UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

RONALD C. JESSE, JR. and **SHIRLEY** A. **JESSE,** on behalf of **NAGEL LUMBER COMPANY, INC. GROUP MEDICAL, PRESCRIPTION DRUG, DENTAL AND SHORT TERM DISABILITY BENEFITS PLAN,**

Plaintiffs,

v.

NAGEL LUMBER COMPANY, INC., and **CATHY A. NORDINE.,**

Defendants.

Case No. **08 CV 400**

COMPLAINT

COME NOW the plaintiffs, Ronald C. Jesse, Jr., and Shirley A. Jesse, by and through their attorneys, HAWKS QUINDEL EHLKE & PERRY, S.C., by Jeffrey P. Sweetland and William E. Parsons IV, and state their complaint against the above-named defendants, as follows:

PARTIES

1. Ronald C. Jesse, Jr. ("Ron") and Shirley A. Jesse ("Shirley") (collectively the "Jesses") are and, at all times material hereto, have been husband and wife. They currently reside at 3755 Highway 45 South, Conover, Vilas County, Wisconsin 54519.

2. Nagel Lumber Company Group Medical, Prescription Drug, Dental and Short Term Disability Plan (the "Plan") is and, at all material times, has been a self-funded employee health and welfare benefit plan sponsored, funded and administered by defendant Nagel Lumber Company, Inc. ("Nagel"), solely for the benefit of Nagel's employees and their covered dependents. At all material times, Nagel has been named as the Plan Administrator, having as its place of business 5135 County Road B, Land o' Lakes, Vilas County, Wisconsin 54540. The Plan is an employee welfare benefit plan, for purposes of the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*

3. At times material hereto, the Jesses were participants or beneficiaries in the Plan for purposes of ERISA, Ron as a covered employee and Shirley as a covered dependent. The Jesses bring this action solely on behalf of the Plan.

4. Defendant Nagel Lumber Company, Inc. ("Nagel") is a Wisconsin corporation having its principal place of business at 5135 County Road B, Land o' Lakes, Vilas County, Wisconsin 54540. Its registered agent for service of process is Edwin A. Nagel at the same address. Nagel's officers are Edwin A. Nagel, president, and defendant Cathy A. Nordine, treasurer. They are also Nagel's sole directors.

5. Defendant Cathy A. Nordine ("Nordine") is an adult individual residing at N1609 Crystal Lake Road, Watersmeet, Gogebic County, Michigan, in the Western District of Michigan. At all times material hereto, Nordine has been secretary or

treasurer of Nagel. Further, at all times material hereto, Nordine handled the day-today operation and administration of the Plan, on Nagel's behalf.

JURISDICTION AND VENUE

6. As described more fully hereinbelow, this is an action by participants and beneficiaries in the Plan to enforce the obligations of Nagel and Nordine as fiduciaries to the Plan under ERISA § 404, 29 U.S.C. § 1104; and to compel them to make good to the Plan all losses it incurred resulting from their breaches of their fiduciary duties, as described more particularly herein, pursuant to ERISA §§ 409 and 502(a)(2), 29 U.S.C. §§ 1109 and 1132(a)(2), which breaches included, but were not limited to, fraud and concealment for purposes of ERISA § 413, 29 U.S.C. § 1113; to obtain equitable redress for such breaches, pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3); and to enforce the Plan's claims against Nagel for the funds necessary to pay benefits owed by the Plan.

7. Jurisdiction over this action is conferred upon this court by ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1) and 28 U.S.C. Sec. 1331, because the claims herein arise under various provisions of ERISA.

8. Venue is proper in the Western District of Wisconsin pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2) and 28 U.S.C. Sec. 1391(b), because a substantial part of the events and omissions giving rise to these claims occurred in this district, because the Plan was administered in this district; because, in substantial part, the breaches asserted herein took place in this district; and because defendant Nagel is domiciled in

Wisconsin, maintains its principal place of business in this District and does substantial business in this District.

9. This court has personal jurisdiction over defendant Nagel pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), because the Plan was administered and the breaches alleged occurred, in substantial part, in the Western District of Wisconsin; because the claims against it arise, in substantial part, as a result of conduct in which it engaged in the Western District of Wisconsin; and because it is domiciled in and may be found in the Western District of Wisconsin, a judicial district of the United States.

10. This court has personal jurisdiction over defendant Nordine pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), because the Plan was administered and the breaches alleged occurred, in substantial part, in the Western District of Wisconsin; because the claims against her arise, in substantial part, as a result of conduct in which she engaged in the Western District of Wisconsin; and because she resides and may be found in a judicial district of the United States.

FACTS COMMON TO ALL CLAIMS

11. At all material times, Nagel operated a sawmill and lumber dealership in Land o' Lakes, Wisconsin.

12. From on or about July 1, 1993, or earlier, until on or about January 1, 2003, or later, Nagel maintained the Plan as a self-funded health and welfare plan to provide health insurance benefits for its active full-time employees who worked an average of

40 hours per week for Nagel. A true and correct copy of the Plan's Summary Plan Description ("SPD") is attached hereto and made a part hereof as **Exhibit 1.**

13. Prior to July 1, 2002, the Plan provided, in pertinent part, that, after payment of an annual deductible of $100 per individual, up to $300 per family, it would pay 80% of covered medical expenses up to $2,000 per individual per year and $5,000 per family per year, and 100% of covered medical expenses thereafter. The insureds would not pay more than $500 per individual per year or $1,300 per family per year for covered medical expenses.

14. Beginning July 1, 2002, the Plan established a preferred-provider-option ("PPO") network and provided that, after payment of an annual deductible of $250 per individual, up to $750 per family, it would pay 90% of covered in-network medical services and 80% of covered out-of-network services, up to $2,500 per individual per year and $5,000 per family per year, and 100% of covered medical expenses thereafter. The insureds would not pay more than $500/ $1,250 in-network or $750/$1,750 out-of-network per year. The notice of "Benefit Plan Design Changes Effective 7/1/02," which Nagel distributed to its covered employees, is attached hereto and made a part hereof as **Exhibit 2.**

15. At times material hereto, including but not limited to the period July 1, 2002 to and through December 31, 2002, Ron was a full-time employee of Nagel eligible to participate in the Plan.

16. Under the terms of the Plan, Nagel was named as the Plan Administrator.

17. At all material times, Nagel designated Nordine to carry out the day-to-day administration and operation of the Plan on Nagel's behalf and to exercise discretion in doing so.

18. Nagel, as employer and Plan Administrator, furnished copies of the SPD to its employees covered by the Plan, including Ron.

19. The SPD provided, in pertinent part: "The Plan shall pay a provider directly for health services rendered by such provider to a covered person, unless otherwise specified by the employee."

20. Nagel established the Plan as a self-funded health and welfare plan. According to the SPD, this meant that "claims are paid directly by the Plan Administrator [Nagel] from its assets."

21. According to the SPD, Nagel, as Plan Administrator, contracted with Claim Management Services, Inc. ("CMS") as third-party administrator ("TPA") of the Plan, "to process claims, maintain Plan data, and perform other Plan connected services; however, final authority to construe and apply the provisions of the Plan rest[ed] exclusively with the Plan Administrator." The SPD further recited that the role of CMS as TPA was "to assure accurate, impartial and timely payment of benefits to, and in behalf of covered employees and their covered dependents."

22. Under the terms of the Plan, Nagel, as Plan Administrator, had discretionary authority to direct CMS to deny or pay claims.

23. At all material times, Nagel designated Nordine to handle or oversee Nagel's day-to-day dealings with CMS as TPA of the Plan and to exercise discretion in doing so.

24. Upon information and belief, under the arrangement between Nagel and CMS, CMS processed provider claims and issued benefit checks to the providers in amounts that it determined was payable under the self-funded Plan, drawn on the Plan's bank accounts. Nagel was required to deposit funds into the Plan's bank accounts sufficient to cover amounts that CMS had paid from the Plan and CMS's service fee for its TPA activities.

25. At or about the same time that it mailed the check to the provider, CMS mailed an Explanation of Benefits ("EOB") to the employee on whose account the claim was paid, in the form attached hereto as **Exhibits 3, 5, 7, 9 and 10.**

26. On each EOB, CMS provided an "employee payment report," informed the employee, *inter alia,* of the name of the provider, the dates of service, the total charge, the amount of deductible, coinsurance or copay on the claim, for which the employee was responsible, the "date paid," the amount of "benefit paid" by the Plan, the name of the "payee" on the claim, the "check no.," and the amount of "payment," which matched the "benefit paid."

27. Under the arrangement between Nagel and CMS, as TPA of the Plan, Nagel and Nordine conferred actual and apparent authority on CMS, as their agent and on behalf of the Plan, to issue EOBs to Plan participants and beneficiaries in the

form attached hereto as **Exhibits 3, 5, 7, 9 and 10,** and containing the information set forth therein and described in paragraph 26, above.

28. Upon information and belief, beginning in approximately January 2000, or earlier, because of funding difficulties, Nagel instructed CMS to start holding checks made payable to the medical providers until Nagel was able to amass sufficient funds to transfer into the Plan's checking accounts to cover the checks.

29. Upon information and belief, CMS was unwilling to hold the checks under those terms. Instead, if, when a check to a provider was prepared, Nagel was not able to provide sufficient funds to cover it, CMS sent the check and matching check register to Nordine under a letter in the form attached hereto as **Exhibits 4, 6, 8 and 11.** The letter recited, in pertinent part:

> Since CMS will not hold these checks in our office as you requested, we are forwarding all checks to you for disbursement. Since you will be controlling the disbursement of these checks, CMS will be directing any inquiries from participants to your attention regarding these payments.

30. Even when it sent a check back to Nordine and Nagel for "disbursement" due to insufficient funds, CMS still sent the matching EOB to the employee, representing that the check had in fact been paid to the provider payee on the date shown in the amount indicated. Nothing on the EOB disclosed that the check had, in fact, been sent to Nagel rather than to the payee.

31. Between on or about July 1, 2002 and on or about December 31, 2002, Shirley and the Jesses' daughter, Shannon McDaniel ("Shannon"), who was also a covered beneficiary under the Plan, incurred charges for medical services provided by

Eagle River Memorial Hospital ("ERMH") in Eagle River, Wisconsin, Howard Young Medical Center ("HYMC") (collectively sometimes the "Hospitals"), Stephen M. Lindsey, M.D. ("Lindsey"), Susan Carol Minikel, M.D. ("Minikel"), William L. Schulte, CRNA ("Schulte") and Bruce Hertel, M.D. ("Hertel") (collectively the "Claims" and "Providers," respectively), as follows:

Date of Service	Provider	Patient	Amount Billed
7/20/02	ERMH	Shirley	$ 627.10
8/9/02	ERMH	Shannon	271.75
9/10/02	ERMH	Shirley	486.50
9/10/02	Lindsey	Shirley	190.75
9/19/02	ERMH	Shirley	337.00
9/19/02	Lindsey	Shirley	159.00
9/24/02	HYMC	Shirley	973.00
9/24/02	Minikel	Shirley	230.50
10/11/02	HYMC	Shirley	11,872.94
10/11/02	Schulte	Shirley	1,057.50
10/11/02	Lindsey	Shirley	95.50
10/11/02	Hertel	Shirley	113.50
		TOTAL	**$ 16,415.04**

32. The Providers submitted the Claims to CMS for payment under the Plan.

33. CMS prepared checks drawn on the Plan's bank accounts, for payment to the Providers on the Claims, as follows:

Date of Service	Payee	Amount Billed	Check Number	Check Date	Amount Attributed to Claim
7/20/02	ERMH	$ 627.10	4464	9/17/02	$ 507.94
8/9/02	ERMH	271.75	4464	9/17/02	156.71
9/10/02	ERMH	486.50	4523	10/22/02	394.06
9/10/02	HYMC for Lindsey	190.57	4561	11/5/02	171.68
9/19/02	ERMH	337.00	4558	11/5/02	303.30
9/19/02	HYMC for Lindsey	159.00	4561	11/5/02	143.10
9/24/02	HYMC	973.00	4514	10/15/02	788.12
9/24/02	HYMC for Minikel	230.50	4514	10/15/02	186.70
10/11/02	HYMC	11,872.94	4561	11/5/02	10,685.65
10/11/02	HYMC for Schulte	1,057.50	4561	11/5/02	951.75
10/11/02	HYMC for Lindsey	95.50	4561	11/5/02	85.95
10/11/02	HYMC for Hertel	113.50	4561	11/5/02	102.15
				TOTAL	**$14,477.11**

34. On or about September 17, 2002, CMS mailed to Ron, as the participating employee, EOBs (the "September 17 EOBs") stating that benefits totaling $664.65 had been paid to ERMH on the following Claims, with the Plan's Check No. 4464 on September 17, 2002:

Date of Service	Payee	Patient	Amount Billed	Amount Allegedly Paid
7/20/02	ERMH	Shirley	$ 627.10	$ 507.94
8/9/02	ERMH	Shannon	271.75	156.71

True and correct copies of the September 17 EOBs are attached hereto and made a part hereof as **Exhibit 3.**

35. As Plan fiduciaries, Nagel and Nordine conferred actual and apparent authority on CMS, as their agent and on behalf of the Plan, to mail the September 17 EOBs to Ron.

36. On the basis of the September 17 EOBs, the Jesses concluded that the Claims identified therein had been paid as stated.

37. At or about the same time that it mailed the September 17 EOBs to Ron, CMS forwarded 15 benefit payment checks totaling $9,172.25, including Check No. 4464, for $2,127.26, to Nordine, rather than to the providers, under a cover letter dated September 17, 2002 (the "September 17 Transmittal"), which recited:

> Since CMS will not hold these checks in our office as you requested, we are forwarding all checks to you for disbursement. Since you will be controlling the disbursement of these checks, CMS will be directing any inquiries from participants to your attention regarding these payments.

A true and correct copy of the September 17 Transmittal is attached hereto and made a part hereof as **Exhibit 4.**

38. Neither CMS nor Nagel nor Nordine informed the Jesses that Check No. 4464 had been sent to Nagel for "disbursement" on September 17, 2002, rather than to

ERMH for payment of its Claims, as falsely stated on the September 17 EOBs. The Jesses did not become aware until approximately May 2005, that the Claims allegedly paid with Check No. 4464 had never in fact been paid.

39. Upon information and belief, Nordine and Nagel received the September 17 Transmittal on or about September 19, 2002, but thereafter failed and refused to place funds in the Plan's bank account to cover Check No. 4464 or send Check No. 4464 to ERMH in payment of its Claims.

40. On or about October 15, 2002, CMS mailed to Ron, as the participating employee, EOBs (the "October 15 EOBs") stating that benefits totaling $ 974.82 had been paid to HYMC on the following Claims, with the Plan's Check No. 4514 on October 15, 2002:

Date of Service	Payee	Patient	Amount Billed	Amount Allegedly Paid
9/24/02	HYMC	Shirley	$ 973.00	$ 788.12
9/24/02	HYMC for Minikel	Shirley	230.50	186.70

True and correct copies of the October 15 EOBs are attached hereto and made a part hereof **as Exhibit 5.**

41. As Plan fiduciaries, Nagel and Nordine conferred actual and apparent authority on CMS, as their agent and on behalf of the Plan, to mail the October 15 EOBs to Ron.

42. On the basis of the October 15 EOBs, the Jesses concluded that the Claims identified therein had been paid as stated.

43. At or about the same time that it mailed the October 15 EOBs to Ron, CMS forwarded 19 benefit payment checks totaling $7,185.41, including Check No. 4514, for $974.82, to Nordine, rather than to the providers, under a cover letter dated October 15, 2002 (the "October 15 Transmittal"), which recited:

> Since CMS will not hold these checks in our office as you requested, we are forwarding all checks to you for disbursement. Since you will be controlling the disbursement of these checks, CMS will be directing any inquiries from participants to your attention regarding these payments.

A true and correct copy of the October 15 Transmittal is attached hereto and made a part hereof as **Exhibit 6.**

44. Neither CMS nor Nagel nor Nordine informed the Jesses that Check No. 4514 had been sent to Nagel for "disbursement" on October 15, 2002, rather than to HYMC for payment of its claims, as falsely stated on the October 15 EOBs. The Jesses did not become aware until approximately May 2005, that the Claims allegedly paid with Check No. 4514 had never in fact been paid.

45. Upon information and belief, Nordine and Nagel received the October 15 Transmittal on or about October 18, 2002, but thereafter failed and refused to place funds in the Plan's bank account to cover Check No. 4514 or send Check No. 4514 to HYMC in payment of its Claims.

46. On or about October 22, 2002, CMS mailed to Ron, as the participating employee, an EOB (the "October 22 EOB") stating that benefits totaling $394.06 had been

paid to ERMH on the following Claim, with the Plan's Check No. 4523 on October 22, 2002:

Date of Service	Payee	Patient	Amount Billed	Amount Allegedly Paid
9/10/02	ERMH	Shirley	$ 486.50	$ 394.06

A true and correct copy of the October 22 EOB is attached hereto and made a part hereof as **Exhibit 7.**

47. As Plan fiduciaries, Nagel and Nordine conferred actual and apparent authority on CMS, as their agent and on behalf of the Plan, to mail the October 22 EOB to Ron.

48. On the basis of the October 22 EOB, the Jesses concluded that the Claims identified therein had been paid as stated.

49. At or about the same time that it mailed the October 22 EOB to Ron, CMS forwarded 26 benefit payment checks totaling $15,367.93, including Check No. 4523, for $3,425.24, to Nordine, rather than to the providers, under a cover letter dated October 22, 2002 (the "October 22 Transmittal"), which recited:

> Since CMS will not hold these checks in our office as you requested, we are forwarding all checks to you for disbursement. Since you will be controlling the disbursement of these checks, CMS will be directing any inquiries from participants to your attention regarding these payments.

A true and correct copy of the October 22 Transmittal is attached hereto and made a part hereof as **Exhibit 8.**

50. Neither CMS nor Nagel nor Nordine informed the Jesses that Check No. 4523 had been sent to Nagel for "disbursement" on October 22, 2002, rather than to ERMH for payment of its claims, as falsely stated on the October 22 EOB. The Jesses did not become aware until approximately May 2005, that the Claims allegedly paid with Check No. 4523 had never in fact been paid.

51. Upon information and belief, Nordine and Nagel received the October 22 Transmittal on or about October 25, 2002, but thereafter failed and refused to place funds in the Plan's bank account to cover Check No. 4523 or send Check No. 4523 to ERMH in payment of its Claims.

52. On or about November 5, 2002, CMS mailed to Ron, as the participating employee, an EOB (the "November 5 EOB-ERMH") stating that benefits totaling $303.30 had been paid to ERMH on the following Claim, with the Plan's Check No. 4558 on November 5, 2002:

Date of Service	Payee	Patient	Amount Billed	Amount Allegedly Paid
9/19/02	ERMH	Shirley	$ 337.00	$ 303.30

A true and correct copy of the November 5 EOB-ERMH is attached hereto and made a part hereof as **Exhibit 9.**

53. Also on or about November 5, 2002, CMS mailed to Ron, as the participating employee, EOBs (the "November 5 EOBs-HYMC") stating that benefits totaling

$12,140.28 had been paid to HYMC on the following Claims, with the Plan's Check No. 4561 on November 5, 2002:

Date of Service	Payee	Patient	Amount Billed	Amount Allegedly Paid
10/11/02	HYMC	Shirley	$ 11,872.94	$10,685.65
9/10/02	HYMC for Lindsey	Shirley	190.75	171.68
9/10/02	HYMC for Lindsey	Shirley	159.00	143.10
10/11/02	HYMC for Lindsey	Shirley	95.50	85.95
10/11/02	HYMC for Schulte	Shirley	1,057.50	951.75
10/11/02	HYMC for Hertel	Shirley	113.50	102.15

True and correct copies of the November 5 EOBs-HYMC are attached hereto and made a part hereof as **Exhibit 10.**

54. As Plan fiduciaries, Nagel and Nordine conferred actual and apparent authority on CMS, as their agent and on behalf of the Plan, to mail the November 5 EOBs to Ron.

55. On the basis of the November 5 EOBs, the Jesses concluded that the Claims identified therein had been paid as stated.

56. At or about the same time that it mailed the November 5 EOBs to Ron, CMS forwarded 18 benefit payment checks totaling $23,135.44, including Check No. 4558, for $8,131.02, and Check No. 4561, for $12,297.48, to Nordine, rather than to the providers,

under a cover letter dated November 5, 2002 (the "November 5 Transmittal"), which recited:

> Since CMS will not hold these checks in our office as you requested, we are forwarding all checks to you for disbursement. Since you will be controlling the disbursement of these checks, CMS will be directing any inquiries from participants to your attention regarding these payments.

A true and correct copy of the November 5 Transmittal is attached hereto and made a part hereof as **Exhibit 11.**

57. Neither CMS nor Nagel nor Nordine informed the Jesses that Checks Nos. 4558 and 4561 had been sent to Nagel for "disbursement" on November 5, 2002, rather than to ERMH and HYMC for payment of their Claims, as falsely stated on the November 5 EOBs. The Jesses did not become aware until approximately May 2005, that the claims allegedly paid with Checks Nos. 4558 and 4561 had never in fact been paid.

58. Upon information and belief, Nordine and Nagel received the November 5 Transmittal on or about November 7, 2002, but thereafter failed and refused to place funds in the Plan's bank account to cover Check No. 4558 and 4561 or send Check No. 4558 and 4561 to ERMH and HYMC in payment of their respective Claims.

59. Upon information and belief, Nagel, Nordine and CMS handled the claims of medical providers for payment of covered medical services provided to other Plan participants and beneficiaries in the manner described in paragraphs 29 through 58, above, and that all or substantially all of said claims remain unpaid.

60. If, when CMS sent Ron the September 17, October 15, October 22 and November 5 EOBs, CMS, Nagel or Nordine had informed the Jesses that, in fact, the

checks had been sent to Nagel for "disbursement" when it had funds to cover them, rather than to the Providers, in payment of their Claims, the Jesses would have had the opportunity to make other arrangements for payment of past and future medical expenses and to defer medical treatments, including but not limited to the surgery that Shirley underwent on October 11, 2002, until they could obtain other insurance or otherwise make alternate payment arrangements.

61. Upon information and belief, on or about January 1, 2003, CMS withdrew as TPA of the Plan.

62. Because their Claims remained unpaid, the Hospitals held the Jesses legally responsible for payment.

63. The Jesses have been unable to pay the Claims from their own resources.

64. Because their Claims remained unpaid, the Hospitals reported them to one or more consumer credit reporting agencies as an outstanding indebtedness owed by the Jesses.

65. As a result of the negative credit references from the Hospitals, the Jesses have been turned down on numerous loan applications.

66. In approximately May 2005, the Jesses learned that the Claims, which CMS had represented as "paid" by the Plan, had, in fact, never been paid, resulting in negative credit references against them from the Hospitals.

67. In approximately May 2005, the Jesses demanded that Nagel make good on all the outstanding Claims.

68. On or about May 31, 2005, Nagel sent a fax message to Ron stating, "Nagel Lumber Company has every intention on paying all past due medical bills." A true and correct copy of said fax is attached hereto and made a part hereof as **Exhibit 12.**

69. Despite the assurances made in the May 31, 2005 fax, Nagel has not made any payments against any of the outstanding Claims.

70. By letter dated April 17, 2006, addressed to Nagel and specifically to Nordine's attention, a true and correct copy of which is attached hereto and made a part hereof as **Exhibit 13,** the undersigned Attorney Jeffrey P. Sweetland ("Attorney Sweetland"), on behalf of the Jesses, demanded that Nagel pay the sum of $14,568.29 to the Hospitals in satisfaction of the Claims, plus $2,500 to his firm against attorney fees that the Jesses had incurred to that point.

71. Neither Nagel nor Nordine has paid any part of the payments demanded in the April 17, 2006 letter.

72. Upon information and belief, after receiving Attorney Sweetland's April 17, 2006 letter, Nordine informed the Hospitals that Nagel would pay the Claims, except patient co-pays. Thereafter, neither Nagel nor Nordine made any payments on the Claims.

73. On or about August 2, 2006, Nordine represented to Attorney Sweetland that Nagel was preparing a payment plan, which she would fax to the undersigned shortly. Thereafter, neither Nagel nor Nordine furnished any such payment plan to the Hospitals, the Jesses or Attorney Sweetland.

74. By letter dated August 24, 2006, addressed to Nagel and specifically to Nordine's attention, a true and correct copy of which is attached hereto and made a part hereof as **Exhibit 14,** Attorney Sweetland, on behalf of the Jesses, demanded that Nagel pay to OSI Collections, Inc. ("OSI"), to whom the Hospitals had turned over the Claims for collections, the sum of $14,932.02, the amount OSI claimed was then owing, plus $5,000 to the undersigned's firm against attorney fees that the Jesses had incurred to that point.

75. Neither Nagel nor Nordine has paid any part of the payments demanded in the August 24, 2006 letter.

COUNT I - BREACH OF FIDUCIARY DUTIES BY NAGEL

76. Paragraphs 1 through 75 are realleged as if fully set forth in this Count I.

77. ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), imposes on every fiduciary under a covered employee benefit plan an obligation to

> discharge his[, her or its] duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of (i) providing benefits to participants and their beneficiaries and (ii) defraying reasonable expenses of administering the plan, with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent [person] acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character with like aims . . . in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with [ERISA].

78. ERISA § 402(a)(1), 29 U.S.C. § 1102(a)(1), requires that every employee benefit plan be established and maintained pursuant to a written instrument which provides for "one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan."

79. ERISA § 402(b)(1), 29 U.S.C. § 1102(b)(1), requires that every employee benefit plan "provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of [ERISA]."

80. At all material times, the Plan named Nagel as the "Plan Administrator."

81. By virtue of its designation as Plan Administrator, Nagel was, at all material times, a fiduciary under the Plan subject to the requirements of ERISA § 404.

82. As a Plan fiduciary, Nagel was under an obligation to operate and administer the Plan solely in the interest of the Plan's participants and beneficiaries. Its fiduciary duties included, but were not limited to:

a. Ensuring that covered medical expense claims were processed and paid in a timely manner;

b. Ensuring that the Plan was properly funded in accordance with its stated funding policy and method in order to assure proper and timely payment of covered medical expenses;

c. Providing only truthful information to Plan participants and beneficiaries concerning the administration of the Plan, its financial condition, their benefits and the handling, processing and payment of claims for covered medical services that they received; and

d. Advancing and prosecuting meritorious claims on behalf of the Plan, including but not limited to claims of breach of fiduciary duties.

83. As TPA, CMS, on behalf of the Plan Administrator (Nagel), processed and, when Nagel made funds available, paid the claims of medical providers for covered medical services received by Plan participants and beneficiaries, including, but not limited to, the Jesses.

84. As a Plan fiduciary, Nagel was, at all material times, responsible for the actions undertaken by CMS pursuant to its actual and apparent authority as the Plan's TPA and Nagel's agent, and all such actions were attributable to Nagel as well as to CMS.

85. In each of the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10), CMS represented to the Jesses that the amount shown as "benefit paid" and "payment" had in fact been "paid" to the "payee" on the "date paid." All of those representations were false.

86. All of the representations of payment contained in the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10), were false statements of material fact.

87. The Jesses reasonably and justifiably concluded, based on the representations of payment contained in the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10), that the Claims identified in the EOBs had, in fact, been paid as stated therein.

88. The Jesses reasonably and justifiably relied on the representations of payment contained in the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10),to their detriment, as described in paragraphs 60 through 65, above.

89. At the time that it mailed each of the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10) to the Jesses, CMS knew that all of the representations of payment contained therein were false.

90. CMS's transmittal of knowingly false representations of payment to the Jesses in each of the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10), pursuant to its actual and apparent authority as Nagel's agent, is also attributable to Nagel, as the Plan Administrator.

91. The transmittal of knowingly false representations of payment to the Jesses in each of the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10) constituted intentional fraud.

92. The intentional fraud described in paragraph 91 is attributable to Nagel, which, as Plan Administrator, had conferred actual and apparent authority on its agent, CMS, to issue the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10) as written, and constituted a breach of Nagel's fiduciary duties.

93. The failure of Nagel, Nordine and CMS to disclose to the Jesses that CMS had, in fact, sent the checks identified in each of the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10) to Nagel and Nordine for "disbursement"

when and if Nagel had enough funds to cover them, at the same time that actual payment was falsely represented, constituted fraudulent concealment.

94. The fraudulent concealment described in paragraph 93 is attributable to Nagel, which , as Plan Administrator, had conferred actual and apparent authority on its agent, CMS, to issue the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10) as written, and constituted a breach of Nagel's fiduciary duties.

95. By failing to fund the Plan sufficiently to pay covered medical expenses incurred by Nagel's covered employees and their covered dependents, Nagel failed to operate and administer the self-funded Plan solely in the interest of its participants and beneficiaries.

96. By perpetuating the self-funded Plan when it knew it did not have sufficient funds to cover medical expenses that its employees and covered dependents had incurred and were likely to incur in the future under the Plan, Nagel failed to operate and administer the Plan with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

97. By applying its operating funds to other purposes, rather than to meet the self-funded Plan's obligations, Nagel placed itself in a conflict of interest, which prevented it from carrying out its duties as a Plan fiduciary.

98. As a result of each of the actions and failures described in paragraphs 28 through 59 and 85 through 97, above, the Plan incurred substantial losses, including, but not limited to, losses equal in amount to the benefits that CMS falsely represented as paid in EOBs sent to the Jesses and to other Plan participants and beneficiaries.

99. ERISA § 409(a), 29 U.S.C. § 1109(a), provides, in pertinent part:

> Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

100. By each of the actions and failures described in paragraphs 28 through 59 and 85 through 97, above, Nagel breached the fiduciary duties it owed to the Plan, in violation of ERISA § 409(a), 29 U.S.C. § 1109(a). Nagel is personally liable to make good to the Plan any losses to the Plan resulting from each such breach, including, but not limited to, losses equal in amount to the benefits that CMS falsely represented as paid in EOBs sent to the Jesses and to other Plan participants and beneficiaries, and to restore to the Plan any profits that it made through its use of assets of the Plan. Nagel is also subject to such other equitable or remedial relief as the Court may deem appropriate.

101. By each of the actions and failures described in paragraphs 28 through 59 and 85 through 97, above, Nagel's breaches of its fiduciary duties owed to the Plan

involved fraud, concealment and fraudulent concealment, for purposes of ERISA § 413, 29 U.S.C. § 1113.

102. By its direct involvement in each of the actions and failures described in paragraphs 28 through 59 and 85 through 97, above, and by its disregard of the Jesses' repeated demands that it pay the Claims following their discovery that the Claims had not been paid as represented by CMS, Nagel has demonstrated that any demand that it, in its capacity as a Plan fiduciary, prosecute the claims asserted herein against itself and its treasurer, Nordine, would be futile.

COUNT II - BREACH OF FIDUCIARY DUTIES BY NORDINE

103. Paragraphs 1 through 102 are realleged as if fully set forth in this Count II.

104. At all material times, Nordine, as Nagel's vice president and on Nagel's behalf, oversaw and carried out the day-to-day operation and administration of the Plan, including, but not limited to, her involvement in the activities described in paragraphs 28 through 59 and 85 through 98, above.

105. As the individual who oversaw and carried out the day-to-day operation and administration of the Plan on behalf of the named corporate Plan Administrator (Nagel), Nordine was, at all material times, a fiduciary under the Plan subject to the requirements of ERISA § 404, 29 U.S.C. § 1104.

106. As a Plan fiduciary and the person who dealt directly with CMS in its provision of administrative services to the Plan on a day-to-day basis, Nordine was, at all material times, responsible for the actions undertaken by CMS in its capacity as the

Plan's TPA. All such actions were attributable to Nordine, as well as to CMS and Nagel.

107. As a Plan fiduciary, Nordine was under an obligation to operate and administer the Plan solely in the interest of the Plan's participants and beneficiaries. Her fiduciary duties included, but were not limited to:

a. Ensuring that covered medical expense claims were processed and paid in a timely manner;

b. Ensuring that the Plan was properly funded in accordance with its stated funding policy and method in order to assure proper and timely payment of covered medical expenses;

c. Providing only truthful information to Plan participants and beneficiaries concerning the administration of the Plan, its financial condition, their benefits and the handling, processing and payment of claims for covered medical services that they received; and

c. Advancing and prosecuting meritorious claims on behalf of the Plan, including but not limited to claims of breach of fiduciary duties.

108. CMS's transmittal of knowingly false representations of payment to the Jesses in each of the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10), pursuant to its actual and apparent authority as Nordine's agent, is also attributable to Nordine, as the Plan fiduciary who handled Nagel's day-to-day administration and operation of the Plan and its day-to-day dealings with CMS.

109. The transmittal of knowingly false representations of payment to the Jesses in each of the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10) constituted intentional fraud.

110. The intentional fraud described in paragraphs 91 and 109 is attributable to Nordine, who, as the Plan fiduciary who handled the day-to-day administration and operation of the Plan and the day-to-day dealings with CMS, conferred actual and apparent authority on her agent, CMS, to issue the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10) as written, and constituted a breach of Nordine's fiduciary duties.

111. The failure of Nagel, Nordine and CMS to disclose to the Jesses that CMS had, in fact, sent the checks identified in each of the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10) to Nagel and Nordine for "disbursement" when and if Nagel had enough funds to cover them, at the same time that actual payment was falsely represented, constituted fraudulent concealment.

112. The fraudulent concealment described in paragraphs 93 and 111 is attributable to Nordine, who, as the Plan fiduciary who handled Nagel's day-to-day administration and operation of the Plan and its day-to-day dealings with CMS, conferred actual and apparent authority on her agent, CMS, to issue the EOBs described in paragraphs 34, 40, 46, 52 and 53 as written, and constituted a breach of Nordine's fiduciary duties.

113. By failing to fund the Plan sufficiently to pay covered medical expenses incurred by Nagel's covered employees and their covered dependents, Nordine failed to operate and administer the self-funded Plan solely in the interest of its participants and beneficiaries.

114. By perpetuating the self-funded Plan when she knew it did not have sufficient funds to cover medical expenses that its employees and covered dependents had incurred and were likely to incur in the future under the Plan, Nordine failed to operate and administer the Plan with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

115. By applying Nagel's operating funds to other purposes, rather than to meet the self-funded Plan's obligations, Nordine placed herself in a conflict of interest, which prevented her from carrying out her duties as a Plan fiduciary.

116. As a result of each of the actions and failures described in paragraphs 28 through 59, 85 through 97, and 108 through 115, above, the Plan incurred substantial losses, including, but not limited to, losses equal in amount to the benefits that CMS falsely represented as paid in EOBs sent to the Jesses and to other Plan participants and beneficiaries.

117. By each of the actions and failures described in paragraphs 28 through 59, 85 through 97, and 108 through 115, above, Nordine breached the fiduciary duties she

owed to the Plan, in violation of ERISA § 409(a), 29 U.S.C. § 1109(a). Nordine is personally liable to make good to the Plan any losses to the Plan resulting from each such breach, including, but not limited to, losses equal in amount to the benefits that CMS falsely represented as paid in EOBs sent to the Jesses and to other Plan participants and beneficiaries, and to restore to the Plan any profits that she made or may have made through her use of assets of the Plan. Nordine is also subject to such other equitable or remedial relief as the Court may deem appropriate.

118. By each of the actions and failures described in paragraphs 28 through 59, 85 through 97, and 108 through 115, above, Nordine's breaches of her fiduciary duties owed to the Plan involved fraud, concealment and fraudulent concealment, for purposes of ERISA § 413, 29 U.S.C. § 1113.

119. By her direct involvement in each of the actions and failures described in paragraphs 28 through 59, 85 through 97, and 108 through 115, above, and by her disregard of the Jesses' repeated demands that Nagel pay the Claims following their discovery that the Claims had not been paid as represented by CMS, Nordine has demonstrated that any demand that she, in her capacity as a Plan fiduciary, prosecute the claims asserted herein against herself and her company, Nagel, would be futile.

COUNT III - NAGEL'S FAILURE TO FUND THE PLAN

120. Paragraphs 1 through 119 are realleged as if fully set forth in this Count III.

121. ERISA requires that employers who agree to contribute benefit payments to any employee welfare plan or benefit fund absolutely comply with that obligation.

122. By establishing the Plan as a self-funded employee welfare benefit plan under ERISA, Nagel obligated itself to provide to the Plan all funds necessary to pay all covered claims made and benefits accrued and payable during the term of the Plan's existence.

123. All of the Claims and benefits identified in the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10) and those related to other participants and beneficiaries, as described in paragraph 59, became obligations of the Plan prior to its termination.

124. By failing and refusing to provide funds to the Plan to cover its obligations, as described in paragraph 123, Nagel has breached its obligation to provide the Plan with all funds necessary to pay all covered claims made and benefits accrued and payable during the term of the Plan's existence.

125. As a result of Nagel's breach of its statutory obligation to fund the Plan, the Plan has incurred substantial liabilities and damages, including, but not limited to, liabilities and damages equal in amount to the benefits that CMS falsely represented as paid in EOBs sent to the Jesses and to other Plan participants and beneficiaries.

COUNT IV - REMOVAL OF NAGEL AND NORDINE AS FIDUCIARIES AND IMPOSITION OF TRUSTEESHIP

126. Paragraphs 1 through 125 are realleged as if fully set forth in this Count IV.

127. ERISA § 409(a), 29 U.S.C. § 1109(a), provides, in pertinent part, that the equitable relief available for a fiduciary's breaches of his, her or its fiduciary duties includes "removal of such fiduciary."

128. Their repeated breaches of their fiduciary duties to the Plan, which breaches involved fraud, concealment and fraudulent concealment, disqualify Nagel and Nordine as proper fiduciaries of the Plan.

129. Nagel and Nordine should be relieved of their fiduciary duties and removed as fiduciaries of the Plan.

130. Nagel and Nordine should be barred and enjoined from any further involvement in the administration and operation of the Plan, including, but not limited to, the Plan's collection of funds from Nagel and Nordine to make good its losses resulting from their breaches as alleged hereinabove, and the payment of claims and benefits in accordance with all EOBs issued by CMS that falsely stated such claims and benefits had been paid, including but not limited to the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10).

131. The Court should appoint an independent trustee ("Trustee") to administer and operate the Plan solely in the interest of its participants and beneficiaries, including but not limited to the Jesses, until the breaches of Nagel's and

Nordine's fiduciary duties, as alleged hereinabove, have been remedied, including, but not limited to, the Plan's collection of funds from Nagel and Nordine to make good its losses resulting from their breaches as alleged hereinabove, and the payment of claims and benefits in accordance with all EOBs issued by CMS that falsely stated such claims and benefits had been paid, including but not limited to the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10).

132. The Court should authorize the Trustee to require that Nagel and Nordine account for all covered claims made and benefits paid or payable under the Plan and all funds that were, at any time, placed in the Plan during the time that they served as fiduciaries of the Plan.

133. The Court should further direct Nagel and Nordine to provide the Trustee with sufficient funds with which to pay any and all outstanding covered claims and the Trustee's reasonable and necessary costs of administering the Plan, and otherwise to cooperate with the Trustee in his or her administration of the Plan.

COUNT V - EQUITABLE ESTOPPEL

134. Paragraphs 1 through 133 are realleged as if fully set forth in this Count V.

135. The Jesses were entitled to rely on the statements made in the EOBs described in paragraphs 34, 40, 46, 52 and 53 (Exhibits 3, 5, 7, 9 and 10) as truthful representations that the Claims identified therein were covered and payable under the Plan in the amounts indicated as "benefits paid."

136. Other Plan participants and beneficiaries who received EOBs from CMS, as to which CMS forwarded the checks to Nagel and Nordine for "disbursement" when and if Nagel had sufficient funds to cover them, rather than to the providers for payment of claims, as indicated on the EOBs, were similarly entitled to rely on the statements made in such EOBs as truthful representations that the claims identified therein were covered and payable under the Plan in the amounts indicated as "benefits paid."

137. If CMS, Nagel and Nordine had handled the checks to the provider payees in the manner that the Plan required, CMS would have forwarded them directly to the provider payees as benefits properly payable under the Plan, and Nagel and Nordine would have placed funds from Nagel's operating accounts into the Plan's bank accounts to cover the checks.

138. Equity requires that any remedy of Nagel's and Nordine's breaches of their fiduciary duties, as alleged hereinabove, treat as done that which would have been done but for their breaches.

139. Equity requires that Nagel and Nordine be estopped from denying that any claims or benefits represented as "paid" on any EOB described in either paragraph 135 or 136 were in fact covered and payable under the Plan in the amounts represented in said EOB.

WHEREFORE, the plaintiffs, Ronald C. Jesse, Jr. and Shirley A. Jesse, on behalf of the Plan, respectfully pray that the Court:

1. Declare that, by the actions and omissions alleged hereinabove, defendant Nagel has breached its fiduciary duties owed to the Plan.

2. Declare that, by the actions and omissions alleged hereinabove, defendant Nagel's breaches of its fiduciary duties have involved fraud, concealment and fraudulent concealment.

3. Declare that, by the actions and omissions alleged hereinabove, defendant Nordine has breached her fiduciary duties owed to the Plan.

4. Declare that, by the actions and omissions alleged hereinabove, defendant Nordine's breaches of her fiduciary duty have involved fraud, concealment and fraudulent concealment.

5. Order and direct Nagel forthwith to make good to the Plan for all losses it incurred as a result of the breaches of Nagel's fiduciary duties, as alleged hereinabove.

6. Order and direct Nordine forthwith to make good to the Plan for all losses it incurred as a result of the breaches of Nordine's fiduciary duties, as alleged hereinabove.

7. Award damages to the Plan against Nagel for its breach of its statutory obligation to fund all of the Plan's covered liabilities, as alleged hereinabove.

8. Remove Nagel and Nordine as fiduciaries of the Plan and enjoin them from any further involvement in the administration and operation of the Plan.

9. Appoint a trustee to administer and operate the Plan solely in the interest of its participants and beneficiaries, until such time as the breaches of Nagel's and

Nordine's fiduciary duties, as alleged hereinabove, have been remedied, with authority to require Nagel and Nordine to account for all covered claims made and benefits paid or payable under the Plan and all funds that were, at any time, placed in the Plan during the time that they served as fiduciaries of the Plan.

10. Order and direct Nagel and Nordine to provide the Trustee with sufficient funds with which to pay all outstanding covered claims and all of the Trustee's reasonable and necessary costs of administering the Plan, and otherwise to cooperate with the Trustee in his or her administration of the Plan.

11. Estop Nagel and Nordine from denying that any claims or benefits represented as "paid" on any EOB that CMS sent to any Plan participant or beneficiary, as to which CMS forwarded the check to Nagel and Nordine for "disbursement" when and if Nagel had sufficient funds to cover them, rather than to the providers for payment of claims, as indicated on the EOBs, were in fact covered and payable under the Plan in the amounts represented in said EOB.

12. Award the Jesses their costs of this litigation, including reasonable attorney fees, pursuant to ERISA § 502(g)(1), 29 U.S.C. § 1132(g)(1).

[Continued on next page].

13. Award the Jesses, on behalf of the Plan, such other and further legal and equitable relief as may be just and proper.

Dated at Milwaukee, Wisconsin on July 16, 2008.

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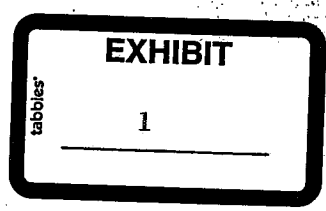
NAGEL LUMBER COMPANY, INC.

Medical, Prescription Drug, Dental and Short Term Disability Benefits

Summary Plan Description

Effective Date of the Revised Plan: July 1, 1993

A Self-Funded Program
Administered By:
Claim Management Services, Inc.



Dear Employee,

We are pleased to present this new benefit booklet. These benefits have been carefully designed to provide you and your family with Group Medical, Prescription Drug, Dental and Short Term Disability Benefits.

This booklet or Summary Plan Description is a brief description of the coverage provided by the Plan. The provisions principally affecting you as described in this booklet are subject to all the terms, conditions, and provisions of the Master Plan Document. In the event that a provision in this booklet conflicts with the Master Plan Document, the Master Plan Document will govern. The Master Plan Document is on file in our Personnel Department and can be viewed in the department during normal working hours.

If, after reading this booklet, you have any questions, you can contact the Personnel Department or call Claim Management Services, Inc. at (414) 497-1589.

Very Truly Yours,

Nagel Lumber Company, Inc.

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PRE-ADMISSION AND CONCURRENT/CONTINUED STAY REVIEW

Pre-admission is a cost containment program designed to monitor medical services and to assure that the treatment a covered person is receiving is necessary and appropriate. Pre-admission verifies the need for all hospital admissions before a covered person is admitted to a hospital. In addition, this service reviews the number of days a physician has planned for a hospital stay. The review also confirms that an admission falls within the guidelines of the Medical Plan. All hospital admissions MUST be pre-authorized before a hospital confinement either in writing, by using the hospital pre-admission review form or by calling the CMS toll-free numbers.

Emergency or Urgent Admissions

An emergency or urgent admission refers to any life threatening situation such as broken bones, severe pain or high fever. If a covered person is admitted to the hospital for an emergency or urgent admission, CMS must be called within 48-hours or the first business day following the emergency admission.

Concurrent/Continued Stay Review

Continued stay review takes place while the covered person is still in the hospital. The CMS review coordinator will remain in contact and will monitor care with the attending physician for the duration of the hospital stay. If the need arises for the covered person to be hospitalized for a longer period of time than that certified by pre-admission review, the attending physician will provide CMS with additional medical information concerning the covered person's condition.

Medical Case Management (MCM)

Individual Medical Case Management (MCM) provides daily monitoring and evaluation of a covered person's medical status, proposed treatment and the availability of any alternative health care services. MCM focuses on those acute or chronic medical cases that result from a serious or debilitating illness or injury. Some common diagnoses that may involve these services are listed below:

* severe burns;

* amputations;

* spinal cord injuries;

* head injuries;

* acquired immune deficiency syndrome;

* organ transplants; or

* cases with over $100,000.00 in accumulated medical expenses.

PRE-ADMISSION AND CONCURRENT/CONTINUED STAY REVIEW

The goal of MCM is to make the most of the covered person's recovery time and to decrease any disability time by coordinating the needs of the covered person, the family, the health care providers and the employer. Some services that may assist MCM in achieving this goal may include the following:

* an on-site evaluation of the covered person's medical status, prognosis and family situation;

* recommendation of alternative medical services including home health care, hospice care and rehabilitation services;

* coordination of outpatient treatment; or

* provisions for specialized medical equipment and supplies.

SCHEDULE OF BENEFITS

The benefits outlined in this schedule are a summary of coverage under the Plan. A more detailed explanation of coverage is provided later in this document.

All benefits specified in the Plan are subject to the Usual and Customary fee that for type of service. All limitations and exclusions of the Plan apply.

All inpatient hospital admissions are subject to the provisions of the Pre-admission and Concurrent/Continued Stay Review Program.

BASIC BENEFITS

Eligible charges as described in the Basic Benefits section of the Plan are payable at 100% up to the maximum amount specified and are not subject to any deductible amount. Eligible charges in excess of the maximum amount are covered under the Major Medical Benefits section of the Plan.

Hospital Room and Board/Hospital Miscellaneous Charges

Semi-private room up to a maximum of 365 days per confinement
Services, supplies and medication required while confined in a hospital

Outpatient Hospital Facility Services

Emergency medical (non-accidental) care
Accident emergency care
Outpatient surgery
X-ray and radiation therapy, including chemotherapy
Diagnostic x-ray and laboratory services

Physician's Services

Basic Benefit Maximum - $25,000.00 Per Illness or Injury

In-hospital medical care
Surgery
Anesthesia
Maternity
Diagnostic x-ray and laboratory services
X-ray and radiation therapy, including chemotherapy

MAJOR MEDICAL BENEFITS

Eligible charges covered under the Major Medical section of the Plan are subject to the deductible and coinsurance amounts listed below.

Individual Deductible

$100.00 Per Person Per Calendar Year.

Family Deductible Limit

$300.00 Per Family Per Calendar Year.

Eligible charges for all family members may be applied toward satisfaction of the family deductible limit, however, no more than $100.00 on any one person will be applied toward the family deductible limit.

Coinsurance Paid By the Plan

Unless otherwise specified, after satisfaction of the deductible, eligible charges are covered at 80% up to a maximum of $2,000.00 for an individual, $5,000.00 for a family. Thereafter, eligible charges are covered at 100% for the remainder of that calendar year.

MISCELLANEOUS BENEFITS

Supplemental Accident Benefit

A maximum of $300.00 will be covered at 100% for each covered accidental injury. Eligible charges are not subject to the deductible amount. Treatment for the accidental injury must be rendered within 90 days of the injury. Thereafter, eligible charges are covered as specified in the Basic and Major Medical Benefit sections of the Plan.

Inpatient Treatment of Mental Health and Substance Abuse

Eligible charges for inpatient treatment of mental health and substance abuse are payable at 100% up to a maximum of 30 days per calendar year. Eligible charges are subject to a separate $100.00 deductible per inpatient admission. Inpatient treatment of substance abuse is limited to one confinement while covered by the Plan.

Outpatient Treatment of Mental Health and Substance Abuse

Eligible charges for outpatient treatment of mental health and substance abuse are payable at 100% up to a maximum of $1,000.00 per calendar year.

Skilled Nursing Facility

Eligible charges rendered in a skilled nursing facility are covered at 100%, not subject to any deductible amount, up to a maximum of 90 days per calendar year. Thereafter, eligible charges are covered subject to the deductible and coinsurance amounts up to a maximum of 90 days per calendar year. Another period of 90 days is available after the covered person has been discharged from a skilled nursing facility for 180 continuous days.

Mandatory Second Surgical Opinion

A covered person must obtain a second surgical opinion for one of the surgical procedures listed herein. Eligible charges for the second opinion examination and related services will be covered at 100%, not subject to the deductible amount.

Mandatory Second Surgical Opinion Non-compliance Penalty

If a covered person fails to obtain a second surgical opinion for a listed surgical procedure, eligible charges in relation to the surgery will be covered at 80%, after satisfaction of the deductible amount.

Home Health Care

Eligible charges for home health care are covered subject to the deductible and coinsurance amounts up to a maximum of 40 visits per calendar year.

Kidney Disease

Eligible charges for the treatment of kidney disease are covered as specified in the Basic and Major Medical Benefit sections of the Plan, up to a maximum of $30,000.00 per calendar year.

X-ray and Radiation Therapy Benefit

Eligible outpatient physician's charges for x-ray and radiation therapy for treatment of malignant and benign conditions are covered subject to the Basic and Major Medical Benefits sections of the Plan. Charges for benign conditions are payable up to $10.00 per visit and $60.00 per calendar year.

Mammography Benefit

Eligible charges for a routine mammogram and related charges are covered at 100%, not subject to the deductible amount. Eligible charges are limited to one mammogram every other year between the ages of 40 and 49 and one mammogram per calendar year following age 50.

MAXIMUM BENEFITS: Applicable for the total period of time in which covered by the Plan.

Maximum Individual Limit For Major Medical Benefits Paid Under the Plan - $500,000.00 Per Person, except as stated below.

PRESCRIPTION DRUG BENEFITS - Effective August 1, 1993

Eligible prescription drugs are payable after satisfaction of the following co-payments:

Generic Prescription - $3.00 Per Generic Prescription.
Brand Name Prescription - $7.00 Per Brand Name Prescription.

DENTAL BENEFITS

Individual Deductible
$25.00 Per Person Per Calendar Year.

Plan Maximum
$750.00 Per Person Per Calendar Year.

Plan Maximum - Orthodontia - Limited to covered dependent children under age 19
$800.00 Per Person While Covered By the Plan.

Class I - Preventive and Basic Services
100% - Subject to the deductible amount.

Class II - Periodontic Services
80% - Subject to the deductible amount.

Class III - Major Services
50% - Subject to the deductible amount.

Class IV - Orthodontic Services
50% - Subject to the deductible amount.

SHORT TERM DISABILITY BENEFITS

Short Term Disability Benefits are available to the employee only.

Waiting Period
Injury - 0 Days.
Illness - Seven Days.

Maximum Benefit
26 Weeks.

Benefit Amount
$150.00 Per Week.

EMPLOYEE ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBLE EMPLOYEES: All active full-time employees who work an average of 40 or more hours per week for the employer. Temporary, seasonal, part-time and retired employees are not eligible for coverage.

EFFECTIVE DATE OF EMPLOYEE COVERAGE: Except as provided below, each employee who is an eligible employee as defined above, shall become effective for coverage on the first day of the month following 60 working days of employment for the employer, provided written application for coverage is made on or before the effective date. If written application for coverage is made after the effective date, Evidence of Good Health must be submitted which is acceptable to the employer. If approved, coverage will become effective on the first day of the month following approval.

NOTE: If a part-time employee becomes full-time for the employer, any days worked on a continuous part-time basis will apply toward satisfaction of the waiting period as specified above.

DELAY OF EFFECTIVE DATE: Coverage will not become effective as stated above if the employee is confined in a medical facility as an inpatient, or is unable to perform the normal duties of employment for the employer as a result of an injury or illness. The effective date of coverage will be delayed until the employee is discharged from the medical facility and is actively at work provided that the employee continues to meet the eligibility requirements as specified by the Plan. This provision only applies to those employees who become eligible to participate after the effective date of the Plan.

EXTENSION OF ACTIVE SERVICE PROVISIONS

MEDICAL AND FAMILY LEAVE ACT OF 1993: Employees who are covered under the Plan and who have been granted leave ("Leave") pursuant to the Medical and Family Leave Act of 1993 (the "Act"), will have coverage under the Plan for the duration of the Leave at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of the Leave.

During a Leave, an employee's participation in the Plan may terminate as a result of non-payment of the employee contribution required in order to participate in the Plan. In such instances, upon the employee's return from Leave, the employee's coverage under the Plan will be restored to that which the employee would have had if the Leave had not been taken and the payment of the employee contribution had not been missed. In such situations, any applicable waiting period and Evidence of Good Health will not apply. The Pre-existing Condition Limitation will apply to the extent not previously satisfied.

APPROVED LEAVE OF ABSENCE: If a personal or medical leave of absence is approved by the employer, coverage will continue during the leave of absence to a maximum of 60 days from the date in which the leave began. If the employee does not return to full-time employment within 60 days, he or she may elect to continue coverage through the COBRA Continuation pro-

vision, provided all other applicable eligibility requirements of the Plan are met.

REINSTATEMENT PROVISIONS

REINSTATEMENT PROVISION: If a covered person's coverage has been terminated for any reason and if the covered person is receiving benefits under the Plan pursuant to the COBRA Continuation provisions, coverage will become effective on the first day of the month following the date on which the person becomes eligible for coverage, provided that there has been no lapse in coverage and all eligibility provisions of the Plan are met. In such instances, the waiting period will not apply. The Pre-existing Condition Limitation will only apply to the extent not previously satisfied. If the covered person is not receiving benefits under the COBRA Continuation provisions of the Plan immediately prior to becoming an employee or dependent eligible for benefits under the Plan, all eligibility requirements of the Plan must be satisfied prior to receiving coverage.

MILITARY LEAVE REINSTATEMENT PROVISION: If coverage terminates for an employee who is a covered person due to entering active military duty of 30 days or more, such person will be eligible for reinstatement into the Plan if written application for such coverage is made within 90 days after the person is discharged from active duty or from hospitalization continuing after discharge for a period of not more than one year and provided the person continues to meet the eligibility requirements of the Plan. In such instances, the waiting period and Pre-existing Condition Limitation shall apply only to the extent those conditions or limitations were not satisfied at the time the person terminated employment to enter active duty.

DEPENDENT ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBLE DEPENDENTS: A dependent is eligible for coverage on:

1. the date the employee is eligible for coverage, if the employee has dependents who may become covered;
2. the date of the employee's marriage for any dependent acquired on the date of marriage;
3. the date of birth of the employee's natural born child; or
4. the date a child is placed in the employee's home for adoption or legal guardianship.

EFFECTIVE DATE OF DEPENDENT COVERAGE: Written application for dependent coverage must be made on or before the employee's effective date of coverage. If written application is made after the employee's effective date, Evidence of Good Health must be submitted which is acceptable to the employer. If approved, coverage will become effective on the first day of the month following approval.

If family coverage is in effect on the date of marriage or on the date of birth of a newborn child, coverage for such spouse or child is effective on that date. If single coverage is in effect, the employee must make written application for family coverage within 31 days of the date of marriage or birth and make any additional contribution, if required. Coverage will then become effective on the date of marriage or on the date of birth. If written application is not submitted within the specified period, Evidence of Good Health must be submitted which is acceptable to the employer. If approved, coverage will become effective on the first day of the month following approval.

DELAY OF EFFECTIVE DATE: Coverage will not become effective as stated above if the dependent is confined in a medical facility as an inpatient, or is unable to engage in the normal activities of a person of similar sex and age in good health. The effective date of coverage will be delayed until the dependent has been discharged from the medical facility and is able to engage in the normal activities of a person of similar sex and age in good health. This provision only applies to dependents of an employee eligible to participate after the effective date of this Plan. This provision does not apply to a newborn child.

Additional eligibility provisions may apply, see the Employee Eligibility and Effective Date of Coverage section of the Plan.

HANDICAPPED CHILD PROVISION: The following provisions apply to a handicapped child who is older than the applicable maximum age. Such a child will be an eligible dependent if:

1. he or she is incapable of earning his or her own living because of physical handicap or mental retardation; and

2. he or she is chiefly dependent upon the covered person for support and maintenance.

Satisfactory proof of (1) and (2) above must be submitted to us within 31 days after the effective date, or the date such dependent attains the age limit.

A handicapped dependent's coverage will be terminated if such dependent marries or ceases to be handicapped.

TERMINATION OF COVERAGE

An employee's or dependent's coverage will terminate upon the earliest of the following occurrences:

1. the date of termination of the employee's employment;
2. the date on which the employee or dependent cease to be in a class eligible for coverage;
3. 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;
4. the date of termination of the Plan;
5. the date on which the employee designates to terminate coverage under the Plan;
6. 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;
7. the date on which the employee or dependent enters military service on an active duty basis, other than for scheduled drills or other training of less than 30 days;
8. the date the employee or dependent no longer meet the eligibility requirements of the Plan;
9. the date a dependent ceases to meet the definition of a dependent;
10. the date on which the employee or dependent is determined to be Totally Disabled;
11. the date on which any extension of coverage expressly provided for in the Plan expires;
12. as to any particular benefit, the effective date on which coverage for the benefit is eliminated by amendment to the Plan; or
13. the date on which the employee or dependent satisfies a Maximum Benefit as specified by the Plan.

CONTINUATION OF COVERAGE (COBRA)

On April 7, 1986, and as amended thereafter, a Federal Law was enacted requiring most employers sponsoring benefit plans to offer employees and their dependents the opportunity for a temporary continuation of coverage. The following will serve as a notice of your rights and obligations under the COBRA Law.

Eligibility For Continuation

A person who is eligible for continuation is called a "**qualified beneficiary.**" The events making a person eligible for continuation are called "**qualifying events.**"

For a covered employee to become a qualified beneficiary, the employee must become ineligible for group coverage because of a qualifying event consisting of one of the following reasons:

1. reduction in the number of hours worked by the employee;
2. voluntary termination of employment by the employee;
3. involuntary termination of employment, except for a termination due to gross misconduct;
4. strike, layoff or walkout of employee;
5. retirement of the employee;
6. a covered employee becoming entitled (covered) under Title XVIII of the Social Security Act (Medicare). If you are covered under Medicare, coverage is not available. If you can provide the employer with proof that you are not covered under Medicare, coverage may be available under the COBRA plan; or
7. employer files for reorganization under Chapter XI of the Bankruptcy Law.

Coverage may continue for a maximum of 18 months for the above circumstances.

In addition to the provisions listed above, a qualified beneficiary who is disabled at the time the employee becomes ineligible for group coverage because of a qualifying event, may be eligible for an additional eleven months beyond the original 18 month continuation, provided that:

1. the qualified beneficiary is "**disabled**" as determined by the Social Security Act under Title II or XVI; and
2. the beneficiary notifies the Administrator of the disability within 60 days of such determination by the Social Security Administration. If a qualified beneficiary has already been determined by the Social Security Administration to be disabled at the time of the qualifying event, the 60 days begins with the day of the qualifying event.

CONTINUATION OF COVERAGE (COBRA)

Continuation is not available to certain non-resident aliens or their dependents. Special rules apply to leased employees and controlled employer groups.

For a covered spouse or covered dependent child to become a qualified beneficiary, the spouse or dependent child must become ineligible for group coverage because of one of the following qualifying events:

1. the death of your spouse or parent (36 months);

2. divorce or legal separation (36 months);

3. termination of your spouse's or parents' employment (for reasons other than gross misconduct) or a reduction in the number of hours worked (18 months);

4. the employee's entitlement to Medicare (36 months). (If you are covered under Medicare coverage is not available.)

5. a dependent child ceasing to meet the eligibility requirements of the Plan (36 months); or

6. the spouse or parents' employer filing reorganization under Chapter XI of the Bankruptcy Law (18 months).

The employee or a family member has the responsibility to inform the employer of a divorce, legal separation, or a child losing dependent eligibility under the Plan within 60 days of the occurrence of any such event. If notice is not received within that 60 day period, the dependent will not be entitled to elect continuation coverage. The employer has the responsibility to notify CMS of the employee's death, termination of employment, reduction in work hours, or Medicare entitlement (coverage). The employee or dependent has at least 60 days to decide whether or not to elect the continuation coverage. The 60 day period runs from whichever is later: (1) the date the notice is given; or (2) the date coverage terminates under the Plan.

If you do not elect continuation coverage, coverage will end. If you elect continuation coverage, coverage will continue for either 18 or 36 months depending on the event that caused the loss of coverage. If during a continuation of only 18 months, another event takes place that would also entitle a dependent spouse or child (other than a spouse or child who became covered after continuation coverage became effective) to continuation coverage, coverage may be extended, but in no case will any period of continuation exceed 36 months.

At the end of the 18 or 36 month continuation, a conversion policy may be available. Your employer is not required to offer you a conversion policy if coverage is terminated prior to the 18 or 36 month continuation period, or if the employer does not normally offer a conversion policy to any other active employee. Please contact your employer for more information concerning this policy.

CONTINUATION OF COVERAGE (COBRA)

Continuation of Coverage will be terminated prior to the 18 or 36 month period for the following reasons:

1. the employer no longer provides coverage to any of its employees;

2. the premium for continuation coverage is not paid in a timely fashion; and

3. you are or become covered under another group plan or Medicare, unless the qualified beneficiary has a condition which is not covered under the other group health plan because of such other group health plan's pre-existing limitation. The qualified beneficiary may have dual coverage, in which case benefits are coordinated in accordance with the terms of each Plan.

Special Bankruptcy Rule

The filing for Chapter 11 Bankruptcy is a qualifying event if coverage is substantially eliminated within one year before or after the bankruptcy filing. The following covered persons are qualified beneficiaries:

1. an employee who retired on or before the date of substantial elimination of coverage under the Plan;

2. a spouse or dependent child of an employee who retired on or before the date of substantial elimination of coverage under the Plan; and

3. a surviving spouse of a deceased retired employee.

Type of Coverage To Be Continued

A qualified beneficiary is entitled to the same coverage that is available to other similarly situated persons covered under the Plan who have not experienced a qualifying event. Evidence of Good Health cannot be required, unless otherwise stated by the Plan.

If there is a choice among types of coverage under the Plan, each qualified beneficiary is entitled to make a separate election among the various coverages. The Plan cannot require a qualified beneficiary to pay for **"non-core"** benefits like dental and vision unless the **"applicable premium"** for core medical coverage would be at least 95% of the **"applicable premium"** for the combined core and non-core (dental and/or vision, if applicable) benefits.

If coverage under the Plan is modified for any group of similarly situated beneficiaries, the coverage will be modified in the same manner for all other qualified beneficiaries covered under the Plan.

Premium For Continuation Coverage

The Plan may require payment of a premium for continuation coverage. The premium cannot exceed 102% of the applicable premium for the period in question. In the case of a disabled qualified beneficiary continuing coverage beyond 18 months, the premium cannot exceed 150%

of the applicable premium for the remainder of the continuation period. The applicable premium is the cost to the Plan for the period in question for similarly situated employees who have not experienced a qualifying event.

For a Self-funded Plan the applicable premium is a reasonable estimate of the cost of providing coverage for the period for similarly situated beneficiaries, determined on an actuarial basis. In the alternative, a Self-funded Plan may determine the applicable premium on the basis of past costs.

Determination of the applicable premium must be made in advance and must apply for a period of 12 months, unless there is a change in the level of benefits in a Plan which results in an increase in the premium amount. Any additional premium increases, because of expanded benefits, may be passed along to COBRA participants on the same basis as any active employees.

Payment of the Applicable Premium

The employer must allow the qualified beneficiary to pay on a monthly basis. The qualified beneficiary has 45 days from the date of their election of coverage to pay for the first month's premium. The employer or designated plan administrator is not required to pay for any claims incurred during the period of time in which the qualified beneficiary elects coverage, and when the qualified beneficiary pays for that coverage. After the first month of coverage under COBRA, the qualified beneficiary has a 30 day grace period for each payment thereafter. The Third Party Administrator will not send the qualified beneficiary a bill each month. The qualified beneficiary is required to remit payment of the applicable premium to the Third Party Administrator on or before the first day of each month. The grace period for premium payment will begin on the date the applicable premium was required. If payment is not received within the amount of time specified and after the grace period has exhausted, continuation of coverage will terminate.

If you have any questions concerning the Continuation of Coverage option, please contact Claim Management Services, Inc. for more information.

PRE-EXISTING CONDITION LIMITATION

Pre-existing condition means an illness or injury for which the employee or dependent has received medical care, treatment, services, prescription drugs, diagnosis or consultation during the three month period immediately prior to the effective date of your coverage under the Plan. The employee or dependent is covered for a pre-existing condition after the earlier of:

1. nine months of continuous coverage under the Plan during which time the employee or dependent did not receive any treatment, medical care, services, prescription drugs, diagnosis or consultation for the pre-existing condition; or

2. twelve months of continuous coverage under the Plan.

BASIC BENEFITS

Eligible charges are covered as specified 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.

Hospital Room and Board

Eligible hospital charges are those incurred for semi-private rooms, wards, intensive care and coronary care units. Eligible charges for a private room are limited to the average semi-private room rate for the facility where confined. When the facility has private rooms only or a private room is medically necessary, the private room rate will be considered.

Hospital Miscellaneous Charges

Eligible charges are covered for medically necessary services and supplies which are provided while hospital confined. Eligible charges are covered for visits made by a physician or medical specialist while confined in a hospital or skilled nursing facility. Personal items which are not medically necessary are not covered.

Outpatient Hospital Services

If a covered person receives care in the outpatient department of a hospital, clinic or in an approved ambulatory surgical center, eligible charges will be covered for the following services:

1. surgery;
2. treatment of an accidental injury;
3. emergency medical care (non-accidental) which is necessitated by the sudden and severe onset of acute symptoms such as fainting, shortness of breath or chest pains;
4. radiation, x-ray and chemotherapy; and
5. pre-admission testing.

PHYSICIAN'S SERVICES

Eligible charges are covered as specified 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.

Diagnostic X-ray and Laboratory Procedures

Eligible charges for x-ray and laboratory services for diagnoses or treatment of an illness or injury are covered when rendered at a physician's office, clinic or a hospital.

Surgical Services

Eligible charges are covered for surgery when performed in a hospital, outpatient department of a hospital, ambulatory surgical center or clinic. Eligible charges include hospital pre-operative and post-operative care. Eligible charges for surgical services are as follows:

1. cosmetic surgery required as a result of an accidental injury which occurred while covered under the Plan;

2. functional repair or restoration of any body part when necessary to achieve normal body function;

3. charges for an assistant surgeon;

4. charges for an elective sterilization for a covered employee or covered dependent spouse; and

5. abortion procedures for a covered employee or covered dependent spouse when the pregnancy is considered a life threatening complication of an non-psychiatric, medical condition. If complications arise following the performance of either an elective or a medically necessary abortion, eligible charges are covered for the complication.

Oral Surgery

Eligible charges for and related to the following oral surgical procedures are covered:

1. surgical exposure or extraction of impacted teeth;

2. excision of exostosis of the jaw and hard palate;

3. treatment of injuries to natural teeth including replacement of such natural teeth. Treatment must begin within 90 days of the accidental injury;

4. apicoectomy - excision of apex of tooth root;

5. external incision and drainage of cellulitis;

6. excision of accessory sinuses, salivary glands or ducts;

7. gingivectomy - excision of loose gum tissue to eliminate infection;

8. alveolectomy - the leveling of structures supporting teeth for the purpose of fitting dentures;

9. frenectomy - the cutting of tissue in the midline of the tongue, usually done to prevent tongue-tie conditions;

10. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is needed;

11. surgery to correct accidental injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth; and

12. extraction of seven or more natural teeth at one time.

Physician's Inpatient Medical Care

Eligible charges incurred by a physician for visits while a covered person is confined in a hospital are covered. Eligible charges are also covered for visits made by required specialists.

Anesthesia

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

Radiation Therapy and Chemotherapy

Eligible charges for x-ray and radium therapy and for chemotherapy are covered when rendered by a provider who is licensed to perform these services.

Maternity Charges

Eligible charges are covered for medical care in connection with pregnancy, childbirth or a related medical condition of a covered employee or covered dependent spouse. Charges for dependent child maternities and any complications thereof are not covered.

Newborn Coverage

Eligible charges for inpatient care of a newborn infant of the covered employee or covered dependent spouse are as follows:

1. hospital nursery room, board and care;

2. necessary x-ray and laboratory services;

3. physician's visits;

4. charges for circumcision;

5. treatment for premature birth; and

6. necessary surgery to repair or restore a body part to achieve normal function.

MAJOR MEDICAL BENEFITS

Eligible charges are covered as specified 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.

Eligible charges are covered for the following:

1. examinations when rendered for the diagnosis and treatment of an illness or injury;

2. services of a Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), and Private Duty Nurses for nursing care ordered by a physician;

3. blood or blood plasma, other than the covered person's or that which has been donated specifically for the covered person;

4. physical, speech, vision and occupational therapy;

5. initial purchase of prosthetic devices and supplies, including artificial limbs, larynx or eyes which replace an absent or malfunctioning body part or organ;

6. casts, splints, trusses, orthopedic braces and crutches;

7. special supplies when prescribed by the attending physician such as:

   * catheters;

   * colostomy bags, rings and belts;

   * flotation pads; and

   * diabetic supplies (i.e., test tape and chemstrips), including one insulin infusion pump each calendar year if the covered person has used that pump for a minimum of 30 days.

8. rental (not to exceed purchase price) or purchase of durable medical equipment, such as wheelchairs, hospital-type beds, iron lung, oxygen equipment (including oxygen) and other durable medical equipment. Durable medical equipment is equipment which:

   * can withstand repeated use;

   * is primarily and customarily used to serve a medical purpose; and

   * generally is not useful to a covered person in the absence of an illness or injury.

Eligible charges for medical equipment which is prescribed by a physician will be covered while the covered person is receiving medical care. Eligible charges are limited to the least expensive item which is adequate for the covered person's needs;

9. injections of medication related to a covered illness or injury;

10. charges for local professional ambulance service. Transportation must be to the nearest hospital qualified to provide treatment for the injury or illness. If the injury or illness requires special treatment not available in a local hospital, transportation to the nearest hospital equipped to provide treatment is covered;

11. orthopedic shoes when attached to a leg brace;

12. charges for routine pap smears; and

13. charges for human organ and tissue transplants are covered if the transplant procedure is not experimental and investigational. When a donor or recipient is involved, charges will be 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, both the donor and the recipient are entitled to the benefits of the Plan. Benefits provided to the donor are charged against the recipient's coverage under the Plan;

    (c) when only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. No benefits are provided to the non-covered transplant recipient; or

    (d) 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, supplies and medications which are dispensed while either an inpatient or outpatient in a medical facility. Benefits are not payable under the Plan if available from another plan, organization or Medicare.

MISCELLANEOUS BENEFITS

Eligible charges are covered as specified 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.

Supplemental Accident

Eligible charges are covered as specified on the Schedule of Benefits when incurred as a result of an accidental injury which occurs while the person covered under the Plan and is treated within 90 days of the accident. Thereafter, eligible charges will be covered on the same basis as otherwise specified by the Plan.

Inpatient and Outpatient Treatment of Mental Health and Substance Abuse

Eligible charges for inpatient and outpatient treatment of mental health and substance abuse are covered as specified on the Schedule of Benefits. Treatment must be rendered in a facility approved in the State in which located. Outpatient services may include partial hospitalization privileges and collateral interviews with the covered person's family. These services must be related to the diagnosed condition.

Skilled Nursing Facility

Eligible charges for care rendered in a licensed skilled nursing facility are covered as specified on the Schedule of Benefits. The covered person must enter a licensed skilled nursing facility within 24-hours after discharge from a hospital confinement. Care must be medically necessary as certified by the attending physician every seven days and which are for the same condition treated in the hospital. The daily rate will not exceed the rate established for such care by the Department of Health and Human Services.

Mandatory Second Surgical Opinion

A covered person must obtain a second surgical opinion for any surgical procedure listed below, unless performed as a result of an emergency. Eligible charges for the second surgical examination and related services will be covered as specified on the Schedule of Benefits. The following surgical procedures require a second surgical opinion:

reconstruction of the hip;
removal of the gall bladder;
surgery of the big toe to correct deformity, including bunion removal;
removal of the uterus;
removal of the vertebral arch (back/spine);
removal of cartilage of the knee;
bone surgery of the foot;
removal of all or part of the kneecap;
surgical reconstruction of the nose, including submuccous resection;
surgery of tendon sheaths (wrists only);

removal of tonsils or adenoids;
surgery of the coronary artery;
removal of all or part of the prostrate gland;
myringotomy (insertion of ear tubes).

When a second surgical opinion examination is required, the covered person must have the physician complete a Second Surgical Opinion Report. The appropriate form can be obtained from the employer.

The physician giving the second opinion must not be in medical practice with the physician who first recommends surgery, also that physician may not perform the surgery. No benefits are payable for a third or more opinion.

After a covered person obtains a second surgical opinion, it is the covered person's decision whether or not to have the surgery, no matter what the results are from the second opinion.

Mandatory Second Surgical Opinion Non-compliance Penalty

If a covered person fails to obtain a second surgical opinion for a surgical procedure listed above, eligible charges in relation to the surgery will be reduced as specified on the Schedule of Benefits.

Home Health Care

Eligible charges for home health care rendered by a hospital or a home health care agency are covered as specified on the Schedule of Benefits. Each four hours in a row or less of home health aide services in any 24-hour period are counted as one home health care visit. The attending physician must certify that: (1) hospitalization or confinement in a skilled nursing facility would be required without home health care; (2) the covered person's family or person living with the patient cannot give necessary care and treatment without causing undue hardship; and (3) home health care services are coordinated by a state licensed, Medicare certified home health care agency or certified rehabilitation agency.

Home health care services are:

* nursing care supervised by a R.N. (part-time or on occasion);

* medically necessary home health aides services (part-time or on occasion) supervised by a R.N., or a medical social worker, if home health aide services are solely for the covered person's care;

* medical supplies, drugs and medications prescribed by a physician, or necessary laboratory services, but only to the extent such services or supplies would have been provided under the Plan had the covered person been hospitalized;

* nutritional counseling rendered by or under the supervision of a registered dietitian when medically necessary;

when medically necessary;

* physical, occupational, speech or respiratory therapy; and

* evaluation of the need for a development of a plan for home health care by a R.N., physician or medical social worker when requested or approved by a physician.

Treatment of Kidney Disease

Eligible charges are covered for the treatment of kidney disease and are limited to the following:

1. hospital, surgical and other necessary medical expenses, including rental of kidney dialysis equipment, incurred during kidney dialysis treatment as a resident inpatient or outpatient of a hospital or in the home of the covered person;

2. hospital, surgical and other necessary medical expenses during a kidney transplant operation or treatment of an artificial kidney;

3. all reasonable medical expenses incurred by a potential donor, including evaluation, hospitalization, surgical and postoperative follow-up expenses; and

4. all reasonable expenses in procurement, transportation and preservation of cadaveric donor kidneys used in a kidney transplant operation on the covered person.

Benefits under the Plan will not be duplicated if they are available under another group plan, organization or Medicare. Eligible charges are covered as specified on the Schedule of Benefits.

X-ray and Radiation Therapy Benefit

Eligible outpatient physician's charges for x-ray and radiation therapy for treatment of malignant and benign conditions are covered as specified on the Schedule of Benefits.

Mammography Benefit

Eligible charges for a routine mammogram and related charges are covered as specified on the Schedule of Benefits. Eligible charges are limited to one mammogram every other year between the ages of 40 and 49 and one mammogram per calendar year following age 50.

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

The following charges are not covered by the Plan. No benefits will be paid with respect to them, except as specified:

1. Those due to an illness or injury which results from war, declared or undeclared, including armed aggression resisting by the forces of any country or combination of countries, or any act incident to war.

2. Claims arising out of, or in any course of any occupation or employment for wage or profit or claims for which the covered person is entitled to benefits under any Workers' Compensation of Occupational Disease Law, whether benefits are claimed or not.

3. Those which the covered person is not legally obligated to pay, which are for custodial care, 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.

4. Those made by a Veteran's Administration hospital for a service-related condition.

5. 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.

6. Those made for routine eye care, eyeglasses, contact lenses, routine hearing checks, hearing aids, or charges for the fitting of eyeglasses, contact lenses or hearing aids, unless otherwise specified by the Plan.

7. Those made for personal comfort items including television and telephone.

8. Charges for routine examinations, routine immunizations, well-baby care and any related charges. Charges for third party examinations such as occupation, court ordered treatment, purchase of insurance, school or employment exams.

9. Charges for dental services, unless otherwise specified.

10. Charges in excess of the "Usual and Customary," as specified in the General Terms and Definitions and General Information sections of the Plan.

11. Charges for services not medically necessary for diagnosis and treatment of an illness or injury. Medical necessity means that care and treatment is the generally accepted, proven and established practice by most other physicians with similar experience and training.

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

12. Services, supplies, human organ and tissue transplants, prescription drugs or medications which are Experimental and Investigational.

13. Travel for health.

14. Custodial care and rest cures.

15. Illness or injury resulting from or attempting to commit a felony.

16. Charges in connection with cosmetic surgery or treatment, except those charges related to an accidental injury which occurs while covered under the Plan, or a congenital defect which impairs the function of a body part.

17. Personal hygiene and convenience items.

18. Charges incurred before the effective date or after the date of termination of coverage.

19. Failure to keep a scheduled visit, phone consultations, completion of claim forms or return to work or school forms.

20. Services rendered by a family member.

21. Purchase or rental of: exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, commodes, grab bars, shower seating, cervical pillows, massagers, or heel lifts.

22. Treatment of infertility and fertility enhancements, including in vitro fertilization, artificial insemination, transsexual surgery or treatment, treatment of sexual dysfunction not related to organic disease, or any other artificial means of conception. Procedures designed to reverse elective or medically necessary sterilizations are not covered.

23. Charges made by a hospital for a private room, unless otherwise specified by the Plan.

24. Home health care charges are not payable for the following:

    * no more than the maximum number of visits specified on the Schedule of Benefits;

    * the maximum weekly benefit for such coverage shall not exceed the Usual and Customary weekly cost for care in a skilled nursing facility;

    * home health care shall be approved by the attending physician, if hospitalized immediately prior to the home health care;

* home health care benefits will not be duplicated if it is available under more than one plan;

* no services will be covered for custodial care;

* no charges will be covered for food, housing, homemaker services or home delivered meals; and

* no charges will be covered for services that are not specified by the Plan.

25. Charges made for wellness programs such as smoking cessation, including deterrents.

26. Charges for treatment of Temporomandibular Joint Dysfunction (TMJ).

27. Charges for a grandchild of the employee, unless the child meets the definition of a dependent specified in the Plan.

28. Charges made for routine foot care such as flat feet conditions, subluxation, corns, callouses or toenails, other than the complete removal of the nail matrix.

29. Charges in excess of any maximum benefit amounts specified on the Schedule of Benefits.

30. Services received from a dental or medical department, maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group.

31. Charges for room, board, and general nursing care for hospital admissions, mainly for physical therapy or for diagnostic studies.

32. Charges for weight loss and treatment of obesity, regardless of medical necessity.

33. Charges for a pre-existing condition, as defined by the Plan.

34. Charges for an abortion, other than an abortion performed in a life threatening situation.

35. Contraceptive medications and devices, including those which are surgically implanted or injected.

36. Chelation therapy, rolfing or reflexology.

37. Charges related to a dependent child maternity and any related complications resulting thereof.

38. Charges for dental implantology.

39. Marriage counseling.

40. Charges incurred for injuries resulting from or caused by chewing food or similar substances.

41. Charges for a self-inflicted illness or injury, whether committed while sane or insane.

42. Acupuncture and hypnosis therapy.

43. Orthotic devices, other than orthopedic shoes when attached to a leg brace.

44. Chiropractic services.

45. Prescription drugs whether covered or not covered under the Bravell Prescription Drug Program.

46. Charges which are reimbursable through medical coverage provided by or available through any applicable "No-Fault" automobile law or coverage, or any other automobile, homeowners, aircraft, boat owners, or similar policy of insurance.

47. Charges incurred for or related to an illness or injury which occurs as the result of: (1) participation in athletics sponsored by a school, college or university; or (2) a school sponsored function which occurs on or off school property, including bus rides to and from the school.

PRESCRIPTION DRUG BENEFITS

Bravell Claims Management will administer the Prescription Drug Plan. All prescription drug claims should be submitted directly to Bravell Claims Management for reimbursement.

Under this benefit, the covered person is responsible for the co-payment as specified on the Schedule of Benefits. After satisfaction of the listed co-payment, eligible charges are covered at 100%.

Eligible prescription drugs are as follows:

1. federal legend drug;
2. compounded medication of which at least one ingredient is a prescription legend drug;
3. insulin on prescription;
4. insulin syringes and needles. Charges for other diabetic supplies may be covered under the Medical Plan; and
5. over-the-counter Meclizine on prescription.

The prescription drug benefit applies if the covered person has the prescription filled by a participating pharmacy. If the covered person is unable to locate a participating pharmacy, the prescription should be submitted directly to Bravell Claims Management at the following address:

Bravell Claims Management
13555 Bishops Court, Suite 230
Brookfield, WI 53005
(414) 784-4600

Payment is limited to the amount usually prescribed by the physician, not to exceed a 34-day supply or 100 unit doses, whichever is greater.

Limitations and Exclusions

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. administration of a covered drug by injection or other means;
3. refills of covered drugs which exceed the number that the prescription order speci-

fies, 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;

12. prescription drugs or medicines for infertility, artificial insemination, in vitro or in vivo fertilization of an ovum, including Pergonal (Menotropins);

13. prescription drugs or medicines used in connection with, or for subsequent treatment of, transplants of body parts, tissues or substances, or implants of artificial or natural organs;

14. the Coordination of Benefits provision listed in the Plan does not apply to the Prescription Drug Benefit. (The Prescription Drug Plan will be the primary payor of benefits);

15. non-legend drugs, other than Insulin and Meclizine;

16. therapeutic devices or appliances, including support garments, and other non-medicinal substances, except those listed herein;

17. topical Minoxidil preparations, whether commercially purchased or compounded;

18. anorectic drugs, used for the treatment of obesity;

19. all drugs which are not self-administered or are administered in a hospital, long-term care facility or other inpatient setting;

20. implantable contraceptives such as Norplant, regardless of intended use;

21. smoking deterrents;

22. human growth hormones;

23. contraceptives, oral or other, unless determined to be medically necessary for a non-contraceptive purpose; or

24. fluoride preparations, other than vitamin combinations.

DENTAL BENEFITS

Eligible charges are covered as specified 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.

Pre-determination of Benefits

Prior to the beginning of extensive dental treatment, the dentist should submit to CMS a pre-treatment estimate stating each service to be done and the charges for these services. The pre-treatment estimate will be reviewed and CMS will determine the eligible benefit. The dentist will be notified of the services covered and the benefits available. All ineligible services or charges are the covered person's responsibility for payment. The final decision regarding dental work is the covered person's.

Class I - Preventive and Basic Services

1. Routine prophylaxis (cleaning and scaling of teeth) by a dentist or a dental hygienist, but not more than once in any six consecutive month period.

2. Topical application of fluoride by a dentist or dental hygienist, limited to one application in any six consecutive month period for covered dependents up to age 19.

3. Routine oral examinations, but not more than once in any six consecutive month period.

4. Dental x-rays - full mouth (once in three consecutive calendar year period); supplementary bitewing (once in six consecutive month period); or any other x-rays needed to diagnose a condition.

5. Oral surgery, except those procedures covered under the Medical portion of the Plan.

6. Endodontics, including pupal therapy and root canal therapy.

7. Emergency palliative treatment.

8. Injections of antibiotic drugs by the attending dentist.

9. Routine extractions.

10. Anesthesia given in connection with covered services, except when covered under the Medical portion of the Plan.

11. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth.

12. Space maintainers that replace prematurely lost teeth for children under the age of 19.

13. Inlays, onlays, or crowns to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive dental caries or fractures cannot be restored with an amalgam,silicate, acrylic, synthetic, porcelain or composite filling restoration. If you and your dentist choose another type of restoration, an allowance equal to the charge for an amalgam, acrylic, silicate, synthetic, porcelain or composite filling restoration will be made, and you will be responsible for the balance.

14. Charges for sealants.

15. Emergency denture repair and adjustments.

Class II - Periodontic Services

1. Treatment of periodontal and other diseases of the gums and tissues of the mouth.

Class III - Major Services

1. Initial insertion of fixed bridges, inlays, onlays or crowns in conjunction with abutments, including repairs and adjustments.

2. Initial insertion of partial or full dentures, including repairs and adjustments incurred within six months following the initial placement, provided:

   * if a cast chrome or acrylic denture will restore the dental arch satisfactorily, payment will not be made toward a more elaborate or precision appliance that the patient and dentist may choose to use. Any balance shall be the responsibility of the patient; or

   * if the patient and dentist decide on personalized restorations or specialized techniques as opposed to the standard procedure, payment shall be limited to the applicable percentage of the cost of the standard denture services. Any balance shall be the responsibility of the patient.

3. Replacement of an existing partial, full denture or fixed bridge or addition of teeth to an existing partial to be a fixed bridge, but only if satisfactory evidence is presented that:

   * the replacement or addition of teeth is required to replace one or more teeth extracted after the existing partial or fixed bridge was inserted;

   * the existing denture or fixed bridge was inserted at least five years prior to its replacement and the existing denture or fixed bridge cannot be made serviceable; or

* the existing denture is an immediate permanent and replacement by a permanent denture takes place within twelve months from the date of initial insertion of the immediate temporary full denture.

4. Relining or rebasing of dentures more than six months after installation or replacement, up to once in any 36 consecutive month period.

Class IV - Orthodontic Services

Orthodontics are dental services which involve an appliance treatment, whether functional or myofunctional or dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as a result of an accidental injury which requires repositioning of teeth to establish normal occlusion.

1. **Method of Payment** - payable at the beginning of treatment and in equal amounts calculated on the basis of the total cost and duration of the treatment plan, regardless of services rendered during any such quarter that the contract is in effect. The payment method is applied to any portion of the treatment plan that is carried out while the contract is in effect.

2. If orthodontic treatment is terminated for any reason before completion, benefits shall cease with payment to the date of termination. If such services are resumed, benefits to the extent remaining, shall resume.

3. Treatment may be terminated by the dentist by written notification to CMS and to the patient for lack of patient interest and cooperation.

4. Related services for orthodontic purposes such as exams, extractions and x-rays shall be covered at the orthodontic coinsurance percentage up to the Plan Maximum.

LIMITATIONS AND EXCLUSIONS OF THE DENTAL PLAN

The following charges are not covered under the Plan. No benefits will be paid with respect to them, except as specified:

1. Benefits or services for injuries or conditions compensable under Workers' Compensation or Employers' Liability Laws, or benefits or services which are available from any Federal or State Government Agency, or from any municipality, county or other political subdivision or community agency, or from any foundation or similar entity.

2. Benefits or services which are determined by CMS to be cosmetic surgery or dentistry for cosmetic reasons, including the alteration or extraction and replacement of sound natural teeth to change appearance.

3. Benefits, services or appliances including prosthodontics (including crowns, dentures and fixed bridges) started prior to the date the patient became eligible under this Plan or rendered after the termination date of coverage.

4. Premedications, prescription drugs, charges for hospitalization, anesthesia for restorative dentistry unless prescribed need is shown, preventive control programs, charges for the failure to keep a scheduled visit with the dentist, services of an anesthesiologist or charges for the completion of claim forms.

5. Benefits and services which are not necessary and customary as determined by the standards of generally accepted dental practice.

6. Appliance or restorations for increasing vertical dimension for restoring occlusion, for replacing tooth structure lost by attrition, for correcting congenital or developmental malformations or for esthetic purposes.

7. No benefits are payable for fees for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist.

8. Dental care of injuries or illness caused by war or act of war, riots or any other form of civil disobedience, injuries sustained while in the act of committing a criminal act, and dental care of injuries or illness caused by atomic or thermonuclear explosion or by radiation resulting therefrom.

9. Replacement of lost or stolen dentures or charges for duplicate dentures, bridgework or appliances.

10. Any service which is not specifically provided for under this program.

11. Periodontal splinting procedures, other than provisional intracornal stabilization of mobile teeth.

LIMITATIONS AND EXCLUSIONS OF THE DENTAL PLAN

12. Precision attachments and precision partials.

13. Treatment partials, except as specifically provided.

14. Charges for myofunctional therapy, athletic mouth guards or night guards.

15. Charges payable under the Medical portion of the Plan.

16. Services rendered by a family member.

17. Charges for porcelain or similar properties of crowns and pontics placed on or replacing teeth, other than the ten most anterior upper and lower teeth.

18. Services or supplies which are Experimental and Investigational.

19. Charges for behavioral management.

20. Dietary counseling, oral hygiene or plaque control.

21. Facings on pontics or crowns behind the second bicuspid.

22. Transplanting teeth or implanting fabricated teeth.

23. Treatment of the Temporomandibular Joint Dysfunction (TMJ).

24. Charges in excess of the "Usual and Customary," as specified in the General Terms and Definitions and General Information sections of the Plan.

25. Any expense not normally charged for in absence of this Plan.

26. Treatment rendered outside of the United States and Canada if the covered person traveled to such location for the sole purpose of receiving dental treatment.

27. Charges for analgesia.

28. Crowns for dependent children under the age of twelve.

29. Repair or replacement of an orthodontic appliance.

SHORT TERM DISABILITY BENEFITS

If an employee is completely unable to perform any and every duty of the employee's occupation and employment as a result of an injury or illness which did not arise out of, or in the course of, employment for wage or profit, the employee may be eligible to receive a weekly benefit. Benefits will be paid as specified on the Schedule of Benefits. The employee must be under the care of a physician. A period of disability will begin on the day the physician is first consulted for that injury or illness.

Commencement and Duration of Benefits

1. If an employee becomes disabled due to an injury, weekly benefits shall begin on the first day the disability occurs.

2. If an employee becomes disabled due to an illness, weekly benefits shall begin on the eighth day following the disability.

3. Benefits under both (1) and (2) above shall be paid up to the maximum specified on the Schedule of Benefits.

Successive Disabilities

1. Separate periods of disability due to the same or related illness or injury will be considered the same period of disability unless the employee returns to active employment for two consecutive weeks between the periods of disability.

2. Separate periods of disability due to unrelated causes will also be considered the same period of disability unless the employee returns to active employment for one full day between the periods of disability.

How To File A Short Term Disability Claim

The employee should notify his or her employer as soon as he or she is unable to work due to an accidental injury or illness. The employer will supply the employee with a Disability Claim Form and additional filing information.

Exclusions

Short Term Disability Benefits will NOT be provided:

1. for any day on which the employee is not under the care of a physician;

2. for any day on which the employee is working for compensation;

3. when such benefits would duplicate benefits payable under a Workers' Compensation Act or any employer liability law;

4. if the employee is imprisoned following conviction of a crime or public offense;

5. for a disability 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;

6. for a disability which results from the use of intoxicants or any controlled substances, unless the substances are prescribed by a physician; or

7. for a disability resulting from a self-inflicted illness or injury, whether committed while sane or insane.

COORDINATION OF BENEFITS

The Plan contains a non-profit provision coordinating it with other plans under which an individual is covered, so that the total benefits available will not exceed 100% of the allowable expense.

Definitions

"Plan" means any Plan providing benefits or services which are provided by a: (a) group, blanket, or franchise insurance coverage; (b) group practice, and other group prepayment coverage; (c) any coverage under labor-management trusted plans, union welfare plans, employer organization plans, or employee benefit organization plans; (d) any coverage under governmental programs such as, but not limited to, Medicare, and any coverage required or provided by any Statute; (e) individual automobile **"no-fault"** and traditional auto insurance; (f) individual or family insurance; (g) subscriber contracts; (h) individual or family coverage through Health Maintenance Organizations (HMO); (i) limited service organizations or any other prepayment; (j) student accident insurance provided through or by an educational institution; and (k) group practice or individual practice plan.

The term **"Plan"** is construed separately with respect to each Plan, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such plan, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

"Allowable Expense" means any necessary, reasonable and customary item of expense, at least a portion of which is covered under at least one of the Plan(s) covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

"Claim Determination Period" means calendar year, except that if in any calendar year the person is not covered under the Plan for the full calendar year, the Claim Determination period for that year will be that portion during which the person was covered under the Plan.

"Claim" means a request that benefits of a Plan be provided or paid.

"Secondary Plan" means a plan which is not a primary Plan according to the Order of Benefit Determination rules, and whose benefits are determined after those of another plan and may be reduced because of the other plan's benefits.

Effect on Benefits

Standard: When a claim is made, the primary Plan pays its benefits without regard to any other plan. The secondary plan adjusts its benefits so that the total benefits available will not exceed the allowable expense. No plan pays more than it would without the coordinating provision.

Order of Benefits Determination

For the purpose of the Effect on Benefits Provision above, the rules establishing the Order of Benefits Determination are:

1. if the other plan doesn't have Coordination of Benefits, that plan pays first;

2. the benefits of a plan which covers the person on whose expenses claim is based other than as a dependent are determined before the benefits of a plan which covers such as a dependent; or

3. **Birthday Rule:** the benefits of a plan which covers the person on whose expenses claim is based as a dependent are determined according to which parent's birthdate occurs first in a calendar year **(day and month)**. If the birthdates of both parents are the same, the plan which has covered the person for the longer period of time will be determined first. If the other plan does not have the birthday rule but has the gender rule, 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.

   If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the dependent are determined in this order:

   * when parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be the primary plan;

   * when parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody are determined before the benefits of the plan which covers that child as a dependent of the stepparent. In addition, the benefits of a plan which covers that child as a dependent of the stepparent are determined before the benefits of a plan which covers that child as a dependent of the parent without custody; and

   * notwithstanding the provisions of the above, if there is a court decree which should otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility are determined before the benefits of any other plan which covers the child as a dependent child.

4. When rules 1., 2., and 3. do not establish an Order of Benefits Determination, the benefits of a plan which covers the person on whose expenses claim is based as a laid-off or retired employee, or as the dependent of such person, are determined after the benefits of a plan which covers such person through present employment.

5. When rules 1., 2., 3., and 4. do not establish an Order of Benefits Determination, the benefits of a plan which has covered the person on whose expenses claim is based

for the longer period of time are determined before the benefits of a plan which has covered such person the shorter period of time.

Right To Necessary Information

The Plan may require certain information in order to apply and coordinate these provisions with other plans. To get the needed information, the Plan, without your consent, will release or obtain from any insurance company, organization or person, information needed to implement this provision. The covered person agrees to furnish any information required to apply these provisions.

Coordination of Benefits with Medicare

In all cases, Coordination of Benefits with Medicare will conform with Federal Statutes and Regulations. If a covered person is eligible for Medicare Benefits, but not necessarily enrolled, benefits under this Plan will be coordinated to the extent benefits otherwise would have been payable under Medicare, as allowed by Federal Statutes and Regulations.

Facility of Payment

Payments made under any other plans, which according to these provisions should have been made by the Plan, will be adjusted. To do this, the Third Party Administrator reserves the sole right to pay the organization(s) which made such payments the amount(s) the Employer determines to be warranted. Any amount(s) so paid are regarded as benefits paid under this Plan. The Third Party Administrator will be fully discharged from any liability under this Plan to the extent of any payment so made.

Right of Recovery

The Plan reserves the right to recover benefit payments made for an allowable expense under this Plan in the amount by which the payments exceed the maximum amount the Plan was required to pay under these provisions. This right of recovery applies against:

1. any person(s) to, for, or respect to whom such payments were made; or

2. any insurance companies or organizations, which according to these provisions, provide benefits for the same allowable expense under any other plan.

HOW TO FILE A CLAIM

The covered employee and covered spouse will receive a Claim Management Services, Inc. I.D. card. It will show the employee's name, group name and group number. The provider of service should bill CMS directly, or the covered person may submit an itemized claim for services to CMS. A separate itemized claim must be sent for each family member for whom benefits are being claimed. The itemized claims should be sent to:

Send Medical and Dental Claims:	Send Prescription Drug Claims:
Claim Management Services, Inc. P.O. Box 10888 Green Bay, WI 54307-0888 (414) 497-1589	Bravell Claims Management 13555 Bishops Court, Suite 230 Brookfield, WI 53005 (414) 784-4600

The covered person may choose any provider of service. There is no restriction as long as the provider of service meets the definitions contained herein. Benefits are payable directly to the provider of service and only to the employee if proof of full payment is submitted. If CMS needs more information to process a claim, the covered person or the provider of service will be contacted. When filing a claim, the covered person must submit proof of each charge by way of an "itemized claim" from the provider of service. An "itemized claim" is one which shows:

1. Employee's name, address, and Social Security number.
2. Name of the dependent, if the claim is on a dependent.
3. Employer name - **Nagel Lumber Company, Inc.**
4. Name and address of the provider of service.
5. Diagnosis.
6. Itemization of charges.
7. Date the illness or injury began, or the date dental treatment started.

Canceled checks, cash register receipts or personally prepared bills are not accepted in lieu of itemized claims from providers of service.

If benefits are subject to the Coordination of Benefits provision, whereby another plan is required to pay benefits first, please also send a copy of the other plan's Explanation of Benefits. This can be done either when initially submitting the claim or as soon as possible thereafter. This procedure will expedite the processing of claims subject to the Coordination of Benefits provision.

GENERAL TERMS AND DEFINITIONS

"ACTIVELY AT WORK" means any day that the employee performs, in the customary manner, all of the regular duties of the employee's position for the employer.

An employee is considered to be actively at work on: (a) each day of regular paid vacation; (b) a regular non-working day; (c) any day the employer allows the employee a leave according to the personnel policies in effect; or (d) any day in which the employee is eligible to receive short term disability benefits, provided in each instance that the employee was actively at work on the last regular work day preceding the absence.

An employee will not be considered Actively at Work if at anytime on the date in question the employee is: (1) hospital confined or (2) totally disabled.

"AMBULATORY SURGICAL CENTER" means a licensed facility: (a) which has permanent operating rooms, at least one recovery room, and all necessary equipment for use before, during, and after surgery; (b) which is supervised by an medical staff including registered nurses available for care in an operating or recovery room; (c) which has a contract with a nearby hospital for immediate care, provided the hospital is not a private office or clinic; and (d) which does not provide for overnight stays.

"CALENDAR YEAR" means the period from January 1 through December 31 of the same year.

"COMPLICATIONS OF PREGNANCY" means:

1. conditions whose diagnosis are distinct from the pregnancy, adversely affected by the pregnancy, or are caused by the pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. A complication of pregnancy does not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; or

2. non-elective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy.

"CONFINEMENT" means the period of time in which a covered person is registered as an inpatient for which a room and board charge is made. Confinement begins with admission and ends with discharge.

"COVERED PERSON" means a person meeting the eligibility requirements for coverage as specified in the Plan, who is properly enrolled in the Plan, and where required, has satisfied the Evidence of Good Health requirement.

"CUSTODIAL CARE" means care designed to help a person in the activities of daily living,

and which does not require the continuous attention of trained medical or paramedical personnel. Such care may involve preparation of special diets, supervision of medication that can be self-administered, and assistance in getting in or out of bed, walking, bathing, dressing and eating.

"DEPENDENT" means:

1. a lawful spouse of the employee;

2. each unmarried child of the employee from birth until attainment of age 19, or attainment of age 23 if a full-time student at an accredited school, college or university. Full-time student status will be based upon the rules of the school. The employee must provide at least 50% support and maintenance to the dependent as defined by the United States Internal Revenue Code. Each child must qualify as a dependent by that definition in the current year on on the most recently filed Federal Income Tax Return. The child must not work on a full-time basis. Child shall mean:

   (a) a natural born son or daughter of the employee;

   (b) a stepchild, legally adopted child or a child for whom guardianship has been court ordered, provided the child meets the support and maintenance requirements listed above; and

   (c) a handicapped child who meets the requirements listed in the Dependent Eligibility and Effective Date section of the Plan.

"EFFECTIVE DATE OF THE PLAN" means July 1, 1984.

"EMPLOYEE" means an active full-time employee working 40 or more hours per week on a regular basis for the employer. Temporary, part-time, seasonal and retired employees are not eligible for coverage.

"EMPLOYER" means Nagel Lumber Company, Inc.

"ENROLLMENT PERIOD" means the period of time during which a person who is eligible for coverage is allowed to make written application for participation in the Plan.

"EVIDENCE OF GOOD HEALTH" means the process of completing questions regarding current and past medical conditions, providing attending physician information, release for medical records and demonstrating proof of good health which is satisfactory to the Plan Administrator. Persons subject to the Evidence of Good Health requirement will be declined coverage if they fail to satisfy the underwriting requirements of the Plan.

"EXPERIMENTAL and INVESTIGATIONAL" means any treatments, procedures, devices, drugs or medicines for which one or more of the following is true:

1. the device, drug or medicine 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 device, drug or medicine is furnished;

2. reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II, or III clinical trial or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis;

3. reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

Experimental and Investigational shall also mean: (a) any treatments, services or supplies that are educational or provided primarily for research; or (b) treatments, procedures, devices, drugs or medicines or other expenses relating to transplant of non-human organs.

"FAMILY MEMBER" means a covered person's spouse, child, parent, brother, sister and any other eligible dependent as described by the Plan.

"HOME HEALTH CARE" means services or supplies rendered to, and in the home of, a covered person or in the home of a family member as an alternative to services and supplies provided as part of an inpatient confinement in a hospital or skilled nursing facility.

Home Health Aide Services means those services which may be provided by a qualified individual, other than a registered nurse, which are medically necessary for the care and treatment of a covered person.

Home Health Care Agency means an agency which: (a) is certified by the covered person's physician as an appropriate provider of home health services; (b) has a full-time administrator; (c) maintains daily clinical records of services provided to the covered person; (d) includes on its staff at least one registered nurse to supervise nursing care; and (e) is coordinated by a state licensed Medicare certified home health care agency or certified rehabilitation agency.

Home Health Care Plan means care and treatment of a covered person for an injury or illness under a plan of home care established and approved in writing by the covered person's attending physician. The physician must also certify that the treatment for the injury or illness would otherwise require confinement in a hospital or a skilled nursing facility. The home health care plan must be reviewed at least every two months.

"ILLNESS" means a bodily disorder, disease, mental or nervous disorder or pregnancy.

"INJURY" means a condition caused by accidental means and from an external force which results in damage to the covered person's body from an external force.

"INTENSIVE CARE UNIT OR CORONARY CARE FACILITY" means a section, ward, or wing within a hospital, which is operated solely for critically ill patients. It provides special supplies, equipment, and constant observation and care by registered nurses or other hospital personnel.

"MASTER PLAN DOCUMENT" means that Document which is signed by the Plan Administrator and which sets forth the terms and conditions of the Plan.

"MAXIMUM BENEFIT" means the total eligible charges that the Plan will pay per covered person while that covered person is covered by the Plan.

"MEDICALLY NECESSARY" means that a service, treatment, procedure, equipment, drug, device or supply provided by a hospital, physician or other health care provider is required to diagnose or treat a covered person's illness or injury and which is, as determined by the Plan Administrator is: (1) consistent with the symptoms or diagnosis and treatment of the covered person's illness or injury; (2) appropriate under the standards of acceptable medical practice to treat that illness or injury; (3) not solely for the convenience of the covered person, physician, hospital, or other health care provider; and (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the covered person and accomplishes the desired end result in the most economical manner. However, the fact that a provider may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make that treatment, service or supply medically necessary.

"MEDICARE" means the program for health benefits under XVIII of the Social Security Act as amended.

"PHYSICIAN" means any individual who is validly licensed to perform services for which benefits are provided under the Plan and who is acting within the scope of that license. 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" means all schedules, provisions, exclusions, and limitations of this employer's Master Plan Document and any Amendments contained thereto.

"PLAN ADMINISTRATOR" means Nagel Lumber Company, Inc.

"PLAN SPONSOR" means Nagel Lumber Company, Inc.

"PLAN YEAR" means the period beginning July 1 and ending June 30.

"SKILLED NURSING FACILITY" means a facility which meets the following:

1. is regularly engaged in providing skilled nursing care for sick and injured persons;

2. requires that the patient be regularly attended by a physician;

3. maintains a daily record of each patient;

4. provides 24-hour nursing care which is supervised by a registered nurse;

5. is not, except incidentally, a home for the aged, a hotel or the like;

6. is not, except incidentally, a place for the treatment of mental health and substance abuse; and

7. is licensed as a skilled nursing facility, if such licensing is required.

"THIRD PARTY ADMINISTRATOR" means **Claim Management Services, Inc.**

"TOTALLY DISABLED DEPENDENT" means a dependent who, as a result of an illness or injury, is unable to engage in the normal activities of a person of similar age and sex in good health.

"TOTALLY DISABLED EMPLOYEE" means an employee who is unable to engage in the normal duties or activities of his or her employment, due to illness or injury.

"USUAL AND CUSTOMARY" means the fee usually and customarily accepted as payment for the same services within a geographical area.

GENERAL INFORMATION

Administration of the Plan

The Plan Administrator administers the Plan. The Plan Administrator has retained the services of Claim Management Services, Inc. as Third Party Administrator. The Plan is a legal entity and service of process directed to the Plan may be filed with, and legal process served upon, the Third Party Administrator.

Claim or Evidence of Good Health Denial

An Explanation of Benefits will be provided by the Third Party Administrator showing the calculation of the total amount of charges which are payable and the reason. If additional information is needed for claim determination, the Third Party Administrator will request this information as needed.

If the claim is denied in whole, or in part, the covered person will receive written notification. If the covered person receives a claim or Evidence of Good Health denial, a review may be requested by sending a written request to the Third Party Administrator or the Employer. On receipt of written request, the Third Party Administrator will review the claim or Evidence of Good Health and all facts relating to the decision. The covered person or that person's authorized representative may examine pertinent documents which the Third Party Administrator has, except such information which the physician does not wish made known.

Request for a review must be filed within 90 days following receipt of a denial. The results of the review will be sent in writing and will outline the reasons for the decision with references to the applicable Plan provisions.

Clerical Error

Clerical error on the part of the Plan Administrator or Third Party Administrator will not invalidate or extend coverage otherwise in force, nor continue coverage otherwise terminated. Upon the discovery of a clerical error, an equitable adjustment will be made as determined by the Third Party Administrator. The covered person agrees to reimburse the Plan for any payment made to the covered person in error.

Common Accident Deductible

If two or more members of the same family are injured in a common accident, only one deductible amount, if applicable, will be applied.

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.

Deductible Carry Over Provision

If a covered person incurs eligible charges during the period beginning October 1 through December 31 which are applied to the deductible for that calendar year, these charges are also applied toward satisfaction of the deductible for the next following calendar year.

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.

Master Plan Document

The Master Plan Document, including Amendments, constitutes the entire Plan.

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 States to military retirees and dependents who are covered by this Plan on an inpatient basis.

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 and Termination

The Plan Administrator reserves the right to terminate, amend, or modify the Plan, in whole or in part at anytime, subject to the applicable provisions of the Plan and the law.

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 Claim Management Services, Inc. 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.

Proof of Claim

Written proof of a claim must be submitted to the Plan by the covered person or the provider of service within six months 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 18 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.

Right of Recovery For Payments Made

The Plan reserves the right to recover payments made under the Plan in the amount by which the payments exceed the maximum amount required to be paid under the provisions of the Coordination of Benefits section or any other provisions of the Plan. This right of recovery applies against:

1. any person to whom, for whom, or with respect to whom such payments were made; or

2. any insurance companies or other organizations, which according to these provisions, provide benefits for the same allowable expense under any other plan.

Self-funding

This is a self-funded Plan which means that claims are paid directly by the Plan Administrator from its assets. The Plan Administrator has entered into a legal arrangement with a Third Party Administrator to assure accurate, impartial, and timely payment of benefits to, and in behalf of, covered employees and their covered dependents.

Subrogation Provision

If a covered person incurs medical, dental, or disability expenses for an illness or injury because of the fault of another person, that person is responsible for any hospital, medical, dental, or disability expenses which may result. Collecting this money may take several months. In such cases, the Plan will pay the appropriate benefits. However, the Plan has the right to seek repayment of those benefits from the party that caused the illness or injury, that person's liability carrier, or the covered person's own auto insurance carrier in cases of uninsured or underinsured motorist coverage, or from no fault or school insurance coverages paid or payable.

The Plan is automatically assigned the right of action and the right of recovery against third parties in any situation in which, and to the extent, benefits are paid, or will be paid to, or on behalf of, a covered person. If a covered person brings a liability claim against any third party, or reimbursement is sought from the covered person's own auto insurance carrier under the uninsured or underinsured motorist endorsement, or from no fault or school insurance coverages paid or payable, then benefits payable under this Plan must be included in the claim and when the claim is settled the covered person must reimburse the Plan for the benefits provided. The covered person is obligated to avoid doing anything which would prejudice the Plan's rights or

reimbursement and is required to sign and deliver documents to evidence or secure those rights. If the Plan required the covered person to sign a reimbursement agreement, all rights of recovery are transferred to the Plan regardless of whether it is actually signed.

The subrogation rights of the Plan shall be superior to and the Plan shall have a first priority over any competing claim or claims of an employee, or covered dependent to any designated or un-designated proceeds of a judgment, award, an insurance settlement, or any other settlement of the claims of the employee, or a covered dependent whether such settlement, judgment, or award relates to or arises from the circumstances giving rise to the medical, dental, or disability expense paid by the Plan.

Summary Plan Descriptions

The employer will issue to each eligible 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 for a Summary Plan Description, as specified in ERISA.

The 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.

Usual and Customary Procedure

CMS will cover the amount which is usually and customarily charged for that type of service. The amount in excess of the usual and customary fee may be pended for additional information. The employee will be notified on the Explanation of Benefits (EOB) or by letter that CMS is requesting additional information. CMS will then contact the provider, which will give the provider the opportunity to supply CMS with additional information which may explain the higher fee. This may include an operative report or medical records if signed authorization is received from the employee. If after receiving the additional information, the higher amount cannot be justified, CMS will outline the reasons for the denial.

Workers' Compensation

The Plan is not issued in lieu of, nor does it affect any requirement of coverage under any act or law which provides benefits for any injury or illness occurring during, or arising from, the employee's course of employment. The Plan will apply the Right of Reimbursement provision for work related injuries or illnesses ever though:

1. benefits are in dispute or are made by means of settlement or compromise;

2. no final determination is made that an injury or illness was sustained in the course of or resulted from, employment;

3. the amount due for health care is not agreed upon, or defined by, the employee or the carrier; or

4. the health care benefits are specifically excluded from settlement or compromise.

In consideration for coverage under the Plan, the employee agrees to notify the Third Party Administrator of any claim made. The employee agrees to reimburse the Plan based on #1 through #4 above.

PLAN INFORMATION

PLAN ADMINISTRATOR:

Nagel Lumber Company, Inc.
Hwy. B
P.O. Box 209
Land O' Lakes, WI 54540-0209
(715) 547-3824

EMPLOYER IDENTIFICATION NUMBER: #39-1023990

PLAN NUMBER: 501

THE FOLLOWING COVERAGE IS INCLUDED IN THIS PLAN:

Basic and Major Medical, Prescription Drug, Dental and Short Term Disability Benefits

TYPE OF ADMINISTRATION:

Self-Funded Health and Welfare Plan

THIRD PARTY ADMINISTRATOR:

Claim Management Services, Inc.
P.O. Box 10888
Green Bay, WI 54307-0888
(414) 497-1589

AGENT FOR SERVICE OF LEGAL PROCESS:

Claim Management Services, Inc.
P.O. Box 10888
Green Bay, WI 54307-0888
(414) 497-1589

COST:

The contributions necessary to finance the Plan are shared by the employer and the employee.

FINANCIAL RECORDS:

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

STATEMENT OF ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. examine, without charge at the Plan Administrator's office and at other specified locations, such as worksites, all Plan Documents, including Insurance Contracts and copies of all Documents filed by the Plan with the U.S. Department of Labor, such as Detailed Reports and Plan Descriptions;

2. obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies; and

3. receive a summary of the Plan's Annual Financial Report. The Plan Administrator is required by Law to furnish each participant with a copy of this Summary Annual Report.

In addition to creating rights for the Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan are called **"fiduciaries"** of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants and beneficiaries. No one, including your Employer, or other person, may force you or otherwise discriminate against you in anyway to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole, or in part, you must receive written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. If you are unsatisfied with the reply and you feel you are unable to obtain a satisfactory answer, and if you want to take the matter further, you may wish to contact your Lawyer or:

The Office of Employee Benefits Services
Labor-Management Services Administration
U.S. Department of Labor
P.O. Box 176
Washington, D.C. 20044

or the nearest regional office to obtain a further action.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in Federal Court. In such case, the Court may require the Plan Administrator to provide the materials and pay a fine determined for each day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If it should happen that the 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 La-

bor, 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.

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, you should contact the nearest area office of the U.S. Department of Labor-Management Services Administration.

NAGEL LUMBER/ASPEN VALLEY
Benefit Plan Design Changes Effective 7/1/02

Benefit Description	Current Plan Design (Prior to 7/1/02)	Plan Design Effective 7/1/02
PPO Network	N/A	AHC PPO Network
Individual Deductible	$100.00	$250.00
Family Deductible	$300.00	$750.00
Coinsurance Paid by the Plan Individual Family	80% of $2,000 after deductible 80% of $5,000 after deductible	90% (In)/80% (Out) of $2,500 after deductible 90% (In)/80% (Out) of $5,000 after deductible
Maximum Out-of-Pocket Expense Individual Family	$500.00 $1,300.00	In Network = $500.00 Out of Network = $750.00 In Network = $1,250.00 Out of Network = $1,750.00
Supplemental Accident Benefit	Payable at 100% up to $300.00 after $300.00 subject to deductible and coinsurance	Benefit is subject to deductible and coinsurance. 90% in network / 80% out of network.
Inpatient Transitional Treatment Mental and Nervous & Substance Abuse	100% payable to Max of 30 days per calendar year.	Benefit is subject to the deductible and coinsurance up to a maximum of 10 days per calendar year. 90% in network / 80% out of network.
Outpatient Mental Nerv. & Substance Abuse	100% payable to a maximum of $1,000 per calendar year.	Benefit is subject to the deductible and coinsurance up to a 20 visits per calendar year. 90% in network / 80% out of network.
Skilled Nursing	100% coverage up to Maximum 90 days, thereafter subject to deductible and coinsurance for an additional 90 days.	Benefit is subject to the deductible and coinsurance up to a maximum of 90 days per calendar year. 90% in network / 80% out of network.
Home Health Care		Benefit is subject to the deductible and coinsurance up to a maximum of 40 days per Calendar Year Benefit 90% in network / 80% out of network.
X-Ray & Radiation Therapy	Charges for Benign conditions are payable up to $10.00 per visit and subject to a $60.00 per calendar maximum	Benefits are subject to deductible and coinsurance 90% in network / 80% out of network.
Mammography Benefit	Eligible charges for a routine mammogram and related charges are covered at 100%, not subject to the deductible amount. Eligible charges are limited to one mammogram every other year between the ages of 40 and 49 and one mammogram per calendar year following age 50.	See Wellness Benefit

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Wellness Benefit	Eligible charges for all Wellness Charges are subject to deductible and coinsurance and paid at 80% after the deductible has been satisfied.	Coverage is only eligible for both PPO and Non PPO Provider Networks. **PPO Provider Benefit:** The deductible does not apply, Eligible amount is paid at 100% to a limit of $300.00 per calendar year. Charges in excess of $300.00 the deductible and coinsurance amounts apply for the remainder of the calendar year. The following routine services re covered: Examinations, limited to one per calendar year; Pap Smears; Well-child Care; mammograms, limited to one every other year between the ages of 40 and 49 and one mammogram per calendar year following age 50; other related X-ray and Laboratory Services; and Immunizations. **Non PPO Provider Benefit:** Eligible charges are subject to the deductible and coinsurance. The following routine services re covered: Examinations, limited to one per calendar year; Pap Smears; Well-child Care; mammograms, limited to one every other year between the ages of 40 and 49 and one mammogram per calendar year following age 50; other related X-ray and Laboratory Services; and Immunizations.
Prescription Drug Card	$3.00 Per Generic Prescription Copay $7.00 Per Brand Name Prescription Copay	Retail Program $10.00 Per Generic Prescription Copay $20.00 per Brand Name Prescription Copay Dispensing Limitation: Not to exceed a 30 day supply for either the $10 and/or $20 Copayment. However the Pharmacy can provide up to a 90 day supply. For this the Copayment would be multiplied by 2 for a 60 day supply or 3 for a 90 day supply. Mail Program $20.00 Per Generic Prescription Copay $40.00 Per Brand Name Prescription Copay Dispensing Limitation: Not to exceed a 90 day supply
Dental Benefit	$750.00 Per Person Calendar Year Plan maximum $800.00 Per Person Orthodontia Plan maximum	$75.00 Family Deductible Limit per calendar year. $1,000 Per Person Calendar Year Plan maximum. $1,500.00 Per Person Orthodontia Plan maximum.
Short Term Disability Benefits	Benefit Amount = $150.00 per week	Benefit Amount = $200.00 per week

CLAIM MANAGEMENT SERVICES, INC.

331625515*0
RONALD C JESSE JR.
[illegible] HWY 45 SOUTH
[illegible]VER, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE : 1
CHECK NO :
DATE PAID : 09-17-02
GROUP : 36838
DIVISION : 1

PROVIDER / DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFIT PAID
EAGLE RIVER MEMORIAL HOSPITAL											
07/20-07/20/02		OUTPT HOSPITAL	23.55	0.00	0.00		0.00	2.36	90%	0.00	21.19
07/20-07/20/02	90784	OUTPT HOSPITAL	63.50	0.00	0.00		0.00	6.35	90%	0.00	57.15
07/20-07/20/02	90784-59	OUTPT HOSPITAL	63.50	0.00	0.00		0.00	6.35	90%	0.00	57.15
07/20-07/20/02	99282	OUTPT HOSPITAL	339.50	0.00	0.00		0.00	33.95	90%	0.00	305.55
07/20-07/20/02	J2765	OUTPT HOSPITAL	23.55	0.00	0.00		0.00	2.36	90%	0.00	21.19
07/20-07/20/02	99282	OUTPT HOSPITAL	113.50	62.71	0.00		0.00	5.08	90%	0.00	45.71
CLAIM 6996157											
SHIRLEY A JESSE		Spouse	627.10	62.71	0.00		0.00	56.45		0.00	[illegible]
NETWORK : ASSOCIATES FOR HEALTH CARE											
		TOTALS	627.10	62.71	0.00		0.00	56.45		0.00	507.94

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
[illegible] RIVER MEMORIAL HOS		0.00	56.45
EAGLE RIVER MEMORIAL HOS	4464	507.94	

IF YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.
If the Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within your group health plan document.

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CMS CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

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EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

FACTS 0069.CMS.BOT

CLAIM MANAGEMENT SERVICES, INC.

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

331625515*0
RONALD C JESSE JR.
37 HWY 45 SOUTH
C , WI 54519

PAGE : 1
CHECK NO :
DATE PAID : 09-17-02
GROUP : 36838
DIVISION : 1

PROVIDER / DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFIT PAID
EAGLE RIVER MEMORIAL HOSPITAL											
08/09-08/09/02	99281	OUTPT HOSPITAL	84.50	0.00	0.00		70.45	1.41	90%	0.00	12.64
08/09-08/09/02	99283	OUTPT HOSPITAL	187.25	27.17	0.00		0.00	16.01	90%	0.00	144.07
CLAIM 6994208											
SHANNON C MCDANIEL		Daughter	271.75	27.17	0.00		70.45	17.42		0.00	156.71
NETWORK : ASSOCIATES FOR HEALTH CARE											
		TOTALS	271.75	27.17	0.00		70.45	17.42		0.00	

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
EAGLE RIVER MEMORIAL HOS		0.00	87.87
EAGLE RIVER MEMORIAL HOS	4464	156.71	

IF YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.

I Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within your group health plan document.

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

FACTS 0069.CMS.BOT

Great Benefit Administration for Great Companies

September 17, 2002

Cathy Nordine
Nagel Lumber Company, Inc.
Highway B
P.O. Box 209
Land O'Lakes WI 54540

RE: Nagel Benefit Payment Check totaling $8,626.10
Aspen Valley Benefit Payment Checks totaling $546.15
Benefit Payment Checks dated September 17, 2002 totaling $9,172.25

Dear Ms. Nordine:

This letter is a follow up to Maureen's phone conversation with Cheryl VanderKinter on September 17, regarding your request to CMS to hold all checks processed for payment by CMS on September 17, 2002.

Since CMS will not hold these checks in our office as you requested, we are forwarding all checks to you for disbursement. Since you will be controlling the disbursement of these checks, CMS will be directing any inquiries from participants to your attention regarding these payments.

I am enclosing all benefit payment checks dated September 17, 2002 for Nagel Lumber Company, Inc. and for Aspen Valley Lumber Company, Incorporated.

Sincerely,

Tracy Laine

Tracy Laine
Vice President, Operations

Encs.

CLAIM MANAGEMENT SERVICES, INC.
P.O. Box 10888 • Green Bay, WI 54307-0888 • (800) 472-7130
P.O. Box 2790 • West Bend, WI 53095-7970 • (800) 245-6142
6425 Normandy Lane, Suite 2 • Madison, WI 53719 • (800) 809-3077

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CHECK REGISTER

09-17-02 TO 09-17-02

GROUP # :36838 NAGEL LUMBER COMPANY, INC.
DIVISION # :1
BANK # :116665

PREPARED: 04-07-06
TIME : 07:44:12

CHECK #	DATE	PAYEE	EMPLOYEE/PROV #	REF #	CLAIM TYPE	CHECK AMOUNT	ADJ.TYPE	ADJUST.AMT.
4462	09-17-02	AFFINITY MEDICAL GROUP	391127163	6993491	MEDICAL	133.09		
4463	09-17-02	CARDIOGRAPHIC INTERPRET	382376006	6995329	MEDICAL	142.40		
4464	09-17-02	EAGLE RIVER MEMORIAL HO	390985690	6996157	MEDICAL	2,127.26		
4465	09-17-02	GRAND VIEW HOSPITAL	382908586	6995333	MEDICAL	34.02		
4466	09-17-02	HOWARD YOUNG MEDICAL CE	390873606	6994666	MEDICAL	426.72		
4467	09-17-02	ONTONAGON MEMORIAL HOSP	382556723	6994608	MEDICAL	68.00		
4468	09-17-02	PETER SCHINDELHOLZ, D.D	391391738*1	6995840	DENTAL	498.67		
4469	09-17-02	SPINE CARE SPECS. OF WI	391842010	6993466	MEDICAL	4,911.40		
4470	09-17-02	THEDACARE BEHAVIORAL HE	391509362*15	6995693	MEDICAL	92.00		
4471	09-17-02	UP ASSOC RURAL HEALTH S	382375778*10	6994557	DENTAL	91.97		
4472	09-17-02	UPPER PENINSULA ASSOC	306829	6995685	MEDICAL	35.20		
4473	09-17-02	UROLOGY SPECIALISTS OF	391912672	6994673	MEDICAL	65.37		

BANK TOTALS $8,626.10 $0.00
NUMBER OF CHECKS ISSUED..... : 12

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $8,626.10

TOTALS FOR DIVISION :1 $8,626.10 $0.00
NUMBER OF CHECKS ISSUED..... : 12

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $8,626.10

Case: 3:08-cv-00400-bbc Document #: 1 Filed: 07/16/2008 Page 103 of 135

CHECK REGISTER

09-17-02 TO 09-17-02

GROUP # :36838 NAGEL LUMBER COMPANY, INC.
DIVISION # :2
BANK # :145755

PREPARED:04-07-06
TIME :07:44:12

CHECK #	DATE	PAYEE	EMPLOYEE/PROV #	REF #	CLAIM TYPE	CHECK AMOUNT	ADJ.TYPE	ADJUST.AMT.
2039	09-17-02	RHINELANDER REGIONAL ME	243752	6994667	MEDICAL	50.00		
2040	09-17-02	HOWARD YOUNG MEDICAL CE	390873606	6994719	MEDICAL	271.15		
2041	09-17-02	STANLEY E BROWN, DDS	323280	6995841	DENTAL	225.00		

BANK TOTALS			$546.15	$0.00
NUMBER OF CHECKS ISSUED..... :	3			
NUMBER OF ADJUSTMENTS..... :	0	TOTAL	$546.15	
TOTALS FOR DIVISION :2			$546.15	$0.00
NUMBER OF CHECKS ISSUED..... :	3			
NUMBER OF ADJUSTMENTS..... :	0	TOTAL	$546.15	
TOTALS FOR GROUP :36838			$9,172.25	$0.00
NUMBER OF CHECKS ISSUED..... :	15			
NUMBER OF ADJUSTMENTS..... :	0	TOTAL	$9,172.25	

SENDER:
- Complete items 1,2 and 3.
- Indicate if restricted delivery is desired.
- Print your name and address on the reverse of this form so that we can return this card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit.
- Write "Return Receipt Requested" on the mailpiece below the article number.
- The Return receipt Fee will provide you the signature of the person delivered to and the date of delivery.

I also wish to receive the following service (for an extra fee):

☐ **Restricted Delivery**

Consult postmaster for fee.

1. Article Addressed to:

CATHY NORDINE
NAGEL LUMBER
PO BOX 209
LAND O' LAKES, WI 54540

2. Article Number

7111 1037 1900 0001 1319

3. Service Type ☒ **CERTIFIED**

Date of Delivery

9-19-02

Received By: (Print Name)

JAN M Ayers

Signature - (Addressee or Agent)

Jan M Ayers

Enter delivery address if different than item 1.

PS Form 3811

DOMESTIC RETURN RECEIPT

CLAIM MANAGEMENT SERVICES, INC.

331625515*0
RONALD C JESSE JR.
HWY 45 SOUTH
R, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE : 1
CHECK NO :
DATE PAID : 10-15-02
GROUP : 36838
DIVISION : 1

PROVIDER / DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFIT PAID
HOWARD YOUNG MEDICAL CENTER											
09/24-09/24/02	74000	OUTPT HOSPITAL	119.75	0.00	0.00		0.00	11.98	90%	0.00	107.77
09/24-09/24/02	78223	OUTPT HOSPITAL	727.25	0.00	0.00		0.00	72.73	90%	0.00	654.52
09/24-09/24/02	A9510	OUTPT HOSPITAL	126.00	97.30	0.00		0.00	2.87	90%	0.00	25.83
CLAIM 7002411											
SHIRLEY A JESSE		Spouse	973.00	97.30	0.00		0.00	87.58		0.	
NETWORK : ASSOCIATES FOR HEALTH CARE											
		TOTALS	973.00	97.30	0.00		0.00	87.58		0.00	788.12

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
HOWARD YOUNG MEDICAL CEN		0.00	87.58
HOWARD YOUNG MEDICAL CEN	4514	788.12	

HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.
If the Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within your group health plan document.

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CMS CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

EXHIBIT
tabbies
5

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

FACTS 0069 CMS BOT

CLAIM MANAGEMENT SERVICES, INC.

331625515*0
RONALD C JESSE JR.
- HWY 45 SOUTH
CO JR, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE : 1
CHECK NO :
DATE PAID : 10-15-02
GROUP : 36838
DIVISION : 1

PROVIDER / DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFIT PAID
SUSAN CAROL MINIKEL, MD											
09/24-09/24/02	78223-26	X-RAY/LAB	190.75	19.08	0.00		0.00	17.17	90%	0.00	154.50
09/24-09/24/02	74000-26	X-RAY/LAB	39.75	3.97	0.00		0.00	3.58	90%	0.00	32.20
CLAIM 7003109											
SHIRLEY A JESSE		Spouse	230.50	23.05	0.00		0.00	20.75		0.00	186.70
NETWORK : ASSOCIATES FOR HEALTH CARE											
		TOTALS	230.50	23.05	0.00		0.00	20.75		0.00	186.70

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
SUSAN CAROL MINIKEL, MD		0.00	20.75
HOWARD YOUNG MEDICAL CEN	4514	186.70	

F YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.

: Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within your group health plan document.

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CMS CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGE... LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

October 15, 2002

Cathy Nordine
Nagel Lumber Company, Inc.
Highway B
P.O. Box 209
Land O'Lakes WI 54540

RE: Nagel Benefit Payment Checks totaling $5,266.45
Aspen Valley Benefit Payment Checks totaling $1,918.96
Benefit Payment Checks dated October 15, 2002 totaling $7,185.41

Dear Ms. Nordine:

This letter is a follow up to Maureen's phone conversation with Cheryl VanderKinter on October 15, 2002, regarding your request to CMS to hold all checks processed for payment by CMS on October 15, 2002.

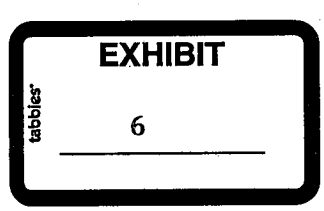
Since CMS will not hold these checks in our office as you requested, we are forwarding all checks to you for disbursement. Since you will be controlling the disbursement of these checks, CMS will be directing any inquiries from participants to your attention regarding these payments.

I am enclosing all benefit payment checks dated October 15, 2002 for Nagel Lumber Company, Inc. and for Aspen Valley Lumber Company, Incorporated.

Sincerely,

Joan Rousseau
Vice President

Encs.



Case: 3:08-cv-00400-bbc Document #: 1 Filed: 07/16/2008 Page 108 of 135

CHECK REGISTER

10-15-02 TO 10-15-02

GROUP # :36838 NAGEL LUMBER COMPANY, INC.
DIVISION # :1
BANK # :116665

PREPARED: 04-07-06
TIME : 07:44:12

CHECK #	DATE	PAYEE	EMPLOYEE/PROV #	REF #	CLAIM TYPE	CHECK AMOUNT	ADJ.TYPE	ADJUST.AMT.
4508	10-15-02	DANIEL C GARCIA, DDS	100640	6998269	DENTAL	167.65		
4509	10-15-02	WRH/HOWARD YOUNG JOINT	225133	7000295	MEDICAL	200.15		
4510	10-15-02	EAGLE RIVER MEMORIAL HO	390985690	6994801	MEDICAL	159.97		
4511	10-15-02	WILLIAM WATSON, CRNA	400650	7000298	MEDICAL	248.83		
4512	10-15-02	GRAND VIEW HOSPITAL	382908586	6995307	MEDICAL	14.00		
4513	10-15-02	GREMBAN & GREMBAN, S.C.	391875755	7001922	DENTAL	3.00		
4514	10-15-02	HOWARD YOUNG MEDICAL CE	390873606	7002411	MEDICAL	974.82		
4515	10-15-02	MARSHFIELD CLINIC	390452970	7002415	MEDICAL	380.40		
4516	10-15-02	NEAL A. POTRYKUS, D.D.S	391485176	6999555	DENTAL	70.00		
4517	10-15-02	PETER SCHINDELHOLZ, D.D	391391738*1	7003404	DENTAL	51.00		
4518	10-15-02	SPINE CARE SPECS. OF WI	391842010	7003173	MEDICAL	80.70		
4519	10-15-02	ST. MARY'S HOSPITAL	391390638	7002716	MEDICAL	2,915.93		

BANK TOTALS
NUMBER OF CHECKS ISSUED..... : 12
$5,266.45 $0.00

NUMBER OF ADJUSTMENTS..... : 0
TOTAL $5,266.45

TOTALS FOR DIVISION :1
NUMBER OF CHECKS ISSUED..... : 12
$5,266.45 $0.00

NUMBER OF ADJUSTMENTS..... : 0
TOTAL $5,266.45

Case: 3:08-cv-00400-bbc Document #: 1 Filed: 07/16/2008 Page 109 of 135

CHECK REGISTER

10-15-02 TO 10-15-02

GROUP # :36838 NAGEL LUMBER COMPANY, INC.
DIVISION # :2
BANK # :145755

PREPARED:04-07-06
TIME :07:44:12

CHECK #	DATE	PAYEE	EMPLOYEE/PROV #	REF #	CLAIM TYPE	CHECK AMOUNT	ADJ.TYPE	ADJUST.AMT.
2058	10-15-02	RHINELANDER REGIONAL ME	243752	7002402	MEDICAL	12.37		
2059	10-15-02	TODD A HEHLI, DDS	262885	7003402	DENTAL	665.00		
2060	10-15-02	COMMUNITY HEALTH CARE C	391670223	7003117	MEDICAL	153.11		
2061	10-15-02	EAR, NOSE & THROAT ASSO	391133811	7000296	MEDICAL	177.95		
2062	10-15-02	HOWARD YOUNG MEDICAL CE	390873606	6997964	MEDICAL	51.30		
2063	10-15-02	LANGLADE MEMORIAL HOSPI	390806429	7002660	MEDICAL	689.23		
2064	10-15-02	STANLEY E BROWN, DDS	323280	7001231	DENTAL	170.00		

BANK TOTALS $1,918.96 $0.00
NUMBER OF CHECKS ISSUED..... : 7

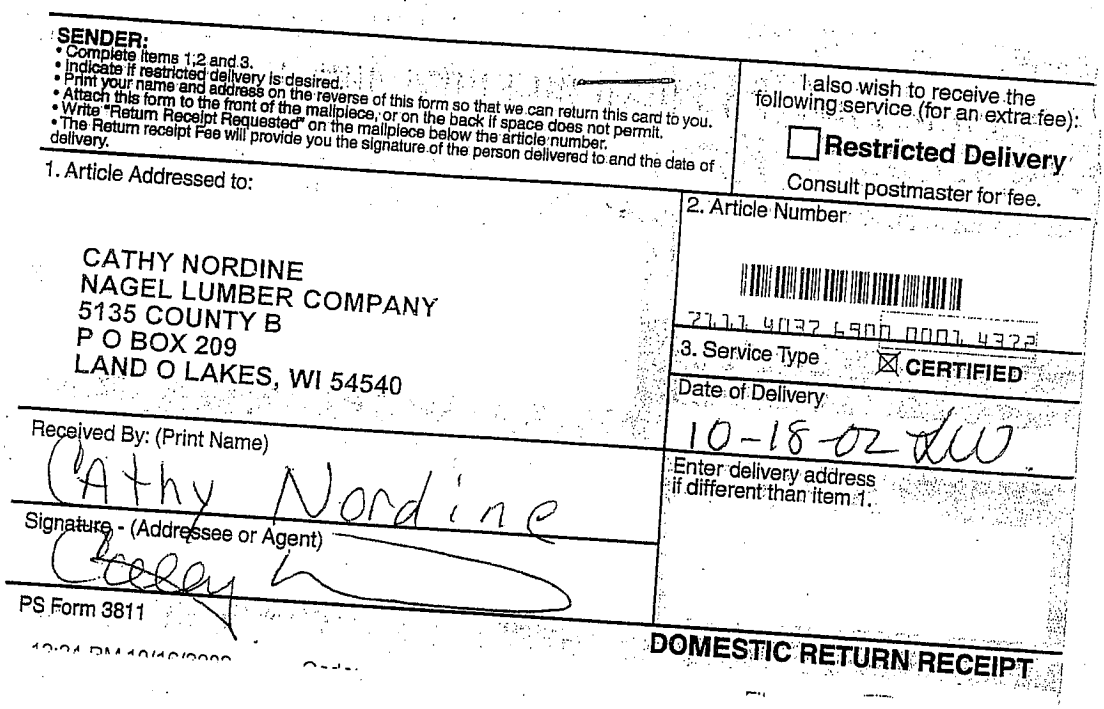
NUMBER OF ADJUSTMENTS..... : 0 TOTAL $1,918.96

TOTALS FOR DIVISION :2 $1,918.96 $0.00
NUMBER OF CHECKS ISSUED..... : 7

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $1,918.96

TOTALS FOR GROUP :36838 $7,185.41 $0.00
NUMBER OF CHECKS ISSUED..... : 19

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $7,185.41



SENDER:
- Complete items 1,2 and 3.
- Indicate if restricted delivery is desired.
- Print your name and address on the reverse of this form so that we can return this card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit.
- Write "Return Receipt Requested" on the mailpiece below the article number.
- The Return receipt Fee will provide you the signature of the person delivered to and the date of delivery.

I also wish to receive the following service (for an extra fee):
☐ **Restricted Delivery**
Consult postmaster for fee.

1. Article Addressed to:

CATHY NORDINE
NAGEL LUMBER COMPANY
5135 COUNTY B
P O BOX 209
LAND O LAKES, WI 54540

2. Article Number
7111 4037 6900 0001 4372

3. Service Type ☒ CERTIFIED

Date of Delivery 10-18-02

Received By: (Print Name) Cathy Nordine

Signature - (Addressee or Agent)

Enter delivery address if different than item 1.

PS Form 3811

DOMESTIC RETURN RECEIPT

CLAIM MANAGEMENT SERVICES, INC.

331625515*0
RONALD C JESSE JR.
17 HWY 45 SOUTH
ER, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE : 1
CHECK NO :
DATE PAID : 10-22-02
GROUP : 36838
DIVISION : 1

PROVIDER / DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFIT PAID
EAGLE RIVER MEMORIAL HOSPITAL											
09/10-09/10/02	76700	OUTPT HOSPITAL	486.50	48.65	0.00		0.00	43.79	90%	0.00	394.06
CLAIM 7005279											
SHIRLEY A JESSE		Spouse	486.50	48.65	0.00		0.00	43.79		0.00	394.06
NETWORK : ASSOCIATES FOR HEALTH CARE											
		TOTALS	486.50	48.65	0.00		0.00	43.79		0.00	394.06

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
EAGLE RIVER MEMORIAL HOS		0.00	43.79
EAGLE RIVER MEMORIAL HOS	4523	394.06	

IF YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.
If the Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within your group health plan document.

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CMS CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

EXHIBIT
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FACTS 0069.CMS.BOT
Printed by DIVIE TROST

October 22, 2002

Cathy Nordine
Nagel Lumber Company, Inc.
Highway B
P.O. Box 209
Land O'Lakes WI 54540

RE: Nagel Benefit Payment Checks totaling $12,663.16
Aspen Valley Benefit Payment Checks totaling $2,704.77
Benefit Payment Checks dated October 22, 2002 totaling $15,367.93

Dear Ms. Nordine:

This letter is a follow up to Maureen's phone conversation with Cheryl VanderKinter on October 22, regarding your request to CMS to hold all checks processed for payment by CMS on October 22, 2002.

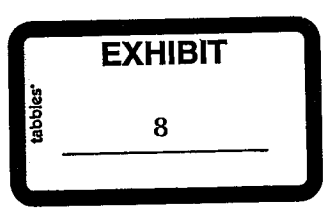
Since CMS will not hold these checks in our office as you requested, we are forwarding all checks to you for disbursement. Since you will be controlling the disbursement of these checks, CMS will be directing any inquiries from participants to your attention regarding these payments.

I am enclosing all benefit payment checks dated October 22, 2002 for Nagel Lumber Company, Inc. and for Aspen Valley Lumber Company, Incorporated.

Sincerely,

Michelle Bosacki
Manager, Operations

Encs.



Case: 3:08-cv-00400-bbc Document #: 1 Filed: 07/16/2008 Page 113 of 135

CHECK REGISTER

10-22-02 TO 10-22-02

GROUP # :36838 NAGEL LUMBER COMPANY, INC.
DIVISION # :1
BANK # :116665

PREPARED:04-07-06
TIME :10:46:27

CHECK #	DATE	PAYEE	EMPLOYEE/PROV #	REF #	CLAIM TYPE	CHECK AMOUNT	ADJ.TYPE	ADJUST.AMT.
4520	10-22-02	WRH/HOWARD YOUNG JOINT	225133	7003557	MEDICAL	535.89		
4521	10-22-02	RHINELANDER REGIONAL ME	243752	7005721	MEDICAL	153.42		
4522	10-22-02	SCOTT BEATTIE, DDS	391856792	7005513	DENTAL	226.00		
4523	10-22-02	EAGLE RIVER MEMORIAL HO	390985690	7005432	MEDICAL	3,425.24		
4524	10-22-02	STEVEN FIORUCCI, D.O.	383134667	7004627	MEDICAL	116.80		
4525	10-22-02	GRAND VIEW HOSPITAL	382908586	7006654	MEDICAL	47.79		
4526	10-22-02	GREMBAN & GREMBAN, S.C.	391875755	7005584	DENTAL	210.00		
4527	10-22-02	HOWARD YOUNG MEDICAL CE	390873606	7000056	MEDICAL	914.89		
4528	10-22-02	IRON COUNTY COMMUNITY H	383236977	7005067	MEDICAL	3,361.00		
4529	10-22-02	MARQUETTE GENERAL HOSPI	381358036	7006663	MEDICAL	316.00		
4530	10-22-02	RANDY K MULADORE, DDS	363397953	7005583	DENTAL	78.00		
4531	10-22-02	NORTHWOODS FAMILY ORTHO	391913925	7002680	MEDICAL	361.44		
4532	10-22-02	MARSHFIELD CLINIC	390452970	7005193	MEDICAL	1,456.92		
4533	10-22-02	ONTONAGON MEMORIAL HOSP	382556723	7004625	MEDICAL	118.40		
4534	10-22-02	SPINE & SPORT PHYSICAL	391799960	7004395	MEDICAL	70.78		
4535	10-22-02	SACRED HEART HOSPITAL	391390638*1	7003114	MEDICAL	1,180.50		
4536	10-22-02	WAUSAU HOSPITAL	391138241	7003956	MEDICAL	90.09		
BANK TOTALS						$12,663.16		$0.00

NUMBER OF CHECKS ISSUED..... : 17

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $12,663.16

TOTALS FOR DIVISION :1 $12,663.16 $0.00

NUMBER OF CHECKS ISSUED..... : 17

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $12,663.16

Case: 3:08-cv-00400-bbc Document #: 1 Filed: 07/16/2008 Page 114 of 135

C H E C K R E G I S T E R

10-22-02 TO 10-22-02

GROUP # :36838 NAGEL LUMBER COMPANY, INC.
DIVISION # :2
BANK # :145755

PREPARED:04-07-06
TIME :10:46:27

CHECK #	DATE	PAYEE	EMPLOYEE/PROV #	REF #	CLAIM TYPE	CHECK AMOUNT	ADJ.TYPE	ADJUST.AMT.
2065	10-22-02	CARITA A BERGLUND, DDS	264257	7005586	DENTAL	75.00		
2066	10-22-02	COMMUNITY HEALTH CARE C	391670223	7004665	MEDICAL	67.76		
2067	10-22-02	PAUL DIBLEY, D.D.S.	391343500	7005514	DENTAL	421.00		
2068	10-22-02	EAGLE RIVER MEMORIAL HO	390985690	6999418	MEDICAL	72.90		
2069	10-22-02	HOWARD YOUNG MEDICAL CE	390873606	7005052	MEDICAL	177.79		
2070	10-22-02	ANTIGO'S COMPLETE DENTA	318568	7006749	DENTAL	53.00		
2071	10-22-02	LANGLADE MEMORIAL HOSPI	390806429	7002661	MEDICAL	1,690.15		
2072	10-22-02	MARSHFIELD CLINIC	390452970	7005776	MEDICAL	108.25		
2073	10-22-02	RADIOLOGY ASSOCS. OF WA	391203125	7004087	MEDICAL	38.92		

BANK TOTALS $2,704.77 $0.00
NUMBER OF CHECKS ISSUED..... : 9

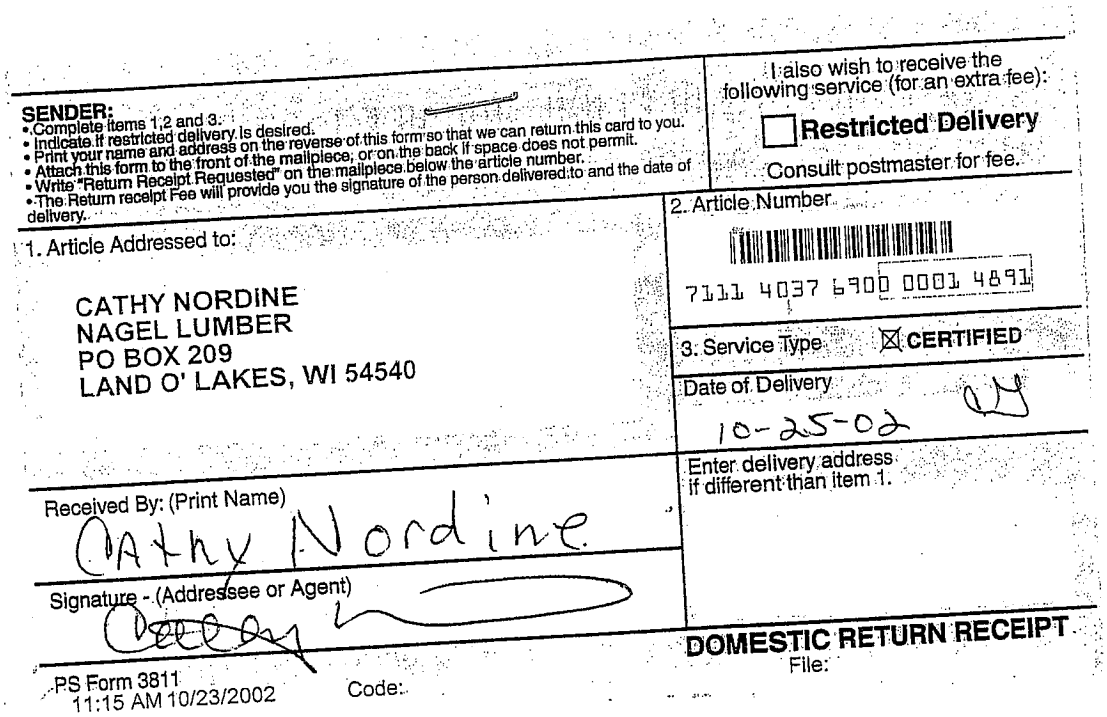
NUMBER OF ADJUSTMENTS..... : 0 TOTAL $2,704.77

TOTALS FOR DIVISION :2 $2,704.77 $0.00
NUMBER OF CHECKS ISSUED..... : 9

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $2,704.77

TOTALS FOR GROUP :36838 $15,367.93 $0.00
NUMBER OF CHECKS ISSUED..... : 26

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $15,367.93



SENDER:
• Complete items 1, 2 and 3.
• Indicate if restricted delivery is desired.
• Print your name and address on the reverse of this form so that we can return this card to you.
• Attach this form to the front of the mailpiece, or on the back if space does not permit.
• Write "Return Receipt Requested" on the mailpiece below the article number.
• The Return receipt Fee will provide you the signature of the person delivered to and the date of delivery.

I also wish to receive the following service (for an extra fee):
☐ Restricted Delivery
Consult postmaster for fee.

1. Article Addressed to:

CATHY NORDINE
NAGEL LUMBER
PO BOX 209
LAND O' LAKES, WI 54540

2. Article Number
7111 4037 6900 0001 4891

3. Service Type ☒ CERTIFIED

Date of Delivery
10-25-02

Received By: (Print Name)
Cathy Nordine

Signature - (Addressee or Agent)

Enter delivery address if different than item 1.

PS Form 3811
11:15 AM 10/23/2002

Code:

DOMESTIC RETURN RECEIPT
File:

CLAIM MANAGEMENT SERVICES, INC.

331625515*0
RONALD C JESSE JR.
? HWY 45 SOUTH
ER, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE :
CHECK NO :
DATE PAID : 11-05-0
GROUP : 3683
DIVISION :

PROVIDER DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFI PAI
EAGLE RIVER MEMORIAL HOSPITAL											
09/19-09/19/02	74246	OUTPT HOSPITAL	279.00	0.00	0.00		0.00	0.00		0.00	279.0
09/19-09/19/02		OUTPT HOSPITAL	58.00	33.70	0.00		0.00	0.00		0.00	24.3
CLAIM 7006440											
SHIRLEY A JESSE		Spouse	337.00	33.70	0.00		0.00	0.00		0.00	303.3
NETWORK : ASSOCIATES FOR HEALTH CARE											
		TOTALS	337.00	33.70	0.00		0.00	0.00		0.00	303.3

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
EAGLE RIVER MEMORIAL HOS	4558	303.30	

IF YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.
If the Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within group health plan document.

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

EXHIBIT
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9

FACTS 0069.CMS.BOT

CLAIM MANAGEMENT SERVICES, INC.

331625515*0
RONALD C JESSE JR.
3[illegible] HWY 45 SOUTH
[illegible]ER, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

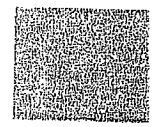
EMPLOYEE PAYMENT REPORT

PAGE :
CHECK NO :
DATE PAID : 11-05
GROUP : 36
DIVISION :

PROVIDER / DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENE
STEPHEN M LINDSEY, MD											
09/10-09/10/02	76700-26	X-RAY/LAB	190.75	19.07	0.00		0.00	0.00		0.00	171
CLAIM 7008544											
SHIRLEY A JESSE		Spouse	190.75	19.07	0.00		0.00	0.00		0.00	171
NETWORK : ASSOCIATES FOR HEALTH CARE											
		TOTALS	190.75	19.07	0.00		0.00	0.00		0.00	171

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
HOWARD YOUNG MEDICAL CEN	4561	171.68	

IF YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.
If the Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within your group health plan document.



***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

EXHIBIT
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10

FACTS 0069 CMS BOT

CLAIM MANAGEMENT SERVICES, INC.

331625515*0
RONALD C JESSE JR.
[illegible] HWY 45 SOUTH
C ER, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE :
CHECK NO :
DATE PAID : 11-05-0
GROUP : 3683
DIVISION :

PROVIDER / DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFI PAI
STEPHEN M LINDSEY, MD											
09/19-09/19/02	74246-26	X-RAY/LAB	159.00	15.90	0.00		0.00	0.00		0.00	143.1
CLAIM 7008543											
SHIRLEY A JESSE		Spouse	159.00	15.90	0.00		0.00	0.00		0.00	143.1
NETWORK : ASSOCIATES FOR HEALTH CARE											
		TOTALS	159.00	15.90	0.00		0.00	0.00		0.00	143.1

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
HOWARD YOUNG MEDICAL CEN	[redacted]	143.10	

IF YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.
If the Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within your group health plan document.

[redacted]

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

CLAIM MANAGEMENT SERVICES, INC.

331625515*0
RONALD C JESSE JR.
[redacted] HWY 45 SOUTH
C[redacted]R, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE : 1
CHECK NO :
DATE PAID : 11-05-02
GROUP : 36838
DIVISION : 1

PROVIDER / DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFIT PAID
STEPHEN M LINDSEY, MD											
10/11-10/11/02	74300-26	X-RAY/LAB	95.50	9.55	0.00		0.00	0.00		0.00	85.95
CLAIM 7010015											
SHIRLEY A JESSE		Spouse	95.50	9.55	0.00		0.00	0.00		0.00	85.95
NETWORK : ASSOCIATES FOR HEALTH CARE											
		TOTALS	95.50	9.55	0.00		0.00	0.00		0.00	85.95

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
HOWARD YOUNG MEDICAL CEN	[redacted]	85.95	

IF YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.
If the Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within your group health plan document.

[redacted]

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

CLAIM MANAGEMENT SERVICES, INC.

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE : 1
CHECK NO :
DATE PAID : 11-05-02
GROUP : 36838
DIVISION : 1

? -25515*0
C JESSE JR.
3 WY 45 SOUTH
CONOVER, WI 54519

PROVIDER DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFIT PAID
WILLIAM SCHULTE, CRNA											
10/11-10/11/02	00790-QZ	ANESTHESIA	1,057.50	105.75	0.00		0.00	0.00		0.00	951.75
10/11-10/11/02	47563-QZ	PROV BILLED SERV	0.00	0.00	0.00	ACW	0.00	0.00		0.00	0.00
CLAIM 7010016											
SHIRLEY A JESSE		Spouse	1,057.50	105.75	0.00		0.00	0.00		0.00	951.75

NETWORK : ASSOCIATES FOR HEALTH CARE
INELIGIBLE CODE ACW = CPT code changed and assigned anesthesia code. See Limitations and Exclusions: Usual and Customary

		TOTALS	1,057.50	105.75	0.00		0.00	0.00		0.00	951.75

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
HOWARD YOUNG MEDICAL CEN	4561	951.75	

YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.
If the Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within your group health plan document.

[redacted]

TED AMOUNT *****

***** PATIENT IS NOT RESPONSIBLE FOR ...

CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

CLAIM MANAGEMENT SERVICES, INC.

3316255l5*0
ONALD C JESSE JR.
755 HWY 45 SOUTH
C ER, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE : 1
CHECK NO :
DATE PAID : 11-05-02
GROUP : 36838
DIVISION : 1

PROVIDER / DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFIT PAID
BRUCE HERTEL, MD											
10/11-10/11/02	88304-26	X-RAY/LAB	113.50	11.35	0.00		0.00	0.00		0.00	102.15
CLAIM 7010014											
SHIRLEY A JESSE		Spouse	113.50	11.35	0.00		0.00	0.00		0.00	102.15
NETWORK : ASSOCIATES FOR HEALTH CARE											
		TOTALS	113.50	11.35	0.00		0.00	0.00		0.00	102.15

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
HOWARD YOUNG MEDICAL CEN	4561	102.15	

IF YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.
Tf the Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within
ar group health plan document.

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

CLAIM MANAGEMENT SERVICES, INC.

331625515*0
RONALD C JESSE JR.
55 HWY 45 SOUTH
'R, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE : 1
CHECK NO :
DATE PAID : 11-05-02
GROUP : 36838
DIVISION : 1

PROVIDER / DATES OF SERVICE	PROC CODE	TYPE OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE AMOUNT	CD	DEDUCT AMOUNT	COINS COPAY	PAYMENT LEVEL	OTHER CARRIER	BENEFIT PAID
HOWARD YOUNG MEDICAL CENTER											
10/11-10/11/02		OUTPT HOSPITAL	230.08	0.00	0.00		0.00	0.00		0.00	230.08
10/11-10/11/02		OUTPT HOSPITAL	20.25	0.00	0.00		0.00	0.00		0.00	20.25
10/11-10/11/02		OUTPT HOSPITAL	101.75	0.00	0.00		0.00	0.00		0.00	101.75
10/11-10/11/02	82948	OUTPT HOSPITAL	71.00	0.00	0.00		0.00	0.00		0.00	71.00
10/11-10/11/02	88304	OUTPT HOSPITAL	84.00	0.00	0.00		0.00	0.00		0.00	84.00
10/11-10/11/02	76000	OUTPT HOSPITAL	436.00	0.00	0.00		0.00	0.00		0.00	436.00
10/11-10/11/02	47563	OUTPT HOSPITAL	6,148.50	0.00	0.00		0.00	0.00		0.00	6,148.50
10/11-10/11/02		OUTPT HOSPITAL	3,707.00	112.93	0.00		0.00	0.00		0.00	3,594.07
10/11-10/11/02	J2250	OUTPT HOSPITAL	16.75	16.75	0.00		0.00	0.00		0.00	0.00
10/11-10/11/02	J2405	OUTPT HOSPITAL	125.86	125.86	0.00		0.00	0.00		0.00	0.00
10/11-10/11/02	J2765	OUTPT HOSPITAL	16.75	16.75	0.00		0.00	0.00		0.00	0.00
10/11-10/11/02	J3010	OUTPT HOSPITAL	50.25	50.25	0.00		0.00	0.00		0.00	0.00
10/11-10/11/02		OUTPT HOSPITAL	588.75	588.75	0.00		0.00	0.00		0.00	0.00
10/11-10/11/02	90782	OUTPT HOSPITAL	69.00	69.00	0.00		0.00	0.00		0.00	0.00
10/11-10/11/02	90782-76	OUTPT HOSPITAL	69.00	69.00	0.00		0.00	0.00		0.00	0.00
10/11-10/11/02	90784	OUTPT HOSPITAL	69.00	69.00	0.00		0.00	0.00		0.00	0.00
10/11-10/11/02	90784-59	OUTPT HOSPITAL	69.00	69.00	0.00		0.00	0.00		0.00	0.00
CLAIM 7009053											
[redacted]EY A JESSE		Spouse	11,872.94	1,187.29	0.00		0.00	0.00		0.00	10,685.65
NE [redacted]K : ASSOCIATES FOR HEALTH CARE											
		TOTALS	11,872.94	1,187.29	0.00		0.00	0.00		0.00	10,685.65

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

CLAIM MANAGEMENT SERVICES, INC.

EXPLANATION OF BENEFITS (THIS IS NOT A BILL)

POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

RONALD C JESSE JR.
3755 HWY 45 SOUTH
CONOVER, WI 54519

EMPLOYEE #	GROUP	DIVISION
331625515	36838	1
GROUP NAME		
NAGEL LUMBER COMPANY, INC		
INSURED NAME		
RONALD C JESSE		
DATE PRINTED	11/16/05	

CLAIM MANAGEMENT SERVICES, INC.

331625515*0
RONALD C JESSE JR.
--- HWY 45 SOUTH
C JR, WI 54519

P.O. BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

EMPLOYEE PAYMENT REPORT

PAGE : 1
CHECK NO :
DATE PAID : 11-05-0
GROUP : 3683
DIVISION :

PAYEE	CHECK NO.	PAYMENT	YOUR RESPONSIBILITY
HOWARD YOUNG MEDICAL CEN	4561	10,685.65	

IF YOU HAVE QUESTIONS REGARDING YOUR CLAIM PAYMENTS PLEASE CONTACT RENEE AT EXT 1493.
If the Deductible, Coinsurance, or Copay columns contain an amount, see the next page for the applicable provision within your group health plan document.

***** PATIENT IS NOT RESPONSIBLE FOR PROVIDER DISCOUNTED AMOUNT *****

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EXPLANATION OF BENEFITS
(THIS IS NOT A BILL)

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POST OFFICE BOX 10888
GREEN BAY, WI 54307-0888
(800) 472-7130

NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIAB

FOR ADDITIONAL INFORMATION CONTACT CLIENT SERVICES (800) 472-7130

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NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIAB

EMPLOYEE #	GROUP	DIVISION
NON-NEGOTIABLE	NON-NEGOTIABLE	NON-NEGOTIAB
GROUP NAME		
NON-NEGOTIABLE	NON-NEGOTIABLE	NON-NEGOTIAB
INSURED NAME		
DATE PRINTED		

Great Benefit Administration for Great Companies

November 5, 2002

Cathy Nordine
Nagel Lumber Company, Inc.
Highway B
P.O. Box 209
Land O'Lakes WI 54540

RE: Nagel Benefit Payment Checks totaling $23,135.44
Aspen Valley Benefit Payment Checks totaling $1,573.61
Benefit Payment Checks dated November 5, 2002 totaling $24,709.05

Dear Ms. Nordine:

This letter is a follow up to Maureen's phone conversation with Cheryl VanderKinter on November 5, regarding your request to CMS to hold all checks processed for payment by CMS on November 5, 2002.

Since CMS will not hold these checks in our office as you requested, we are forwarding all checks to you for disbursement. Since you will be controlling the disbursement of these checks, CMS will be directing any inquiries from participants to your attention regarding these payments.

I am enclosing all benefit payment checks dated November 5, 2002 for Nagel Lumber Company, Inc. and for Aspen Valley Lumber Company, Incorporated.

Sincerely,

Michelle Bosacki

Michelle Bosacki
Manager, Operations

Encs.

CLAIM MANAGEMENT SERVICES, INC.
P.O. Box 10888 • Green Bay, WI 54307-0888 • (800) 472-7130
P.O. Box 2790 • West Bend, WI 53095-7970 • (800) 245-6142
6425 Normandy Lane, Suite 2 • Madison, WI 53719 • (800) 809-3077

EXHIBIT
tabbies
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Case: 3:08-cv-00400-bbc Document #: 1 Filed: 07/16/2008 Page 125 of 135

CHECK REGISTER

11-05-02 TO 11-05-02

GROUP # :36838 NAGEL LUMBER COMPANY, INC.
DIVISION # :1
BANK # :116665

PREPARED: 04-07-06
TIME : 07:45:29

CHECK #	DATE	PAYEE	EMPLOYEE/PROV #	REF #	CLAIM TYPE	CHECK AMOUNT	ADJ.TYPE	ADJUST.AMT.
4554	11-05-02	WRH/HOWARD YOUNG JOINT	225133	7009595	MEDICAL	371.52		
4555	11-05-02	EYE CARE ASSOCIATES	273186	7008622	MEDICAL	106.65		
4556	11-05-02	APPLETON MEDICAL CENTER	390824015	7010022	MEDICAL	115.20		
4557	11-05-02	CARDIOVASCULAR ASSOC OF	391449611	7008136	MEDICAL	1,297.80		
4558	11-05-02	EAGLE RIVER MEMORIAL HO	390985690	7006444	MEDICAL	8,131.02		
4559	11-05-02	STEVEN FIORUCCI, D.O.	383134667	7005300	MEDICAL	92.80		
4560	11-05-02	GRAND VIEW HOSPITAL	382908586	7009662	MEDICAL	94.00		
4561	11-05-02	HOWARD YOUNG MEDICAL CE	390873606	7008543	MEDICAL	12,297.48		
4562	11-05-02	ROBERT J. JOHNSON, D.D.	382275896	7009791	DENTAL	69.00		
4563	11-05-02	KEWEENAW MEMORIAL HEALT	235672	7010251	MEDICAL	20.00		
4564	11-05-02	MARSHFIELD CLINIC	390452970	7008994	MEDICAL	91.04		
4565	11-05-02	NEAL A. POTRYKUS, D.D.S	391485176	7011276	DENTAL	106.21		
4566	11-05-02	PETER SCHINDELHOLZ, D.D	391391738*1	7009794	DENTAL	236.00		
4567	11-05-02	SPINE & SPORT PHYSICAL	391799960	7006739	MEDICAL	106.72		

BANK TOTALS $23,135.44 $0.00
NUMBER OF CHECKS ISSUED..... : 14

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $23,135.44

TOTALS FOR DIVISION :1 $23,135.44 $0.00
NUMBER OF CHECKS ISSUED..... : 14

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $23,135.44

C H E C K R E G I S T E R

11-05-02 TO 11-05-02

GROUP # :36838 NAGEL LUMBER COMPANY, INC.
DIVISION # :2
BANK # :145755

CHECK #	DATE	PAYEE	EMPLOYEE/PROV #	REF #	CLAIM TYPE	CHECK AMOUNT	ADJ.TYPE	ADJUST.AMT.
2079	11-05-02	HEALTHSOUTH WAUSAU SURG	621525773	7010030	MEDICAL	958.22		
2080	11-05-02	LANGLADE MEMORIAL HOSPI	390806429	7002405	MEDICAL	268.78		
2081	11-05-02	MARSHFIELD CLINIC	390452970	7010577	MEDICAL	38.00		

BANK TOTALS $1,265.00 $0.00
NUMBER OF CHECKS ISSUED..... : 3

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $1,265.00

TOTALS FOR DIVISION :2 $1,265.00 $0.00
NUMBER OF CHECKS ISSUED..... : 3

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $1,265.00

Case: 3:08-cv-00400-bbc Document #: 1 Filed: 07/16/2008 Page 126 of 135

Case: 3:08-cv-00400-bbc Document #: 1 Filed: 07/16/2008 Page 127 of 135

CHECK REGISTER

11-05-02 TO 11-05-02

GROUP # :36838 NAGEL LUMBER COMPANY, INC.
DIVISION # :4
BANK # :145755

PREPARED:04-07-06
TIME :07:45:29

CHECK #	DATE	PAYEE	EMPLOYEE/PROV #	REF #	CLAIM TYPE	CHECK AMOUNT	ADJ.TYPE	ADJUST.AMT.
2082	11-05-02	FIRST IMPRESSIONS, S.C.	391825887	7009787	DENTAL	308.61		

BANK TOTALS $308.61 $0.00
NUMBER OF CHECKS ISSUED..... : 1

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $308.61

TOTALS FOR DIVISION :4 $308.61 $0.00
NUMBER OF CHECKS ISSUED..... : 1

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $308.61

TOTALS FOR GROUP :36838 $24,709.05 $0.00
NUMBER OF CHECKS ISSUED..... : 18

NUMBER OF ADJUSTMENTS..... : 0 TOTAL $24,709.05

SENDER:
- Complete items 1, 2 and 3.
- Indicate if restricted delivery is desired.
- Print your name and address on the reverse of this form so that we can return this card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit.
- Write "Return Receipt Requested" on the mailpiece below the article number.
- The Return receipt Fee will provide you the signature of the person delivered to and the date of delivery.

I also wish to receive the following service (for an extra fee):

☐ **Restricted Delivery**

Consult postmaster for fee.

1. Article Addressed to:

ED NAGEL PRESIDENT
NAGEL LUMBER COMPANY INC
5135 COUNTY B
LAND O LAKES, WI 54540

2. Article Number

7111 4037 6900 0001 6390

3. Service Type ☒ **CERTIFIED**

Date of Delivery

11-7-02

Received By: (Print Name)

Cathy Nordine

Signature - (Addressee or Agent)

Enter delivery address if different than item 1.

PS Form 3811

DOMESTIC RETURN RECEIPT

11:35 AM 11/5/2002 Code: File:

Case: 3:08-cv-00400-bbc Document #: 1 Filed: 07/16/2008 Page 128 of 135

FACSIMILE TRANSMITTAL FORM

NAGEL LUMBER COMPANY, INC.

P.O. BOX 209
LAND O' LAKES, WI 54540
FAX: 715-547-3715

PLEASE DELIVER THE FOLLOWING PAGE(S) TO:

NAME: Lou Jesse Jr

FIRM:

ADDRESS:

FAX NO.: 479 8259

FROM:

DATE: 5-31-05 TIME: NO. PAGES 1
(including this page)

Nagel Lumber Company has every intention on paying all past due medical Bills

Note: If you have any problems receiving transmission, please contact _____ immediately at 715-547-3361.

EXHIBIT
tabbies
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ATTORNEYS AT LAW
HQEP HAWKS QUINDEL EHLKE & PERRY, S.C.

700 West Michigan, Suite 500
P.O. Box 442
Milwaukee, WI 53201-0442

MILWAUKEE OFFICE

SHAREHOLDERS
Katherine L. Charlton
Timothy E. Hawks
Thomas Nelson
Lynn M. Novotnak
Richard Perry
Barbara Zack Quindel
Israel Ramon
Richard Saks
Daniel R. Schoshinski
Amy L. Shapiro
B. Michele Sumara
Jeffrey P. Sweetland

414-271-8650
Fax 414-271-8442
www.hqeplaw.com
Offices also in Madison

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Michele A. Peters

OF COUNSEL TO FIRM
Walter F. Kelly
Robert J. Lerner
Howard N. Myers
Vicki Schaut
Daniel L. Shneidman

April 17, 2006

VIA FAX (715) 547-3715 AND REGULAR MAIL
Nagel Lumber Company, Inc.
P. O. Box 209
Land O' Lakes, WI 54540

ATTN: Kathy Nagel Nordine

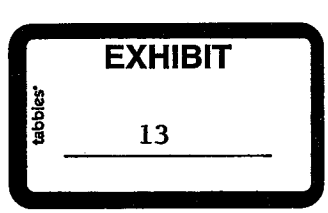
RE: Ronald and Shirley Jesse and Nagel Lumber Co., Inc. (Nagel) Group Medical Plan (Plan)
Employee No. 331625515 Group No. 36838
Our File No. 60179

Dear Ms. Nordine:

Ronald and Shirley Jesse have retained this law firm in connection with the above-referenced Plan's failure to pay for certain covered hospital and medical services received in 2002. Specifically, Howard Young Medical Center and Eagle River Memorial Hospital (Hospitals) claim they are still owed approximately $14,568.29 for services provided to the Jesses as follows:

Date of Service	Patient	Outstanding Balance
7/20/02	Shirley	$ 627.10
8/9/02	Shannon	$ 271.75
9/10/02	Shirley	$ 486.50
9/19/02	Shirley	$ 337.00
9/24/02	Shirley	$ 973.00
10/11/02	Shirley	$ 11,872.94

The Hospitals submitted all of these bills in the ordinary course to the Plan's third party administrator, Claim Management Services, Inc. (CMS), which processed them for payment. CMS sent explanations of benefits (EOBs) to the Jesses, copies of which I have enclosed with the hard copy of this letter, stating that each of the above bills had been paid to the Hospitals on a particular date with a particular check. In fact, unbeknownst to the Jesses, CMS forwarded the checks to Nagel, rather than the providers, because there were insufficient funds in the Plan's account to back them up.



As a result of the Plan's failure to pay these bills, the Hospitals are looking to the Jesses to pay them. The Hospitals have placed the unpaid balances on the Jesses' credit records, making it difficult, if not impossible, for the Jesses to obtain any credit.

We believe the Jesses have claims against Nagel, as the administrator of the Plan, for non-payment of benefits and breach of fiduciary duty under the federal Employee Retirement Income Security Act (ERISA) and for civil penalties under the Racketeering Influenced and Corrupt Organizations Act (RICO), arising from the handling of these claims by Nagel and its agent, CMS. Remedies for RICO violations include triple damages plus awards of attorney fees.

The Jesses are prepared to pursue these claims in federal court if Nagel does not, *within 15 calendar days of the date of this letter:*

(a) Pay the sum of $14,568.29 to the Hospitals, along with whatever additional interest and carrying charges may have accrued, in order to pay all of the aforementioned bills for services in full; and

(b) Pay the sum of $2,500 to this firm, Hawks Quindel Ehlke & Perry, S.C., to cover the attorney fees the Jesses have incurred in this matter thus far.

Govern yourselves accordingly.

Very truly yours,

HAWKS QUINDEL EHLKE & PERRY, S.C.

By _____
Jeffrey P. Sweetland

JPS:mc
Enclosures
c: Ronald and Shirley Jesse

P.01

TRANSACTION REPORT

APR-17-2006 MON 02:22 PM

FOR:

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DATE	START	RECEIVER	TX TIME	PAGES	TYPE	NOTE	M#	DP
APR-17	02:21 PM	1715547371560179#	56"	3	FAX TX	OK	792	

TOTAL : 56S PAGES: 3

Hawks Quindel Ehlke & Perry, S.C.

700 West Michigan Street, Suite 500
Post Office Box 442
Milwaukee, Wisconsin 53201-0442

(414) 271-8650
Fax (414) 271-8442

FACSIMILE TRANSMISSION

April 17, 2006

TO: Nagel Lumber Company, Inc. FAX #: (715) 547-3715

FROM: Jeffrey P. Sweetland

RE: Ronald and Shirley Jesse

FILE #: 60179

Any problems or questions with this transmittal should be directed to Nancy at (414) 271-8650.

Total number of pages including cover sheet: 3

Original to follow via U.S. Mail? Yes

ADDITIONAL COMMENTS:

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ATTORNEYS AT LAW
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700 West Michigan, Suite 500
P.O. Box 442
Milwaukee, WI 53201-0442

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Walter F. Kelly
Robert J. Lerner
Howard N. Myers
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Daniel L. Shneidman

August 24, 2006

VIA FAX (715) 547-3715 AND REGULAR MAIL
Nagel Lumber Company, Inc.
P. O. Box 209
Land O' Lakes, WI 54540

ATTN: Kathy Nagel Nordine

VIA FAX 459-6229 AND REGULAR MAIL
Atty. Mary C. Nash
Anthem Blue Cross Blue Shield of Wisconsin
6775 W Washington St
Milwaukee, WI 53214

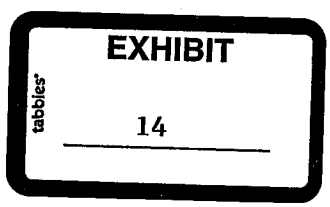
RE: Ronald and Shirley Jesse and Nagel Lumber Co., Inc. (Nagel) Group Medical Plan (Plan)
Employee No. 331625515 Group No. 36838
Our File No. 60179

Dear Ms. Nordine and Ms. Nash:

Several months ago I wrote to both of you demanding that Nagel Lumber Company, Inc. and/or Claim Management Services, Inc. (CMS) pay an outstanding balance of $14,568.29 to Howard Young Medical Center and Eagle River Memorial Hospital (Hospital) for services received in 2002 that were covered by the above-referenced Plan. The Hospitals have turned the matter over to OSI Collections, Inc., in Schaumberg, Illinois for collection. According to Marla Lumpkin at OSI, the outstanding balance, as of Tuesday, August 22, 2006, is now $14,936.02.

We understood that Ms. Nordine contacted the Hospitals about this matter after receiving my letter, and indicated that Nagel would pay all except any patient co-pays. Ms. Nordine made similar representations to me on Wednesday, August 2, 2006, assured me she was preparing a payment plan and said she would shortly fax me a copy. Neither the Hospitals nor I have heard anything further from Nagel. From this I can only conclude that Ms. Nordine's assurances of payment were merely a stalling tactic.

It is imperative that Nagel and/or CMS pay the outstanding balance of $14,936.02 directly to OSI and reimburse the Jesses for their attorney fees, which now stand at $5,000, by no later than *Wednesday, September 6, 2006.* If that is not done, the Jesses and I intend to meet with other former Nagel employees in the same situation, who have expressed interest in joining in an action against both of your organizations. Such action will assert



claims under both the Employee Retirement Income Security Act (ERISA) and the Racketeer Influenced and Corrupt Organizations Act (RICO), as I described in my previous letters to you.

The payment to OSI should be mailed to:

OSI Collection Services
1375 East Woodfield Road
Schaumburg, IL 60173

ATTN: Marla Lumpkin

The attorney fees are to be paid to the Hawks Quindel Ehlke & Perry, S.C., Client Trust Account, and mailed to the address shown on the letterhead.

Govern yourselves accordingly.

Very truly yours,

HAWKS QUINDEL EHLKE & PERRY, S.C.

By _____
Jeffrey P. Sweetland

JPS:mc
Enclosures
c: Ronald and Shirley Jesse
Jon Numrich, Nicollet Credit Union (via fax 715-479-9557 and regular mail)
Dawn Rymsha, Howard Young Med. Ctr. (via fax 715-356-8286 and regular mail)
Marla Lumpkin, OSI Collections (via fax 847-969-7920 and regular mail).

P. 01

TRANSACTION REPORT

AUG-24-2006 THU 03:54 PM

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DATE	START	RECEIVER	TX TIME	PAGES	TYPE	NOTE	M#	DP
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FROM: Jeffrey Swedland FILE# 60179

DATE: 8/24/06

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