SUMMARY PLAN DESCRIPTION
OF
LTX, Inc. Medical Care Expense Reimbursement Plan (HRA)

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ARTICLE I.
INTRODUCTION

Your employer, LTX, Inc. (the "Employer"), is pleased to sponsor an employee benefit program known as the LTX, Inc. Medical Care Expense Reimbursement Plan (HRA) (the "Plan") for certain eligible employees.

This summary plan description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. To make maximum use of this Plan, be sure to proceed through this booklet carefully, so that you can make informed decisions that are right for you.

If there is a conflict between the underlying Plan and this summary plan description, the intention is for the Plan document to govern.

If you have any unanswered questions after reading this summary plan description, please contact: LTX, Inc. Attn: Bill Frank, President of Lawrence Risk Management Services, Inc. 1515 Industrial Drive NW Rochester, MN 55901 Phone: 800-328-7224

ARTICLE II.
GENERAL INFORMATION ABOUT THE PLAN

2.1 What is the purpose of the Plan?

The purpose of the Plan is to provide certain Employees with an opportunity to receive reimbursement for eligible Health Care Expenses as provided in this Plan. It is the intention of the Employer that the benefits payable under this Plan be eligible for exclusion from the gross income of Participants as provided by Sections 105(b) and 106 of the Internal Revenue Code (the "Code").

2.2 When did the Plan take effect?

The Plan became effective 1/1/2009. This Summary is effective 1/1/2013.

The Plan operates on a Plan Year running from the first day of January through the last day of December.

2.3 Who can participate in the Plan?

In order to participate in this Plan, a person must:

(a) be a full-time Employee of the Employer regularly scheduled to work at least thirty-two (32) hours per week;

(b) have at least ninety (90) days of continuous service with the Employer; and

(c) be actually covered under the group medical plan sponsored by the Employer.

These employees are called Eligible Employees. Those Eligible Employees who actually participate in the Plan are called "Participants."

"**Employee**" means a common-law employee of the Employer who is on the Employer's W-2 payroll, except that the term "Employee" does not include any common-law employee who is a leased employee (including but not limited to an individual defined in Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer, but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" also does not include any individual who is deemed to be "self-employed" under the Code, such as a partner, a member of a limited liability company, and an individual who owns more than two percent (2%) of an S corporation and the members of such individual's family. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits under the Plan.

2.4 How do I enroll?

Once you become eligible to participate, you will automatically be enrolled in the Plan and become a Participant. You do not need to complete any special enrollment form to enroll in this Plan. Participation begins on the first day of the month coincident with or following the date you become an Eligible Employee.

As a condition of participation and receipt of benefits under this Plan, you agree to:

(a) observe all Plan rules and regulations;

(b) consent to inquiries by the Claims Administrator and Plan Administrator with respect to any provider of services involved in a claim under this Plan;

(c) submit to the Plan Administrator all notifications, reports, bills, and other information required by the Plan or which the Claims Administrator and Plan Administrator may reasonably require; and

(d) cooperate with all reasonable requests of the Claims Administrator and Plan Administrator that may be necessary for the proper administration of the Plan.

Failure to satisfy these conditions relieves the Plan of any obligations with respect to you and any others claiming entitlement to benefits under this Plan through you.

2.5 How long will I be able to participate in the Plan?

Your participation ceases at midnight of the earliest of the following dates:

(a) The date of your death;

(b) The date you cease to meet the eligibility requirements described in Section 2.3, including the date on which your employment with the Employer terminates;

(c) The date on which your HC Account balance reaches zero if no additional contributions will be made on your behalf; or

(d) The date of termination of the Plan.

Your participation in the Plan may also be terminated for cause (e.g., for failure to comply with the conditions of participation described in Section 2.4 or for fraud or misrepresentation of material facts). In some cases, termination for cause will be effective retroactively (i.e., it will be rescinded). Rescissions will comply with applicable law. See also Section 3.9 for a description of additional events upon which your HC Account may be forfeited.

Note: Termination of participation may entitle you to continuation coverage as described in Article IV. In addition, termination of access to your HC Account is subject to the provisions of Section 3.8.

2.6 May I waive participation?

You may elect to permanently opt out of and waive future reimbursements under this Plan. You may wish to make such an election if you want to seek a tax credit (subsidy) for health insurance coverage purchased through a public insurance exchange. Coverage under this Plan disqualifies you from being eligible for such a tax credit.

The opportunity to make such an election will be made available on an annual basis. (It is also available upon termination of employee in certain cases as further discussed later in this SPD.) An election to opt out shall be made in accordance with procedures established by the Plan Administrator and it will become effective as of the last day of the Plan Year in which it is made.

If you elect to opt out, you will receive no reimbursements for eligible Health Care Expenses incurred after the election to opt out becomes effective. However, unless otherwise prohibited by applicable law (including regulatory guidance), you may continue to submit claims for eligible Health Care Expenses incurred prior to the effective date of the opt out election until the close of the applicable claim run-out period described below.

2.7 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate the program in whole or in part at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended or terminated accordingly. You will be informed if changes are made to the Plan. No termination of the Plan will affect benefits accrued prior to the termination.

2.8 How does reimbursement under this Plan affect my tax deductions?

You should realize that any medical expense for which you are reimbursed under this Plan cannot be claimed as a medical expense deduction on your income tax return. However, unless your health expenses exceed seven and one-half percent (7.5%) of your adjusted gross income, you are not permitted to use the deduction anyway.

2.9 Who has authority to interpret the Plan?

To the fullest extent permitted under applicable law, the Plan Administrator (and the Claims Administrator to the extent the Claims Administrator is acting as a fiduciary) shall have the authority and discretion to interpret and apply Plan terms.

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ARTICLE III.
HEALTH CARE ACCOUNT

3.1 What benefits are provided under the Plan?

The Plan reimburses eligible Health Care Expenses up to the balance of your Health Care Account.

3.2 What is my Health Care Account and what contributions are made to it?

A Health Care Account ("HC Account") will be established in your name to keep a record of the benefits under this Plan to which you are entitled. Your Employer will contribute a specified amount into your HC Account on a monthly basis. The amount of the contribution will be communicated to you by the Employer prior to the beginning of each Plan Year. The Plan does not require or permit employee contributions to the HC Account.

Your HC Account is a bookkeeping account only. There is no trust. Benefits under the Plan are paid from the Employer's general assets.

Any balance remaining in your HC Account at the end of the Plan Year will be carried over to future Plan Years for the sole purpose of reimbursing you for your eligible Health Care Expenses unless you waive participation or voluntarily forfeit your Health Care Account.

3.3 What is an "eligible" Health Care Expense?

Only eligible Health Care Expenses may be reimbursed under this Plan. An eligible Health Care Expense is an expense that meets the definition of "medical care" within Section 213(d) of the Code (including, for example, amounts for hospital bills, doctor and dental bills, prescription medicines, other medicines and drugs to alleviate or treat personal injuries and sickness, copays, and insurance premiums). Please review the attached sheet entitled "Eligible Health Care Expenses" for further examples of included expenses.

Health Care Expenses ***include*** certain over-the-counter items that constitute medical care (under Section 213(d) of the Internal Revenue Code). Over-the-counter drugs and medicines (other than insulin) must be prescribed. For this purpose, a "prescription" means a written or electronic order for a medicine or drug (1) that meets the legal requirements of a prescription in the state in which the medical expense is incurred; and (2) that is issued by an individual who is legally authorized to issue a prescription in that state.

Furthermore, to be an eligible Health Care Expense, the expense must be:

(a) "incurred" while you are a Participant; and

(b) "incurred" for you, your Spouse or your Dependents.

An expense is "**incurred**" when the service that gives rise to the expense has been provided, not when you are billed or when you pay the expense.

For purposes of this Plan, "**Spouse**" means an individual who is legally married to you (under applicable state law) and who is treated as your spouse under the Internal Revenue Code and the Defense of Marriage Act.

For purposes of this Plan, "**Dependent**" means a dependent for purposes of Section 105 of the Internal Revenue Code. In accordance with Section 105(b) of the Code, Dependent includes the Participant's child who does not reach age 27 by tax year end. Dependent also includes a qualifying child and certain other relatives. A qualifying child is a child who: (i) is your child (son, daughter, stepson, or stepdaughter), brother, sister, stepbrother, or stepsister, or a descendant of any such person; (ii) has the same principal place of abode as you

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for at least one-half of the relevant year; (iii) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled; (iv) did not provide over half of his/her own support during the relevant year; (v) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico; (vi) is younger than you; and (vii) does not file a joint tax return with his or her spouse. The other relatives that may be "dependents" for purposes of the Plan are individuals who: (i) are your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household; (ii) generally have received more than one-half of their support from you during the relevant year; (iii) are not a qualifying child of you or someone else; and (iv) a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

Note: The definition "Dependent" is different than the definition applicable under the Code for purposes of identifying who you may claim as an exemption on your federal income tax return. Furthermore, an individual eligible for dependent coverage under the group medical plan sponsored by the Employer is not necessarily a "Dependent" for purposes of this Plan. Additional special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

3.4 How do I receive my benefits under the Plan?

You may receive benefit either by using the electronic payment card provided to you or by submitting a paper claim to the Claims Administrator in accordance with the rules described in this Section 3.3.

Electronic Payment Card Claims. The electronic payment card allows you to pay for eligible Health Care Expenses at the time that you incur the expense. The electronic payment card works as follows:

(a) You must make an election to use the card. In order to be eligible for the electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program as set forth herein and in the electronic payment cardholder agreement (the "Cardholder Agreement"), including agreeing to any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset ineligible claims, etc. A Cardholder Agreement will be provided to you. The Cardholder Agreement is part of the terms and conditions of your Plan and this summary.

(b) The balance of the card is limited to the balance of your HC Account.

(c) The card will be turned off when you terminate employment or coverage under the Plan.

(d) You must certify proper use of the card. As specified in the Cardholder Agreement, you certify during the applicable Plan Year that the amounts in your HC Account will only be used for Health Care Expenses (i.e., medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(e) Reimbursement under the card is limited to health care providers and certain other places where you could purchase health care related items. The electronic payment card may be used only at merchants: (i) who have health care related merchant category codes other than the drug store or pharmacies merchant category code; (ii) who have the drug store or pharmacies merchant category code and with respect to whom ninety percent (90%) of the store's gross receipts during the prior taxable year consisted of items that qualify as expenses for medical care under Section 213(d) of the Code ("90% Pharmacies"); or (iii) who participate in an inventory

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information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.

(f) You swipe the card at the health care provider like you do any other credit or debit card. When you incur a Health Care Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under your HC Account (or as otherwise limited by the program) at the time you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment is being made is a Health Care Expense and that you have not been reimbursed by any other source nor will you seek reimbursement from another source.

(g) You must obtain a third party statement from the health care provider (e.g. receipt, invoice, etc.) each time you swipe the card that includes the following information:

(1) The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over the counter drug, the written statement must indicate the name of the drug;

(2) The date the expense was incurred; and

(3) The amount of the expense.

Although it is not required to be submitted for all purchases, you must retain this receipt for one year following the close of the Plan Year in which the expense was incurred. Even though payment may be made under the card arrangement, a written third party statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the Claims Administrator if a third party statement is needed. If requested, you must provide the third party statement to the Claims Administrator within forty-five (45) days (or such longer period provided in the letter from the Claims Administrator) of the request.

(h) There are situations in which you will not be required to provide the written statement to the Claims Administrator, including:

(1) Co-Pay Match. No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-providers that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the payment matches a specific co-payment you have under the Employer's group medical plan for the particular service that was provided or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, $20, $30, $40, or $50, you will not be required to provide the third party statement to the Claims Administrator.

(2) Previously Approved Claim Match. No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-provides that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the expense is in the same amount, for the same duration, and at the same provider as a previously approved expense (e.g. the Claims Administrator approves a thirty (30) count prescription with three (3) refills that was purchased at ABC Pharmacy; each time the card is swiped for subsequent refills at

ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount).

(3) Provider Match Program. No third party statement is required to be submitted to the Claims Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g. your prescription benefits manager) that identifies the nature of the expenses and verifies the amount of the expense and that the expense is a Health Care Expense.

(4) Inventory Information Approval System. No third party statement is required to be submitted to the Claims Administrator if the electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider. Such system verifies, at the time of purchase, that the goods being purchased constitute medical care.

Note: You should still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator does request it.

(i) Special rules apply to the use of the electronic payment card to purchase over-the-counter drugs and medicines other than insulin. Notwithstanding the rules described above regarding the use of the card to purchase medical care, the card may be used to purchase such over-the-counter drugs and medicines only in the following circumstances:

(1) At any ninety percent (90%) pharmacy if the expense is substantiated after the purchase in accordance with paragraph (7) above.

(2) At drug stores, pharmacies, non-health care merchants that have pharmacies, and mail order or web-based merchants that sell prescription drugs if (i) the cardholder presents the prescription to the pharmacist; (ii) the pharmacist assigns a prescription number and dispenses the over-the-counter drug or medicine in accordance with applicable law; (iii) the pharmacy retains a record of the transaction, including the name on prescription, prescription number, date, and the amount of the purchase; (iv) the pharmacy's records are accessible by the employer or its agent; (iv) the debit card system does not allow over-the-counter drugs or medicines without a prescription number; and (v) the expense is substantiated in accordance with the standard rules described above in paragraphs (7) and (8).

(3) At merchants having healthcare related merchant codes (other than merchants described in item b above) if the expense is substantiated in accordance with the standard rules described above in paragraphs (7) and (8).

Note: If the over-the-counter medicine cannot be purchased with the electronic payment card, it may still be reimbursed using the manual reimbursement procedures described above.

(j) If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator within the applicable time period, the card will be turned off and you must repay the Plan for the unsubstantiated expense by the deadline established by the Plan Administrator. If you do not repay the Plan within the applicable time period, then the amount of the improperly paid claim may be withheld from your pay (if allowed by applicable law). If the Employer is unable to withhold the amount from your pay, an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Plan. If no claims are submitted prior to the

date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, the remaining unpaid amount may be treated as indebtedness to the Employer.

(k) You can use either the payment card or the paper claims approach. You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the paper claims approach discussed above. Claims for which the electronic payment card has been used cannot be submitted as paper claims.

(l) Your use of the payment card is not a claim. The use of an electronic payment card does not constitute a "claim" under the claims procedures.

Paper Claims. When you incur an expense that is eligible for reimbursement, you may submit a claim to the Claims Administrator on an administrative form that will be supplied to you. The form will typically require:

(a) the amount, date and nature of the expense,

(b) the name of the person or entity to which the expense was paid,

(c) your statement that the expense has not been reimbursed or is not reimbursable through any other source, and

(d) such other information as the Claims Administrator may require.

You must also submit copies of bills or receipts from the provider(s) to support your claim. For over-the-counter drugs and medicines (other than insulin), you must submit either (1) a copy of the prescription for the drug or medicine; or (2) a receipt identifying the purchaser of the drug or medicine (or the patient), the date and amount of the purchase, and an Rx number.

"**Claims Administrator**" means MOR Strategy Group, LLC. The address for claims submission is: 958 Mezzanine Drive, #B, Lafayette, IN 47905. The phone number is (888) 900-4MOR. Our fax is (765) 446-1701.

You may receive reimbursement for eligible Health Care Expenses up to the amount of the balance in your HC Account at the time a reimbursement request is processed. This maximum reimbursement requirement applies to you, your Spouse, and your Dependents on an aggregate basis, not an individual basis. If the balance of your HC Account is insufficient to fully reimburse a claim for an eligible Health Care Expense, the unreimbursed portion will be reimbursed in subsequent months as additional amounts are contributed to your HR Account.

Generally, you will be able to receive reimbursement for paper claims weekly. Reimbursements may be paid by separate check, direct deposit to your savings, or checking account.

In order to be eligible for payment, you must submit a claim within twenty-four (24) months of the date on which the expense was incurred.

3.5 Do I submit claims for reimbursement under my Employer's cafeteria plan first?

Yes. Claims for eligible Health Care Expenses (see Question 3.2) must first be submitted for reimbursement to your Employer's health flexible spending account under its cafeteria plan. If that claim is not fully reimbursed, the balance of the claim will automatically be submitted to this Plan.

3.6 What happens if my claim for benefits is denied?

In most cases, within thirty (30) days after a claim for benefits is filed, the claim will either be paid or the Claims Administrator will notify you of the claim denial. If the Claims Administrator denies the claim, you will be provided with the following information in writing:

(a) Information sufficient to identify the claim involved, including the date of service, the identity of the health care provider, and the claim amount, and information regarding your right to request diagnosis and treatment codes (if any) and their corresponding meanings;

(b) The specific reasons for the denial (including the denial code (if any) and its corresponding meaning);

(c) The Plan's standard, if any, used to make the determination;

(d) The specific reference to the Plan provisions on which the denial is based;

(e) A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary;

(f) A description of the Plan's internal and external review processes (if any) and appropriate information as to the steps to be taken if you wish to appeal the Claims Administrator's determination, including your right to submit written comments and have them considered, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim;

(g) Any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

(h) In cases in which the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to claimant's medical circumstances (or a statement that such explanation will be provided at no charge upon request); and

(i) The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes (if any).

Such a notice will also be provided if your coverage under the Plan is rescinded. For this purpose, a rescission occurs if there is a cancellation or discontinuation of coverage under the Plan that has retroactive effect, other a cancellation or discontinuation attributable to fraud or intentional misrepresentation of material fact.

Within one hundred eighty (180) days after you receive notice that your claim has been denied, you or your representative may file a written request with the Claims Administrator appealing the denial and requesting review of it. You or your representative are entitled to review the pertinent documents and may also submit issues and comments in writing to be considered as part of the review.

"**Authorized representative**" means a person entitled to act on your behalf and recognized by the Plan Administrator. In order to be recognized by the Plan Administrator, the person must have a completed "Authorized Representative Form" on file with the Claims Administrator.

The Plan Administrator will review and decide your appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify you of its decision in writing. The individual who decides your

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appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. (The identity of a medical expert consulted in connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

(a) Information sufficient to identify the claim involved, including the date of service, the identity of the health care provider, and the claim amount, and information regarding your right to request diagnosis and treatment codes (if any) and their corresponding meanings;

(b) A discussion of the determination, including the basis of said determination, the denial code (if any) and its corresponding meaning, and the Plan's standard, if any, used to make the determination;

(c) The specific Plan provision(s) on which the decision is based;

(d) A statement of your right to review (on request and at no charge) relevant documents and other information;

(e) Any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

(f) In cases in which the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to claimant's medical circumstances (or a statement that such explanation will be provided at no charge upon request);

(g) A description of the external review process available under the Plan (if any);

(h) A statement of your right to bring suit under ERISA § 502(a); and

(i) The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the external review process (if any).

Upon completion of the internal review process, you may have the right to have the claim reviewed pursuant to an external review process. External reviews are not available if the Plan is a grandfathered plan (as indicated below). Furthermore, an external review is available only if and to the extent federal law requires non-grandfathered health reimbursement arrangements to provide such review (e.g., only if a claim is denied based upon medical necessity). For more information regarding whether external reviews are available under the Plan and, if so, the external review process, please contact the Plan Administrator.

Exhaustion is required. Exhaustion of the administrative procedures described above is required prior to the initiation of a legal action related to a claim for benefits under the Plan. Thereafter, legal action must be initiated within one (1) year of receipt of the written notification of denial upon appeal. You may not bring a legal action after expiration of this time period.

3.7 What if I am subject to a medical child support order?

Notwithstanding any provision of the Plan to the contrary, the Plan shall recognize Qualified Medical Child Support Orders ("QMCSOs"). To be recognized, specific procedures must be followed. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

3.8 Will I have any administrative costs under the Plan?

The cost of administering the Plan is paid by your Employer.

3.9 What happens to my HC Account if my participation in the Plan terminates?

[If your participation in the Plan terminates as described in Section 2.5 and there is a balance in your HC Account, you may continue to access your HC Account following termination of participation for purposes of obtaining reimbursement of Health Care Expenses unless you waive participation or voluntarily forfeit your HC Account. Such access shall continue until the earlier of: (1) the date on which the HC Account balance reaches zero; or (2) the date of your death. If continuation coverage is required by applicable law, the access described herein shall be provided only if offered as and selected in lieu of such continuation coverage.]

[Notwithstanding anything herein to the contrary, upon your death, your surviving Spouse and Dependents, if any, may continue to access the your HC Account for purposes of obtaining reimbursement of Health Care Expenses until the earlier of: (1) the date on which the HC Account balance reaches zero; or (2) the date on which the last surviving Spouse or Dependent dies. No claim shall be paid to a surviving Spouse or Dependent unless a certified copy of the deceased Participant's death certificate has been provided to the Claims Administrator. If continuation coverage is required by applicable law, the access described herein shall be provided only if offered as and selected in lieu of such continuation coverage.]

3.10 In what situations will the balance of my HC Account be forfeited?

Amounts attributed to your HC Account shall be forfeited as follows:

(a) All amounts in your HC Account shall be forfeited upon termination of your participation in the Plan following the claims run out period or the spend down period described in Section 3.8, if any, and upon termination of the Plan.

(b) Certain small HC Account balances will also be forfeited. If no further contributions will be made to your HC Account, the balance of the HC Account will be forfeited in two instances: (i) when the balance is below $5.00 and you have not submitted any claims for a period of six months; or (ii) when the balance is below $25.00 and you have not submitted a claim for a period of twelve months.

(c) If you waive participation as described in Section 2.6, your HC Account will be forfeited.

(d) You may also voluntarily forfeit your HC Account balance at any time. To do so, you need to direct the Plan Administrator, in writing, to forfeit your HC Account. You will not be provided anything in exchange for the forfeiture.

Forfeitures will be used by the Plan Administrator to defray the reasonable administrative costs of the Plan or for any other purpose permitted by law.

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3.11 How do I obtain a certificate of creditable coverage?

When your coverage under the Plan terminates, you will be provided with a certification of creditable coverage by the Plan Administrator (or its designee). In addition, the Plan Administrator (or its designee) will provide a certification of creditable coverage upon your request if made while you are covered by this Plan or within two (2) years of termination of your coverage under this Plan. A request for a certification of creditable coverage should be directed to the Plan Administrator at the address identified in Article VIII. Upon request, the Plan Administrator (or its designee) will issue the certification of creditable coverage as soon as reasonably possible.

3.12 What are any further limitations on my benefits?

The Plan does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are payable under any workers' compensation law or other employer, union association, or governmental sponsored insurance plan.

This Plan does not cover expenses incurred for any loss caused by or resulting from injury or disease for which you, or your Spouse or Dependents, received benefits under any health accident policy or program, whether or not premiums are paid by the Employer or by you or your Spouse or Dependents.

Amounts reimbursed under a dependent care assistance program shall not be reimbursed under this Plan.

3.13 What if I receive erroneous payments from the Plan?

If the Plan makes a payment for benefits in excess of the benefits required by the Plan, or makes a payment to or on behalf of an individual who is not currently covered by the Plan, the Plan shall be entitled to recover such erroneous payment from the recipient thereof.

Furthermore, if an erroneous payment is the result of fraud or an intentional misrepresentation of material fact by you or your Spouse or Dependent, your coverage under the Plan may be terminated retroactively (i.e., rescinded) to the date of the fraud or intentional misrepresentation. Coverage may be rescinded only to the extent allowed by the Patient Protection and Affordable Health Care Act, as amended.

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ARTICLE IV.
CONTINUATION COVERAGE

A Participant, and any others who are covered through that Participant, ***may*** be entitled to elect to continue coverage under the Plan in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), as described below.

4.1 What are my continuation rights under COBRA?

COBRA requires most employers with twenty (20) or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premiums for the continuation coverage.

This section is intended to inform persons covered under the Plan, in summary fashion, of their rights and obligations under the continuation coverage provision of the law. It is intended that no greater rights be provided than those required by this law. It does not fully describe your continuation coverage rights. The Plan Administrator has developed additional policies regarding the provision of continuation coverage under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

QUALIFYING EVENTS

Upon the commencement of a "qualifying event" each person that loses coverage may have rights as a "qualified beneficiary."

> **Qualifying event**. A qualifying event is the occurrence of an enumerated event (described below) that results in a loss of coverage under the terms of the group health plan.

> **Qualifying beneficiary**. A qualified beneficiary is the employee, employee's spouse and/or employee's dependent children who on the day before the qualifying event was covered under the group health plan. A spouse whose coverage was reduced or terminated in anticipation of divorce is also a qualified beneficiary. In addition, a child born to or place for adoption with a qualified beneficiary ***who was the employee*** is a qualified beneficiary is if he or she was covered under the group health plan on the day before the qualifying event. Furthermore, an individual for whom the employee must provided coverage under the group health plan pursuant to a medical child support order is a qualified beneficiary.

Employee Loss. If covered by any of the group health plans described above, the employee has the right to elect continuation coverage if he or she loses coverage under such plan due to termination of employment (other than for gross misconduct) or a reduction in hours of employment.

Spouse's Loss. If covered by any of the group health plans described above, a spouse has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

(a) the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

(b) the employee's death; or

(c) divorce or legal separation from the employee.

Note: If an employee eliminates coverage for his or her spouse from coverage in anticipation of a divorce of legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier.

Dependent Child's Loss. If covered by any of the group health plans described above, a dependent child has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

(a) the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

(b) the employee's death;

(c) divorce or legal separation of the employee and the child's other parent; or

(d) the child ceasing to be a "dependent child" under the terms of the plan.

Employer's Bankruptcy. Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees), if the employer commences a Chapter 11 bankruptcy proceeding.

RESPONSIBILITY TO NOTIFY

In certain circumstances, you are required to provide notification to the Plan Administrator in order to protect your rights under COBRA.

Notice of Qualifying Event. Under the law, the employee or a family member (or a representative acting on behalf of the employee or a family member) has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the plan within sixty (60) days of the latest of: (1) the date of the qualifying event; (2) the date coverage would be lost because of the qualifying event; or (3) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notification must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notification must be postmarked no later than the last of the sixty (60) day notice period described above. The notification must:

(a) state the name of the Plan;

(b) state the name and address of the employee or former employee who is or was covered under the Plan;

(c) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event;

(d) include a detailed description of the event;

(e) identify the effective date of the event; and

(f) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it

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applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no continuation coverage will be provided.

You must, if the Plan Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the Plan Administrator, so that the Plan Administrator can determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you are unable to provide satisfactory evidence within thirty (30) days after a written or oral request from the Plan Administrator, the coverage may be terminated (retroactively if necessary) as of the date that COBRA coverage would have started. The Plan will require repayment to the Plan of all benefits paid after the termination date.

Notice of Second Qualifying Event. In addition, the employee or a family member (or a representative acting on behalf of the employee or family member) must notify the Plan Administrator of the death of the employee, divorce or separation from the employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(a) state the name of the Plan;

(b) state the name and address of the employee or former employee who is or was covered under the Plan;

(c) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;

(d) identify the nature and date of the initial qualifying event the qualified beneficiaries to COBRA coverage;

(e) include a detailed description of the event;

(f) identify the effective date of the event; and

(g) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan Administrator is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

You must, if the Plan Administrator requests it, provide documentation of the date of the second qualifying event that is satisfactory to the Plan Administrator, so that the Plan Administrator can determine if you gave timely notice of the second qualifying event. If you are unable to provide satisfactory evidence within thirty (30) days after a written or oral request from the Plan Administrator, the coverage may be terminated (retroactively if necessary) as of the date that the extension of COBRA coverage would have started. The Plan will require repayment to the Plan of all benefits paid after the termination date.

Notice of Disability. Also, an employee or a family member (or a representative acting on behalf of the employee or a family member) must notify the Plan Administrator when a qualified beneficiary has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of: (1) the date of the disability determination; (2) the date of the qualifying event; (3) the date coverage would be lost because of the qualifying event; or (4) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. (Notwithstanding the foregoing, the notice must be provided before the end of the first eighteen (18) months of continuation coverage.) The notification must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(a) state the name of the Plan;

(b) state the name and address of the employee or former employee who is or was covered under the Plan;

(c) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;

(d) identify the nature and date of the initial qualifying event the qualified beneficiaries to COBRA coverage;

(e) state the name of the disabled qualified beneficiary;

(f) identify the date upon which the disabled qualified beneficiary became disabled;

(g) identify the date upon which the Social Security Administration made its determination of disability; and

(h) include a copy of the determination of the Social Security Administration.

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan Administrator is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided with thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the Plan Administrator of that determination within thirty (30) days of the later of: (1) the date of such determination; or (2) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be in writing and be mailed to the Plan Administrator at the address identified below. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins thirty (30) days after the date of the determination, or the end of the initial coverage period, if later. If you do not provide the notification within the required time, the Plan reserves the right to seek reimbursement of any benefits provided by the Plan between the date coverage terminates and the date the notification is provided.

Failure to provide timely notification of a qualifying event ends the right to COBRA continuation coverage.

ELECTION RIGHTS

When a qualifying event occurs, or when the Plan Administrator is notified that a qualifying event has occurred in the case of those events in which the employee has an obligation to provide notice, the Plan Administrator must notify the qualified beneficiaries of the right to elect continuation coverage. Because the Employer and the Plan Administrator are the same entity, the Plan Administrator has forty-four (44) days to provide the option to elect COBRA coverage. Under the law, qualified beneficiaries have at least sixty (60) days to elect continuation coverage measured from the later of (1) the date coverage would be lost because of a qualified event, or (2) the date a notice of election rights is provided. An election is considered "made" on the date sent. If continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If continuation coverage is not elected within this period, coverage under the Plan ends.

Each qualified beneficiary has an independent right to elect continuation coverage. Employees and spouses (if the spouse is a qualified beneficiary) may elect continuation coverage on behalf of all qualified beneficiaries and parents may elect continuation coverage on behalf of their children. Furthermore, other third persons can elect continuation coverage on behalf of a qualified beneficiary.

Note: Qualified beneficiaries who are entitled to elect COBRA may do so even if they are covered by Medicare effective on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if he or she first becomes covered by Medicare effective after the date on which COBRA is elected.

DURATION

The law requires that qualified beneficiaries generally be allowed to maintain continuation coverage as follows:

Eighteen (18) Months. If the qualifying event is the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is eighteen (18) months measured from the date of the qualifying event.

Disability Extension. For qualified beneficiaries receiving continuation coverage because of the employee's termination or reduction in hours, the continuation period may be extended eleven (11) months, for a total maximum of twenty-nine (29) months where a qualified beneficiary receives a determination under the Social Security Act that at the time of the employee's termination of employment or reduction of hours, or within sixty (60) days of the start of the eighteen (18) month continuation period, the qualified beneficiary was disabled. The extension is available to all qualified beneficiaries in the family group.

Pre-Qualifying Event Medicare Extension. The eighteen (18) month continuation period may be extended if the employee became entitled to (actually covered under) Medicare prior to the employee's termination of employment (other than for gross misconduct) or a reduction in hours. Qualified beneficiaries other than the employee are entitled to the greater of (1) eighteen (18) months measured from the qualifying event; or (2) thirty-six (36) months measured from the date of the employee's Medicare entitlement.

Thirty-Six (36) Months. For qualifying events other than termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period is thirty-six (36) months measured from the date of the qualifying event.

Second Qualifying Events. If during the initial eighteen (18) month continuation period (or during an extension of that period for disability or for pre-termination Medicare entitlement) a second qualifying event occurs (e.g., divorce or legal separation, death of employee, loss of dependent status) that would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred, the

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continuation period for the particular qualified beneficiaries affected by the second qualifying event may be extended to thirty-six (36) months.

Under no circumstances may the total continuation period be greater than thirty-six (36) months from the date of the original qualifying event that triggered the continuation coverage.

TYPE OF COVERAGE

Initially, the coverage will be the same coverage as immediately preceding the qualifying event. Thereafter, coverage must be identical to the coverage provided to similarly situated employees or family members that have not experienced a qualifying event. In addition, special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") will apply to those who have elected COBRA.

COST

A person electing continuation coverage may have to pay all or part of the cost of continuation coverage. You will receive additional information regarding the cost requirements following the occurrence of a qualifying event. The amount charged cannot exceed one hundred two percent (102%) of the cost to the plan of providing the coverage. The amount may be increased to one hundred fifty percent (150%) for the months after the eighteenth (18th) month of continuation coverage when the additional months are due to a disability under the Social Security Act. Payment is generally due monthly. Payment is considered "made" on the date sent.

CANCELLATION OF COVERAGE

The law provides that continuation coverage shall automatically end for any of the following reasons:

(a) the Employer no longer provides group health coverage to any of its employees;

(b) the premium for continuation coverage is not paid on time (including any applicable grace period);

(c) after electing COBRA, the qualified beneficiary becomes covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any applicable pre-existing condition that you have;

Note: Under HIPAA, an exclusion or limitation of the other group health plan might not apply at all, depending on the length of the qualified beneficiary's creditable coverage prior to enrolling in the other group health plan. If the other plan has applicable exclusions or limitations, then COBRA coverage terminates after the exclusion or limitation no longer applies (for example, after a twelve (12) month pre-existing condition waiting period expires).

(d) after electing COBRA coverage, the qualified beneficiary becomes entitled to (actually covered under) Medicare;

Notice Obligation: The employee or a family member must notify the Plan Administrator immediately if any qualified beneficiary actually becomes covered by another group health plan or Medicare. Regardless of when such notification is provided, coverage will terminate retroactively to the date of the coverage under the other group health plan or Medicare. If, for whatever reason, a qualified beneficiary receives any medical benefits under the Plan after coverage is to cease under these rules, the Plan reserves the right to seek reimbursement from the qualified beneficiary.

(e) with respect to disability extension coverage, a final determination that the qualified beneficiary is no longer disabled; or

Note: This cuts short the coverage for all qualified beneficiaries with extended coverage.

(f) termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

TRADE ACT OF 2002

Pursuant to the Trade Act of 2002, certain employees and former employees who are receiving trade adjustment assistance ("TAA") may be eligible for a special second COBRA election and a tax credit for premiums paid for continuation coverage. TAA is generally available to those employees who have lost their jobs or suffered a reduction in hours because of import competition and shifts in production to other countries. If you are potentially eligible for these rights under the Trade Act, you will receive additional information regarding it at the time of your qualifying event.

ADDRESS CHANGES

Important information is distributed by mail. In order to protect your family's rights, if a qualified beneficiary's address changes, the qualified beneficiary or someone on its behalf should notify the Plan Administrator immediately.

More Information: All questions, notices, and other communications regarding COBRA and the Plan should be directed to:

LTX, Inc.
Attn: Bill Frank, President of Lawrence Risk Management Services, Inc.
1515 Industrial Drive NW
Rochester, MN 55901
Phone: 800-328-7224

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

4.2 What are my continuation rights under USERRA?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as amended, requires all employers to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "U-continuation coverage") at group rates where health coverage under employer-sponsored group health plan(s) would otherwise end because of the employee's service in the uniformed services.

This section is intended to inform persons covered under a group health plan, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe your U-continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the USERRA Administrator.

Service Leave Event. If covered by any of the group health plans described above, the employee has the right to elect U-continuation coverage for him/herself and his/her dependents if they lose coverage under such plan due to an absence from employment for service in the uniformed services (a "service leave").

Service in the Uniformed Services. Service in the uniformed services generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

Election Rights. You have sixty (60) days to elect U-continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. An election is considered "made" on the date sent. If U-continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If U-continuation coverage is not elected within this period, coverage under the Plan ends. However, if the no election is made in a situation in which you are not required (in accordance with USERRA) to provide advance notice of your service (e.g., because such notice was impossible, unreasonable, or precluded by service necessity), your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

Note: Your dependents with coverage under the Plan(s) do not have an independent right to elect U-continuation coverage. Their coverage may be continued only if you elect U-continuation coverage.

Duration. The law requires that you generally be allowed to maintain U-continuation coverage for a twenty-four (24) month period beginning on the date of your absence from employment for the purpose of performing service begins.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated employees or family members that are not on service leave.

Cost. A person electing U-continuation coverage may have to pay all or part of the cost of U-continuation coverage. If you perform service in the uniformed services for fewer than thirty-one (31) days, you will pay the same amount for the coverage that you normally pay. If your service exceeds thirty (30) days, the amount charged cannot exceed one hundred two percent (102%) of the cost to the plan of providing the coverage.

Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. You will be given a grace period of within which to make the payment. The length of the grace period will be thirty (30) days.

Termination of the Continue Coverage. The U-continuation coverage may be terminated for any of the following reasons:

(a) the Employer no longer provides group health coverage to any of its employees;
the premium for U-continuation coverage is not paid on time (including the grace period);

(b) your failure to return from service or apply for a position of employment as required under USERRA; or termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

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Insurability. You do not have to demonstrate insurability to elect U-continuation coverage.

USERRA Administrator: All questions, notices, and other communication regarding USERRA and the Plan should be directed to:
LTX, Inc. Attn: Bill Frank, President of Lawrence Risk Management Services, Inc. 1515 Industrial Drive NW Rochester, MN 55901 Phone: 800-328-7224

ARTICLE V.
OTHER FEDERAL LAWS

5.1 Family and Medical Leave Act of 1993 ("FMLA")

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more employees. If your Employer is subject to FMLA, This Plan shall be administered in a manner consistent with the FMLA and the Employer's FMLA Policy required thereunder. In that case, you will be provided with a complete explanation of FMLA rights and responsibilities.

5.2 The Affordable Care Act of 2010 ("Health Care Reform")

The Plan is intended to be exempt from the provisions of the Patient Protection and Affordable Health Care Act (the "Affordable Care Act") to the fullest extent allowed by law.

The Plan is intended to be a grandfathered plan under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The Plan is intended to be exempt from the Affordable Care Act because the Plan is an excepted benefit under HIPAA.

The Plan is intended to be an integrated HRA (as defined under applicable regulatory guidance) and as a result is exempt from certain requirements of the Affordable Care Act.

5.3 Newborns' and Mothers' Health Protection Act ("NMHPA")

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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

5.4 Women's Health and Cancer Rights Act of 1998 ("WHCRA")

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For purposes of this Plan, the expenses for the following services will be eligible Health Care Expenses, provided they otherwise meet the definition of Health Care Expense found in Section 3.2:

(a) all stages of reconstruction of the breast on which the mastectomy was performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) prostheses; and

(d) treatment of physical complications of the mastectomy, including lymphedema.

If you would like more information on WHCRA benefits, call the Plan Administrator at the telephone number identified in Article VII.

5.5 Medicare

This Plan shall comply with the Medicare secondary payer rules. In some cases, you will be required to use your benefits under the Plan before submitting a claim to Medicare.

ARTICLE VI.
ERISA RIGHTS

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plans and Benefits. ERISA provides that all Participants shall be entitled to:

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

(b) Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each Participant with a copy of any required summary annual report.

COBRA and HIPAA Rights. As a Participant in the Plan you may be entitled to:

(a) Continue health coverage for yourself, your spouse or your dependents if there is a loss in coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights, and

(b) Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

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

Enforce Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the

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materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

Plan Administrator. Your Employer is the Plan Administrator. MOR Strategy, LLC is the Claims Administrator and acts as your Employer's designee. All notices and other communication should be directed to:

MOR Strategy Group, LLC
958 Mezzanine Drive, #B
Lafayette, IN 47905
Phone: (888) 900-4MOR
Fax: (765) 446-1701

ARTICLE VII.
ADMINISTRATIVE INFORMATION

Plan:

Plan Name:	LTX, Inc. Medical Care Expense Reimbursement Plan (HRA)
Plan Type:	Section 105 Accident & Health Plan
Plan Number:	

Employer & Plan Administrator:

Name:	LTX, Inc.
Address:	1515 Industrial Drive NW
City, State Zip:	Rochester, MN 55901
Phone Number:	800-328-7224
EIN:	41-0908878
Contact Person:	Bill Frank

Agent for Service of Legal Process:

Name:	LTX, Inc.
Address:	1515 Industrial Drive NW
City, State Zip:	Rochester, MN 55901
Phone Number:	800-328-7224

Claims Administrator:

Name:	MOR Strategy Group, LLC
Address:	958 Mezzanine Drive #B
City, State Zip:	Lafayette, IN 47905
Phone Number:	(888) 900-4MOR
Fax Number:	(765) 446-1701

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EXHIBIT A
Eligible Health Care Expenses

Attention: This list of eligible Health Care Expenses is applicable to and for use with only this Plan.

Medical and dental expenses that qualify as expenses for medical care under IRS rules generally qualify as eligible expenses for reimbursement under a health reimbursement arrangement. Those may take the form of co-pays, deductibles, and medical expenses not covered by other insurance.

Some specific examples are identified below. The following is not an exhaustive list and there may be other expenses that are eligible if they satisfy the IRS rules.

Expense Type:	**Allowable Expense:**	**Expenses Specifically Disallowed by the IRS:**
Dental & Orthodontic Care	• Dental Treatment • Artificial teeth/Dentures • Braces, orthodontic devices	• Teeth whitening • Toothbrushes and toothpaste, even if special type is recommended by dentist
Therapy Treatments	• X-ray treatments • Treatment for alcoholism or drug dependency • Legal sterilization • Acupuncture • Vaccinations • Physical therapy (as a medical treatment) • Fee to use swimming pool for exercises prescribed by physician to alleviate specific medical condition such as rheumatoid arthritis • Speech therapy • Smoking cessation programs and prescribed drugs to alleviate nicotine withdrawal	• Physical treatments unrelated to a specific health problem (e.g., massage for general well being) • Any illegal treatment • Cosmetic Surgery • Treatment for baldness (unless it is for a specific medical condition and not for cosmetic purposes)
Fees/Services	• Physician's fees and hospital services • Nursing services for care of a specific medical ailment • Cost of a nurse's room and board if paid by the taxpayer where nurse's services qualify • The Social Security tax paid with respect to wages of a nurse where nurse's services qualify • Services of chiropractors • Christian Science practitioner fees • Diagnostic tests	• Payments to domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a non-medical nature • Nursemaids or practical nurses who render general care for healthy infants • Fees for exercise, athletic, or health club membership when there is no specific health reason for needing membership • Marriage counseling provided by clergyman
Hearing Expenses	• Hearing aids and hearing aid batteries • Hearing aid repair • Special telephone equipment	
Medicines and Drugs	• Medicine and drugs that require a prescription • Insulin • Prescribed over the counter medicine and drugs when used to alleviate or treat personal injuries or sickness (including antacids, antihistamines, aspirin/pain relievers, cold medicines, acne medicine, etc.)	• Medicine and drugs for personal, general health, or cosmetic purposes • Dietary supplements if for general health

Expense Type:	Allowable Expense:	Expenses Specifically Disallowed by the IRS:
Medical Equipment	• Blood Sugar test kits • Wheelchair or autoette (cost of operating/maintaining) • Crutches (purchased or rented) • Special mattress & plywood boards prescribed to alleviate arthritis • Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition • Artificial limbs • Support hose (if medical necessary) • Wigs (where necessary to mental health of individual who loses hair because of disease) • Excess cost of orthopedic shoes over cost of ordinary shoes • Breast pumps for nursing mothers	• Wigs, when not medically necessary for mental health • Vacuum cleaner purchased by an individual with dust allergy • Mechanical exercise device not specifically prescribed by a physician
Physicals	• Physicals and other well visits • Immunizations	• Physicals for employment purposes
Vision Care	• Optometrist's or ophthalmologist's fees • Eyeglasses and prescription sunglasses • Insurance for replacement of lost or damaged contact lenses • Contact lens and contact lens solutions • Laser eye surgery	
Assistance for the Handicapped	• Cost of guide for a blind person • Cost of note-taker for a deaf child in school • Cost of Braille books and magazines in excess of cost of regular editions • Seeing eye dog (cost of buying, training and maintaining) • Household visual alert system for deaf person • Excess costs of specifically equipping automobile for handicapped person over cost of ordinary automobile; device for lifting handicapped person into automobile • Special devices, such as tape recorder and typewriter, for a blind person	
Psychiatric Care	• Services of psychotherapists, psychiatrists and psychologists	• Psychoanalysis undertaken to satisfy curriculum requirements of a student
Miscellaneous Charges	• X-rays • Expenses of services connected with donating an organ • Excess cost of medically prescribed diet • The cost of a medically prescribed weight loss program • Breast reconstructive surgery following mastectomy as part of treatment for cancer	• Expenses of divorce when doctor or psychiatrist recommends divorce • Cost of toiletries, cosmetics, and sundry items (e.g., soap, toothbrushes, etc.) • Cost of special foods taken as a substitute for regular diet, when the special diet is not medically necessary or taxpayer cannot show cost in excess of cost of a normal diet • Maternity clothes

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Expense Type:	Allowable Expense:	Expenses Specifically Disallowed by the IRS:
	• Contraceptives • Fertility Treatments • Medical records charges • Bandages • Lactation supplies for nursing mothers	• Diaper service • Distilled water purchased to avoid drinking fluoridated County water supply • Installation of power steering in automobile • Pajamas purchased to wear in hospital • Mobile telephone used for personal calls as well as calls to physician • Union dues for sick benefits for members • Contributions to state disability funds • Auto insurance providing medical coverage for all persons injured in or by the taxpayer's automobile, where amounts allocable to taxpayer and dependent is not stated separately • Long-term care services • Funeral expenses
Insurance	• Health insurance premiums (including individual and non-employer sponsored coverage and including continuation premiums) • Long term care insurance premium	• Premiums that could be paid on a pre-tax basis through the Employer's flex plan