
    a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    b. If both parents have the same birthday, the benefits of the plan that covers the parent longer are determined before those of the plan that Covered the other parent for a shorter period of time.
    c. However, if the other plan does not have the rules described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
3. Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a Dependent child and the parents are divorced or separated, benefits for the child are determined in this order:
    a. First, the plan of the parent with custody of the child;
    b. Then, the plan of the spouse of the parent with custody of the child; and
    c. Finally, the plan of the parent not having custody of the child.

    Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses, or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to Rule (b) above.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee. The benefits of a plan which Covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a plan which Covers that person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule is ignored.

   Note: If a Dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a Dependent of the active employee, the federal Medicare regulations shall supercede this Rule.

5. The benefits of any medical insurance policy issued to a student by or through a school, university or college are determined before the benefits of this Plan.

6. Continuation Coverage. If an individual is Covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:

   a. First, the benefits of a plan covering the person as an employee (or as that employee's Dependent);

   b. Second, the benefits of coverage purchased under the continuation plan.

   If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan that Covered a participant longer are determined before those of the plan that Covered that participant for the shorter time.

Effect On The Benefits Of This Plan: This COB section applies when, in accordance with "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" below.

The provisions will apply only when the sum of the allowable expenses under this plan and any other plan would in the absence of this coordination of benefits provisions or any similar provision in the other plan exceed the allowable expenses.

Benefits provided under this plan during a claim determination period for allowable expenses incurred by you will be determined as follows:

1. If benefits under this Plan are to be paid after any other plan, the benefits under this plan will be reduced so total benefits payable by all plans will not exceed the total of allowable expenses of this plan; and

2. If benefits under this plan are to be paid before benefits are paid under any other plan, benefits under this plan will be paid without regard to the other plan.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. This plan will not administer the Coordination of Benefits with a reserve amount.

Right To Receive And Release Necessary Information: Certain facts are needed to apply these COB rules. This Plan has the right to decide which facts are needed. This Plan may get needed facts from or give them to any other organization or person. This Plan need not tell participants or get participant's consent to do this. Each participant claiming benefits under This Plan must provide any facts needed to pay the claim.

Plan's Rights of Recovery If the amount of the payments made by This Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or,
3. Other organizations.

Facility of Payment A payment made under another plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan.

This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

PLAN'S RIGHTS TO RIGHTS OF RECOVERY / SUBROGATION AND REIMBURSEMENT:

As a condition to receiving medical or disability benefits under this Plan, Covered Person (as used in this Section to include any Dependant of the Covered Person), agrees to transfer to the Plan their rights to make claim, sue and recover medical or disability expenses against any person or business entity from any funds which are paid or payable as a result of a personal injury claim or any reimbursement of medical/disability expenses. Alternatively, if a Covered Person receives any funds, by way of judgment, settlement or otherwise, from another person or business entity, the Covered Person agrees to reimburse the Plan in full, in first priority, for any medical or disability expenses incurred by the Plan. In other words, the Plan shall be first reimbursed fully from any monies received, with the balance, if any retained by the Covered Person.

The obligation to reimburse the Plan in full, in first priority, exists regardless of whether the Covered Person is made whole or the settlement designates the recovery, or a portion thereof, as including or excluding the Plan's medical disability expenses. Where medical expenses incurred by the Plan have been subject to contractual discounts or capitation agreements, the Plan shall be entitled to reimbursement on the basis of the Usual and Reasonable Charge by health care providers of such services without regard to such contractual discounts or capitation. A repayment agreement may be required to be signed. However, this clause remains in effect regardless of whether it is actually signed.

The Plan's right of full recovery, either by way of subrogation or right of reimbursement, may be from funds the Covered Person or guardian receives or is entitled to receive from the third party, any liability or other insurance covering the third party, any first party benefits such as uninsured motorist insurance, underinsured motorist insurance, any medical payments, no- fault or school insurance coverage's which are paid or payable. The Plan may enforce its reimbursement or subrogation rights by requiring the Covered Person or guardian to assert a claim to any foregoing to which he/she may be entitled.

A Covered Person by receipt of benefits under this Plan agrees to cooperate fully with the Plan and shall provide any information requested by the Plan within five days of request. The Covered Person shall within five days give the Plan or its administrator notice in writing of any personal injury claim or any other claim for reimbursement of medical or disability expenses filed with any person or business entity. The Covered person shall not settle or compromise any claim unless the Plan or its administrator is thereto in writing. Regardless of whether the settlement or judgment purports to include or exclude medical disability expenses, the Covered Person shall immediately repay the amount of any benefits the Plan has incurred plus interest at the rate of 1/2% per month commencing on the date of settlement or judgment. A Covered Person who waives subrogates or impairs the Plan's recovery rights or otherwise fails to comply with the obligations specified herein, relieves the Plan from any obligation to pay any past or future medical disability expenses of the Covered Person.

The Plan will not pay attorney fees or costs associated with the Covered Person's claim/lawsuit without prior written authorization. Once the personal injury claim is settled the Plan will not pay past or future benefits or claims related to that injury or accident without prior written authorization.

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage in certain instances where coverage under the Plan would otherwise end.

This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to the statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first.

The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). COBRA continuation coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event.

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

3. A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U .S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full- time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provides that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee.
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
3. The divorce or legal separation of a covered Employee from the Employee's Spouse.
4. A covered Employee's enrollment in the Medicare program.
5. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).
6. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave. For Details regarding FMLA leaves please refer to the Covered Expenses section of this Plan Document.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage.

An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

1. A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.

2. The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.

2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

3. The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

5. The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

   a. 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

   b. The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to

make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

    a. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

    b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

3. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

4. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

5. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified

beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary .

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180- day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

GENERAL INFORMATION:

***Administration of the Plan* (Plan Administrator Responsibility):** TTI, Incorporated is the Plan Sponsor and Plan Administrator. The Plan must be administered in accordance with the provisions of ERISA. An individual may be appointed by TTI, Incorporated to be a Third Party Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, TTI, Incorporated shall appoint a new Plan Administrator as soon as reasonably possible. A Plan Administrator is not the same as a Claims Administrator.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Service of legal process may be made upon the Plan Administrator.

***Administration of the Plan* (Duties of the Plan Administrator):**

1. Administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims according to the plan.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
9. To delegate to any person or entity such powers, duties and responsibilities, as it deems appropriate.

***Administrator(Plan) Compensation*:** The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Amending and Terminating The Plan: If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

Clerical Error: Any clerical error on the part of the Plan Administrator or Third Party Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The covered person agrees to reimburse the Plan for any payment made to or for the covered person in error.

Conformity with Government Law: If a provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Duplication of Benefits If any eligible charge is described as covered under two or more provisions within this Plan, the Plan will provide benefits based on the greater benefit. Only one benefit will be provided per covered expense.

Financing and Administration No insurance company, insurance service, HMO or other state licensed entity is responsible for the financing or administration of the Plan. Benefits under the Plan are not guaranteed by a policy of insurance.

Master Plan Document The Master Plan Document, including all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto, constitutes the entire Plan.

Newborns' and Mothers' Health Protection Act Notice Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Maternity stays exceeding either the 48 hour or 96 hour period, require certification by Cypress Benefit Administrators or benefits may not be payable for the remainder of the hospital stay.

No Loss – No Gain Persons who have pre-existing conditions on the effective date of this Plan shall continue to have the price plan's Pre-existing Condition Limitation administered, provided:

1. the covered persons were validly covered under the prior group plan on the date the plan terminated or was validly covered under the plan on the date immediately preceding the effective date of this Plan;

2. they are members of an eligible class in this Plan; and

3. they are covered under the Plan.

The Plan will give credit for deductibles, coinsurance limits and waiting periods that were met under the prior plan and applied to this calendar year, as long as the covered person supplies sufficient evidence of having satisfied those requirements.

Participant Contributions. The amount an employee is required to pay in order to participate in the Plan. Individuals who are participating in the Plan by virtue of having exercised their rights under the section of the Plan entitled "Continuation of Coverage (COBRA)" will receive a separate notice, which will indicate the cost in order to participate in the Plan. The Plan Sponsor reserves the right to amend the Appendix – "Participant Contributions" at any time.

Payments Directly to Providers. The Plan shall pay a provider directly for health services rendered by such provider to a covered person, unless otherwise specified by the employee.

Physical Examination. The Plan at its expense shall have the right and opportunity to have the covered person examined for evaluation and verification of an illness or injury as often as it may be required during the pending of a claim.

Plan Amendment or Termination While the Plan Sponsor expects and intends in good faith to continue the Plan for an indefinite period of time, it reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time. Such amendment or termination of the Plan shall be performed in writing and executed by an officer or other authorized individual of the Plan Sponsor. The Board of Directors o

the Plan Sponsor either will have pre-approved or will later ratify by corporate resolution, including by general ratification, any such Plan amendment or termination of the Plan.

In the event the Plan is terminated, any covered expenses which have been incurred prior to the date of termination will be payable in accordance with the terms and conditions of the Plan. Plan assets will be allocated first to the payment of claims, and thereafter in a manner that is for the exclusive benefit of the participants, except that any taxes and administration expenses may be made from Plan assets.

Plan Interpretation The Plan Administrator shall have full and discretionary authority to interpret and apply all the Plan Provisions, including, but not limited to, all issues concerning eligibility for and determination of benefits. The Plan Administrator has contracted with Cypress Benefit Administrators to process claims, maintain Plan data, and perform other Plan connected services; however, final authority to construe and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator, made in good faith, shall be final and binding.

Plan Is Not A Contract. The Plan shall not be deemed or constitute a contract between the employer and any employees or other persons or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the employer, or to interfere with or abridge the right of, the employer to discharge any employee at anytime.

Proof of Claim Written proof of a claim must be submitted to the Plan by the covered person or the provider of service within 90 days after the date such claim is incurred. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to provide written proof of the claim within the time required, except that no claim shall be eligible for payment if it is submitted more than 15 months from the date the claim was incurred. A claim shall be considered as incurred on the date the services or supplies are rendered or received.

Rescission of Coverage The Plan has the right to rescind coverage for which the employee or covered person made a material misrepresentation on his or her application for coverage form or change notice form. To rescind means to cancel coverage effective on the date coverage was granted in reliance on the material misrepresentation. A material misrepresentation is an untrue statement which leads the Plan to cover the employee or a covered person or cover a medical condition of the employee or a covered person when it would not have done so if it had known the truth. The Plan will refund all contributions paid for any coverage rescinded, however claims paid will be offset from this amount. In addition, the Plan reserves the right to recover from the employee, covered person or provider of service the amount paid on claims incurred during the period for which coverage is rescinded.

Rights With Respect To Medicaid Payments of benefits with respect to a covered person under the Plan will be made in accordance with any assignment or rights made by, or on behalf of, such covered person as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a) (1) (A) of such Act (as in effect on the date of the enactment of the Omnibus Budge Reconciliation Act of 1993).

Summary Plan Description The employer will issue to each covered employee or dependent, COBRA participant and retired employee a Summary Plan Description which summarizes the benefits to which the covered person is entitled. The booklet is intended to satisfy the requirements of a Summary Plan Description, as specified in ERISA.

Use of Network or PPO Providers Preferred Provider Organizations are referred to in the Plan as PPOs and medical providers within those PPOs are referred to as network providers or PPO providers. The section of the Plan entitled “Information Regarding PPO and Non-PPO Providers” provides general information regarding the use of PPO providers. In addition, the Schedule of Benefits section of the Plan indicates how benefits of the Plan will be determined, depending on whether and how the participant uses an PPO provider. Generally, a covered person will receive a greater benefit under the Plan if he or she elects to use the services of an PPO provider and may receive a lesser benefit if he or she elects to use a

Non-PPO provider. If the distinction between PPO and Non-PPO providers is applicable to the Plan, then the Schedule of Benefits provides information which describes the instances for which a covered person may receive the PPO level of benefits, even though a Non-PPO provider is used.

A separate description of the network and a listing of network providers can be obtained by viewing the Preferred Provider Organization's web-sight or by contacting the PPO direct for verification that the provider you are seeking care from continues to be contracted with the assigned PPO .

The Plan shall not be liable for any benefits after the date the Plan has terminated.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If a Plan Participant's claim for a benefit is denied, in whole or in part, the Plan Participant must receive a written explanation of the reason for the denial. The Plan Participant has the right to have the Plan review and reconsider the claim. Under ERISA there are steps that the Plan Participant can take to enforce the above rights. For instance, if the Plan Participant requests materials from the Plan and does not receive them within 30 days, that person may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits that is denied or ignored, in whole or in part, that participant may file suit in state or federal court.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIP AA), that Plan Participant should contact either the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

GENERAL PLAN INFORMATION

Plan Name: TTI, Incorporated Employee Health and Welfare Plan

Plan Number: C58

Tax ID Number: 39-1601474

Plan Effective Date: July 1, 1997

Plan Year Ends: June 30

Employer Information:

TTI, Incorporated

2266 Hwy B

Eden, WI 53019

Primary Plan Administrator:

TTI, Incorporated

2266 Hwy B

Eden, WI 53019

Agent for Service of Legal Process:

TTI, Incorporated Medical and Prescription Drug c/o Cypress Benefit Administrators

P O Box 7020

Appleton, WI 54912-7020

Claims Administrator:

Cypress Benefit Administrators, LLC

P O Box 7020

Appleton, Wisconsin 54912-7020

Financial Records:

The financial records of the Plan are kept on a Plan Year basis ending on June 30.