PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

for the

AGGRESSIVE TOOLING, INC.

GROUP INSURANCE PLAN

TO OUR EMPLOYEES

Aggressive Tooling, Inc. ("Employer") has established the **Aggressive Tooling, Inc. Group Insurance Plan** ("Plan") to provide certain health and welfare benefits to eligible participants. Some benefits under the Plan such as medical/prescription drug benefits, group term life insurance, and short-term and long-term disability benefits are provided on a fully-insured basis. The certificate or booklet from the insurers along with this document is intended to serve as the Summary Plan Description ("SPD") for these fully-insured benefits.

Other benefits under the Plan (specifically the dental benefit) are provided on self-funded basis which means that benefits will be paid by Plan Sponsor from its general assets rather than through a separate trust fund or an insurance company. This document is intended to serve as both the Plan document and the Summary Plan Description for the self-funded dental benefit.

If you have any questions about your benefits under the Plan, please contact Angie Peterman at 616-754-3206.

AGGRESSIVE TOOLING, INC.

October, 2017

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GROUP INSURANCE PLAN

The Group Insurance Plan is an "umbrella plan." It consists of health and welfare benefit plans (each called a "Sub-Plan") for employees of Aggressive Tooling, Inc. The Sub-Plans are listed in the "OTHER BASIC INFORMATION ABOUT THE PLAN" section at the end of this Summary Plan Description. You have already received a certificate or booklet describing each fully-insured Sub-Plan in which you are eligible to participate. This Summary Plan Description is intended to supplement those materials. This document does not replace the provisions of the master plan and/or group insurance contract for a fully-insured Sub-Plan, including any applicable certificates and/or riders.

Each certificate or booklet for a fully-insured Sub-Plan will contain the following information:

- The eligibility and participation conditions for any dependent coverage.
- A summary of benefits.
- With respect to health benefits, a description of any deductibles, coinsurance or copayment amounts.
- A description of any annual or lifetime caps or other limits on benefits.
- With respect to health benefits, whether and under what circumstances preventive services are covered.
- With respect to health benefits, whether and under what circumstances prescription drugs are covered.
- With respect to health benefits, whether and under what circumstances coverage is provided for medical tests, devices and procedures.
- With respect to health benefits, provisions governing the use of network providers (if any). If there is a network, the booklet or certificate will contain a general description of the provider network and you will be entitled to obtain a list of providers in the network from the insurer.
- With respect to health benefits, whether and under what circumstances coverage is provided for any out-of- network services.
- With respect to health benefits, any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.
- With respect to health benefits, any conditions or limits applicable to obtaining emergency medical care.
- With respect to health benefits, any provisions requiring preauthorization or utilization as a condition to obtaining a benefit.

ELIGIBILITY AND PARTICIPATION

Each full-time employee of Employer who is regularly scheduled to work at least 30 hours per week will be eligible to receive all of the coverage's under the Plan. A newly-eligible full-time employee will be eligible to participate in these benefits as follows:

Medical/Prescription Drug Benefits/Voluntary Vision

On the day the employee has completed 60 days of service for Employer.

Dental Benefits

On the day the employee has completed one year of service for Employer.

Group Term Life Insurance and Short-Term and Long-Term Disability Benefits

On the day the employee has completed 60 days of service for Employer.

Employees classified as part-time or temporary are ineligible to participate.

SOURCES OF CONTRIBUTIONS AND COST OF COVERAGE

Employer may contribute to the cost of coverage under each Sub-Plan. In addition, you may be required to contribute to the cost of coverage under one or more of the Sub-Plans, as periodically determined by Employer. If you are required to contribute to the cost of coverage, Employer will notify you of the required contribution. Benefits under the Sub-Plans are funded in the following manner:

Self-Insured

Benefits under a Sub-Plan may be funded on a self-insured basis (e.g., dental benefits). If this is the case, Employer will pay benefits under that Sub-Plan from its general assets. Employer may establish a separate bank account for the payment of self-insured benefits. If a separate bank account is established, however, it will be for bookkeeping purposes only.

Insured

Employer may purchase insurance either to provide benefits under a Sub-Plan (e.g., medical/prescription drug benefits, group term life insurance and short-term and long-tem disability benefits) or, in the case of a Sub-Plan funded on a self-insured basis, to protect Employer from large individual and aggregate losses.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Notwithstanding any contrary provision in any group health benefit under the Plan, an eligible dependent child may include a child for whom you are required to provide coverage pursuant to a qualified medical child support order ("QMCSO"). You may obtain, without charge, a copy of the Plan's QMCSO procedures from the plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act of 1996, a federal law, provides certain rights to newborns and mothers. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998, a federal law, provides certain rights to participants. Group health plan expenses for a mastectomy include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act of 1996, a federal law known as HIPAA, provides participants with the following rights:

Pre-Existing Conditions/Certificates of Creditable Coverage

Group health plans may not impose pre-existing condition exclusions with respect to individuals beyond 12 months (18 months for late enrollees). Further, an individual's period of creditable coverage under another health plan must reduce the pre-existing condition exclusion. Group health plans and health insurance issuers must provide individuals with a certificate of creditable coverage following termination of coverage. Individuals may also request a certificate of creditable coverage if the request is made within 24 months after coverage ends.

Special Enrollment Rights

If an individual experiences a loss of coverage or if an employee has a new dependent, an eligible employee and/or a dependent may have special enrollment rights to participate in the group health plan immediately without being required to wait until the next annual open enrollment period. For this purpose, a loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), the other coverage is an HMO and the individual no longer lives or works in the HMO service area, or coverage is lost due to the application of the other plan's maximum lifetime limit on all benefits. A loss of other coverage for this purpose does not include, however, termination due to the nonpayment of required contributions, for cause due to the filing of a fraudulent application or claim, or where the individual voluntarily terminates other coverage. The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption. Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable.

Privacy and Security

Fully-insured group health plans and self-funded group health plans with 50 or more eligible employees and/or that are administered by a third party claims administrator are subject to the HIPAA privacy and security rules. Under the rules, group health plans and health insurance issuers must make sure that medical information identifying a participant is kept private, must maintain and follow privacy policies and procedures and must notify participants of the privacy policies and procedures. In addition, group health plans and health insurance issuers must conduct a written risk analysis and maintain and follow policies and procedures to ensure the security of protected health information maintained or transmitted in electronic form.

TERMINATION OF COVERAGE

In order to remain eligible for coverage under the Plan, the employee must remain a regularly scheduled full-time employee actively working for Employer. However, health coverage (medical/prescription drug and dental) under the Plan can be continued if the employee goes on a family or medical leave, as defined by the Family and Medical Leave Act of 1993 ("FMLA"). Health coverage in this instance will continue for the period prescribed by FMLA (generally up to 12 weeks but, effective as of January 28, 2008, up to 26 weeks to care for a qualifying military service member injured in the line of active duty). The employee must pay the same premium amount for the coverage during the leave as actively-working employees.

Except for an FMLA leave situation, the medical/prescription drug and dental benefits terminate for an employee the day the individual quits, is terminated, or otherwise leaves full-time employment. Short and long term disability and life insurance will terminate at the end of the month of the employee's change of full-time status. Long-term disability benefits will generally terminate on the date as of which the employee's employment ends. However, if the person is disabled and has applied for long-term disability benefits, after the elimination period for long-

term disability benefits has been satisfied, the employment relationship will be terminated and the terminated employee will receive the long-term disability benefit for as long as the policy requirements are met.

However, in certain circumstances, the employee and/or his or her eligible dependents may be eligible for COBRA continuation coverage and/or a conversion policy, as explained in the following sections.

COBRA CONTINUATION COVERAGE

Continuation coverage is required under the federal law known as COBRA. COBRA continuation coverage allows you and/or your dependents (including a child for whom you are required to provide health insurance coverage pursuant to a QMCSO) an opportunity to temporarily extend health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end.

The plan administrator may delegate some or all of its responsibilities with respect to COBRA to a third-party COBRA administrator. You and your spouse (if any) will be informed if a COBRA administrator is appointed and which responsibilities the COBRA administrator has assumed, including whether notices required to be provided to the plan administrator should be sent to the COBRA administrator.

Eligibility

You and/or your dependents who are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to or adopted by or placed for adoption with the employee during a period of COBRA continuation coverage, the newborn or newly-adopted child will also be a qualified beneficiary. However, the newborn or newly-adopted child's maximum continuation period will be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a qualified beneficiary to continuation coverage are "qualifying events." The qualifying events occur when health coverage is lost, even if Employer pays the cost of continuation coverage for a certain period of time. The qualifying events, the qualified beneficiaries, and the maximum initial continuation period are described in the following chart:

Qualifying Event	**Qualified Beneficiary**	**Continuation Period (Months)**
Reduced hours* or termination of employment**	Employee and Dependents	18
Employee's death	Dependents	36

Employee's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee's divorce/legal separation***	Dependents	36

* A reduction in hours due to a family or medical leave, as defined by the FMLA, will not cause your participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a qualifying event. However, if you do not return to work at the end of the FMLA leave, a qualifying event will occur as of the last day of the FMLA leave.

** Continuation coverage is not available if employment is terminated for gross misconduct.

*** Elimination of your spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example) is not a qualifying event, but it also does not cause the subsequent divorce or legal separation to fail to be a qualifying event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the date of the divorce or legal separation.

Extension of Continuation Coverage

If you and/or your dependents become entitled to continuation coverage as a result of your termination of employment or reduction in hours, the 18-month continuation period may be extended for you and/or your dependents in the three circumstances described below ("extension events").

Second Qualifying Event

If a second qualifying event that is a divorce, legal separation, your death, or a dependent child's loss of eligibility for health coverage under the Plan occurs during the initial 18-month period (or 29 months, if there is a disability extension), your dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of your termination of employment or reduction in hours. ***Notice of this second qualifying event must be provided to the plan administrator within 60 days of the date of the second qualifying event.***

Employee's Entitlement to Medicare

If you become entitled to Medicare benefits during the initial 18-month period, your dependents may be eligible to elect continuation coverage for a period of 36 months, if, ignoring the original qualifying event, your entitlement to Medicare would have been a qualifying event under the Plan. The 36-month continuation period begins on the date of your termination of employment or reduction in hours. ***Notice of your entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the date on which you became entitled to Medicare.***

A special rule applies if you became entitled to Medicare before your termination of employment or reduction in hours. In that situation, the maximum continuation period for your dependents may be extended, and may end on the later of: 36 months after the date of your Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of your termination of employment or reduction in hours. ***Notice of your entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of your termination of employment or reduction in hours.***

Social Security Disability Determination

If it is determined that you or one of your dependents is entitled to Social Security disability benefits either before your termination of employment or reduction in hours or within 60 days after your termination of employment or reduction in hours, the disabled individual and the qualified beneficiaries who are his or her family members will be entitled to an additional 11 months of continuation coverage (29 months total). ***Notice of the Social Security disability determination must be provided to the plan administrator within 60 days of the date of the disability determination (or within 60 days of your termination of employment or reduction in hours, if later) and before the end of the 18-month continuation period.***

If there is a final determination that the disabled qualified beneficiary is no longer disabled, the disabled qualified beneficiary ***must notify the plan administrator of that determination within 30 days of the date of the final determination.*** In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the "Termination" subsection below).

Plan Administrator's Notice Obligations

The plan administrator will provide you and your spouse (if any) with certain information regarding your rights under COBRA in the following situations:

Notice of Eligibility to Elect COBRA

The plan administrator will generally notify qualified beneficiaries of their eligibility for continuation coverage within 44 days of a qualifying event.

However, a special rule applies where the qualified beneficiary is required to provide the plan administrator with notice of a qualifying event in order to trigger the qualified beneficiary's eligibility for continuation coverage (see the "Qualified Beneficiary's Notice Obligations" subsection below). In that situation, the plan administrator will notify the qualified beneficiary of his or her eligibility for continuation coverage within 14 days of receiving notice of the qualifying event, but only if the notice of the qualifying event was timely submitted in accordance with the requirements described in the "Notice Procedures" subsection.

Notice of Unavailability of Continuation Coverage

The plan administrator will provide a notice of the unavailability of continuation coverage in the following situations:

- Where the plan administrator determines that continuation coverage is not available after receiving notice of a potential initial qualifying event that is a divorce, legal separation or a dependent child's loss of eligibility for health coverage under the Plan.

- Where the plan administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential extension event.

The determination that continuation coverage or an extension of continuation coverage is not available could be made because the plan administrator determines that no qualifying event or extension event occurred, or because the notice of the qualifying event or extension event was defective. A notice will be defective if it is not provided within the applicable time limit or is not provided in accordance with the requirements of the "Notice Procedures" subsection.

The plan administrator will provide the notice of unavailability of continuation coverage within 14 days of the date the plan administrator receives the notice of the potential qualifying event or extension event, or if later, the deadline for submission of additional information requested by the plan administrator to supplement a defective notice. The notice of unavailability of continuation coverage will be sent to the individual who submitted the notice of the qualifying event or extension event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

Qualified Beneficiary's Notice Obligations

In some situations, you and/or your dependents have the obligation to provide notice of a qualifying event or extension event to the plan administrator in order to trigger eligibility for continuation coverage or an extension of continuation coverage. You and/or your dependents have this obligation in the following situations:

Notice of Certain Initial Qualifying Events

You, one of your dependents, or an individual acting on behalf of you and/or your dependents must inform the plan administrator of a qualifying event that is a divorce or legal separation, or of a child losing dependent status under the Plan within 60 days after the later of:

- The date of the qualifying event; or

- The date the qualified beneficiary loses health insurance coverage under the Plan on account of that qualifying event.

Notice of an Extension Event

In order to qualify for an extension of the continuation coverage period due to an extension event described in the "Extension of Continuation Coverage" subsection, you, one of your dependents, or an individual acting on behalf of you and/or your dependent must notify the plan administrator of the extension event within the time limits that apply to that extension event as described in the "Extension of Continuation Coverage" subsection.

These notices must be provided in accordance with the requirements of the "Notice Procedures" subsection. If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the qualifying event or extension event.

Notice Procedures

This subsection describes the procedures a qualified beneficiary must follow to notify the plan administrator of qualifying events and extension events.

The plan administrator has a form which may be used to provide the required notice. The form may be obtained by contacting the plan administrator at the address or telephone number on the last page of this Summary Plan Description. While use of the notice form will help ensure that the qualified beneficiary provides all of the required information, use of the notice form is not required. Written notification that contains all of the following information will also be accepted:

- Your name.
- The name of the individual(s) for whom continuation coverage is being requested (i.e., the qualified beneficiary(ies)).
- The current address of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.
- The date of the qualifying event or extension event.
- The nature of the qualifying event or extension event (for example, a divorce).
- If the notice relates to a divorce, a copy of the judgment of divorce.
- If the notice relates to a legal separation, a copy of the judgment of separate maintenance.
- If the notice relates to your entitlement to Medicare, a copy of the document(s) establishing the entitlement.

- If the notice relates to a determination that a qualified beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.

- If the notice relates to a determination that a qualified beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

Notice that is not furnished by the applicable deadline and is not made in writing and/or does not contain all of the required information is deemed to be defective and may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

If the plan administrator receives notice of a qualifying event or extension event that is defective because it is not in writing or does not contain all of the required information, the plan administrator will request the missing information. If the defective notice was provided by the representative of a qualified beneficiary or a potential qualified beneficiary, the plan administrator will send the request to the representative and each individual who is a qualified beneficiary or a potential qualified beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the plan administrator requests the additional information, the notice may be rejected. If the notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

The plan administrator may also request additional information or documentation that is deemed necessary to determine whether a qualifying event or extension event has occurred. If the plan administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

Qualified Beneficiary's Election of Continuation Coverage

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the plan administrator within 60 days after the later of:

- The date the qualified beneficiary loses health coverage on account of the qualifying event; or

- The date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage.

Notification is made by timely returning the election form to the plan administrator at the address specified in the election notice. If the qualified beneficiary does not choose continuation coverage during the 60-day period, his or her participation in the Plan will end as provided in the "Termination" subsection.

Special Trade Adjustment Assistance Election

Special COBRA rights may apply to you if you terminate employment or experience a reduction of hours and qualify for a "trade adjustment allowance" or "alternative trade adjustment assistance" under federal trade laws. In this situation, you are entitled to a second opportunity to elect COBRA continuation coverage for yourself and certain family members (if they did not already elect COBRA continuation coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after group health plan coverage ended.

If you qualify or may qualify for assistance under the federal trade laws, contact the plan administrator for additional information. You must contact the plan administrator promptly after qualifying for assistance under the federal trade laws or you will lose these special COBRA election rights.

Coverage

If a qualifying event occurs, the qualified beneficiaries must be offered the opportunity to elect to receive the group health insurance coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that if the qualified beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the qualifying event (medical/prescription drug and/or dental). Each qualified beneficiary has the right to make an independent election to receive continuation coverage. Alternatively, the qualified beneficiary may initially elect to purchase one or more of the medical, prescription drug and dental coverages which are provided by Employer pursuant to any separate group health plans. However, each coverage is initially available only if the qualified beneficiary was receiving coverage immediately before the qualifying event.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to the qualified beneficiary and his or her dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during the annual enrollment period just as active employees.

Cost of Continuation Coverage

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law).

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of

the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the qualified beneficiary initially elects continuation coverage.

Termination

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner for any of the following reasons:

Coverage Terminated

Employer no longer offers a group health plan to any of its employees.

Unpaid Premium

The premium for continuation coverage is not timely paid, to the extent payment is required.

Other Coverage

A qualified beneficiary becomes covered under another group health plan. Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision will not apply during any time period the other group health plan contains an exclusion or limitation with respect to any pre-existing conditions, other than an exclusion or limitation which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to HIPAA.

Medicare

A qualified beneficiary becomes entitled to Medicare (Part A or Part B). Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B).

Cause

A qualified beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-qualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits). Continuation coverage will end as of the date on which the qualified beneficiary's coverage is terminated for cause.

The plan administrator will notify the qualified beneficiary if continuation coverage terminates before the end of the initial 18- or 36-month continuation period or before the

end of any additional 11- or 18-month continuation period for which the qualified beneficiary has elected continuation coverage. The notification will be provided as soon as practicable following the plan administrator's determination that continuation coverage will terminate.

Questions

You and/or your dependents should contact the plan administrator at the address or telephone number listed at the end of this Summary Plan Description with any questions regarding COBRA that are not answered in this Summary Plan Description. You and/or your dependents may also contact the nearest District or Regional office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") or visit the EBSA's website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

Keep Plan Administrator Informed of Address Changes

To protect your rights under COBRA, it is important that you and your dependents keep the plan administrator informed of any changes in address. You should also keep a copy, for your records, of any notices that are sent to the plan administrator.

CONTINUATION OF HEALTH COVERAGE UPON MILITARY LEAVE

If you cease to be eligible for health coverage under the Plan due to service in the U.S. military, you and your eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). You and your dependents may also be entitled to elect to continue your health coverage under COBRA if you cease to be eligible for health coverage due to your military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

You may elect to continue health coverage under the Plan for yourself and your eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day you are absent from work to perform military service; or

- The period beginning on the first day you are absent from work to perform military service and ending with the date you fail to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If you give Employer advance notice of a period of military service that will be 30 days or less, the plan administrator will treat your notice as an election to continue your health

coverage during your military service unless you specifically inform Employer, in writing, that you want to cancel your health coverage during your military leave. You will have to pay the required premiums for your health coverage, but you will not have to complete any additional forms or paperwork to continue your health coverage during your military service.

If you give Employer advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide you with a notice of your right to elect to continue health coverage pursuant to USERRA and a form for you to elect USERRA continuation coverage for yourself and your eligible dependents. Unlike COBRA, your dependents do not have a separate right to elect USERRA coverage. If you want USERRA continuation coverage for any member of your family, you must elect it for yourself and all eligible dependents who are covered under the Plan when your military service begins.

If you choose USERRA continuation coverage, you must return the USERRA election form to the plan administrator within 60 days of the date it was provided to you. If you do not timely return the election form, USERRA continuation coverage will not be available to you and your eligible dependents.

A special rule applies if you do not give Employer advance notice of your military service. In that case, you and your eligible dependents will not be provided with USERRA continuation coverage during any portion of your military service, but you can elect to reinstate your health coverage (and the coverage of your eligible dependents) retroactive to the first day you were absent from work for military service under the following circumstances:

- You are excused from providing advance notice of your military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for you to provide advance notice or the advance notice was precluded by military necessity);

- You affirmatively elect to reinstate the coverage; and

- You pay all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

For the first 30 days of military service, your required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If your period of military service is more than 30 days, beginning on the 31st day of your military service your required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if you do not timely pay any required premiums for that coverage. If your USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated.

The initial premium must be paid within 45 days after the date you elect USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after you initially elect USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of your USERRA continuation coverage.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

CONVERSION PRIVILEGES

When you or one of your dependents are no longer eligible under the Plan (either as an active participant, the eligible dependent of an active participant or as a qualified beneficiary receiving continuation coverage) you and/or your dependents may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility are set forth in the policy with each insurance carrier. This conversion is not available for self-insured benefits.

DENTAL BENEFITS

This section describes the types of eligible dental services under the self-funded dental benefit plan.

Types of Eligible Dental Services

- **Preventive Maintenance 100% Coverage**
    - Routine exams, cleaning (once per six months)
    - Fluoride treatment for dependent children under age 19 (once per 12 months)
    - X-ray (full mouth or panorex – once per 36 months; bitewing – one set per 12 months)
    - Desensitizing medicament

- Sealants
- Periodontics (gum disease treatments)

- **Services Covered at 75%**
  - Simple fillings (amalgam or resin)
  - Simple extractions

- **Services Covered at 75% subject to a $600 Annual Maximum per Participant**
  - Major restorative services (crowns and inlays)
  - Endodontics (root canals)
  - Prosthetics (bridges and dentures)
  - Space maintainers
  - Repairs to crowns and dentures
  - Oral surgery (other than simple extractions)
  - TMJ guard – bite splint – for grinding of teeth

- **Services Covered at 50% subject to a $1,500 Annual Maximum and a $2,500 Lifetime Maximum per Participant**
  - Orthodontics
  - Note: Upon receipt of the complete orthodontics bill, Employer will pay 25% of the 50% annual maximum down and pay the balance in monthly installments for the rest of the year, up to the $1,500 annual maximum

Exclusions

The Plan will **not cover** the following services and supplies:

- **Dentist's Order**. Any service or supply not furnished by a dentist, except x-rays ordered by a dentist and services of a licensed dental hygienist working under a dentist's supervision.
- **Loss or Theft**. Replacement of a lost or stolen appliance or prosthetic device.

- **Already Covered**. Eligible Expenses already covered under another group welfare plan maintained by Employer.

- **Appliance Attachments**. Except as otherwise specifically provided, charges for precision or other elaborate attachments for any appliance.

- **Cosmetic**. Expenses incurred for cosmetic purposes.

- **Unnecessary**. Charges for myofunctional therapy, athletic mouth guards, oral hygiene, dietary or plaque control programs.

Other Rules Applying to the Dental Benefits

- **Enrollment**. An employee may enroll in the dental benefits on the one year anniversary date of employment. If they decline to do so at this time they may also enroll during the annual open enrollment period which is from Dec 1 to Dec 31.

- **Dependents**. The definition of dependent (the employee's spouse and dependent children) will be defined in the same manner as coverage under the medical/prescription drug benefit. A dependent's eligibility will end at the same time the employee's eligibility ends or sooner, if the dependent ceases to meet the eligibility requirements for dependent coverage.

- **Coordination of Benefits**. If a participant is covered under the dental benefits portion of this Plan and any other plan providing dental benefits, benefits will be coordinated. Where this Plan is the secondary plan, it will consider the balance of the claim not covered by the primary plan and will determine the Plan's applicable coinsurance to the outstanding balance in determining the eligible amount for payment. The following rules will determine which plan will be primary and which plan will be secondary where the participant has coverage under multiple dental benefit plans:

    - If the other plan does not contain a coordination of benefits provision or states that its coverage is primary, it will be the primary plan.

    - If the other plan contains a coordination of benefits provision, benefits will be payable as follows:

        - Benefits under the Plan which covers the claimant on a basis other than as a dependent will be determined before the benefits under the Plan which covers the claimant as a dependent.

        - If both plans cover the claimant as a dependent, the plan which covers the employee or non-dependent whose

birthday occurs earlier in the year will be the primary plan. This is known as the birthday rule.

- **Subrogation/Reimbursement**. If the participant's illness or injury is the fault of another person or organization, that person or organization should be responsible for any dental benefits payable by the Plan.

  Dental benefits may be withheld when it appears that a third party is responsible for the participant's illness or injury and his/her resulting dental expenses until the liability is legally determined. Any amounts he/she receives or is entitled to receive from the third party or its insurer will reduce and be an offset against any dental benefits he/she would otherwise be entitled to receive under the Plan.

  If the Plan pays dental benefits when it appears that another party (other than the participant) may be liable for the expenses, the Plan has two rights. The first is the right of reimbursement to recover 100% of the amount of dental benefits paid by the Plan to the participant or on his/her behalf, from the participant, from the other party, or from an insurer or plan. The second is the subrogation right to bring an action against the other party if the participant does not bring an action against the other party which caused the need for the dental benefits paid by the Plan within a reasonable time after the claim arises.

  The participant must do whatever is necessary and cooperate fully to secure the rights of the Plan described in this section. This includes assigning his/her rights against any other party to the Plan and the plan administrator and executing any other legal documents that may be required by the Plan and the plan administrator. The participant must give the plan administrator written notice of any claim against another party within 90 days after the claim arises. The participant may not compromise or settle any claim against another party without the prior written consent of the Plan and the plan administrator.

CLAIMS

The insurance certificate(s) or booklet(s) from the insurer(s) for a Sub-Plan that are coupled with this Summary Plan Description may contain a summary of the claims procedures. However, the claims procedures must provide you with claims and appeal rights at least as favorable as the following:

Initial Decision

A claimant will be notified of a benefit determination as follows:

Urgent Care Health Claims

An urgent care health claim is a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A claimant will be notified of a benefit determination regarding an urgent care health claim within 72 hours after the Plan's receipt of the claim unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the claimant will be notified within 24 hours after the Plan's receipt of the claim of the information necessary to complete the claim. The claimant will be granted 48 hours to provide the information. The claimant will then be notified of the benefit determination within 48 hours after the earlier of the Plan's receipt of the information or the end of the period granted the claimant to provide the information.

Pre-Service Health Claims

A pre-service health claim is a claim for a benefit which is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining medical care. A claimant will be notified of a benefit determination regarding a pre-service health claim within 15 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of the extension will describe the required information and the claimant will be granted 45 days from receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Post-Service Health Claims

A post-service health claim is a claim for a health benefit which is not a pre-service claim or an urgent care claim. If a post-service health claim is denied, in whole or in part, the claimant will be notified of the adverse determination within 30 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies

the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will be granted 45 days from the receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Concurrent Care Health Claims

If the Plan has approved an ongoing course of health treatment to be provided over a period of time or over a number of treatments, any reduction or termination by the Plan of that course of treatment (other than by Plan amendment or termination) will constitute an adverse benefit determination. Notice will be provided in accordance with the "Benefit Determination Notice" subsection below and will be given at least 30 days before the course of treatment is reduced or terminated in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. Any request to extend a course of treatment for urgent care will be decided as soon as possible and the claimant will be notified of the determination within 24 hours, provided the claim is made to the Plan at least 24 hours before the expiration of the prescribed course of treatment for urgent care.

Disability Claims

If a disability claim is denied, in whole or in part, the claimant will be notified of the adverse benefit determination within 45 days after receipt of the claim. This period may be extended for up to 30 days, provided the Plan both determines that such an extension is necessary due to matters beyond of the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be made. If, prior to the end of the first 30-day extension period, the Plan determines that, due to matters beyond the control of the Plan, a decision cannot be made within the first 30-day extension period, the time for making the determination may be extended for up to an additional 30 days provided the Plan notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which a decision is expected to be made. Any extension notice will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. The claimant will be granted 45 days within which to provide the required information. The Plan's period for making the benefit determination will be the 30-day period beginning on the date the claimant responds to the request for

additional information. If the claimant does not provide the additional information within 45 days from the date of the receipt of the extension notice, the Plan may issue a denial of the claim within 30 days after the end of the 45-day period.

Other Welfare Claims

If a claim for another welfare benefit (such as group term life or AD&D insurance) is denied, in whole or in part, the Plan must notify the claimant of the adverse benefit determination within 90 days after receipt of the claim, unless the Plan determines that special circumstances require an extension of the time for processing the claim. If the Plan determines that an extension of time for processing the claim is required, written notice of the extension will be furnished to the claimant before the end of the initial 90-day period. In no event will the extension exceed a period of 90 days from the end of the initial period. The extension will indicate the circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Benefit Determination Notice

The claimant will be provided with a written or electronic notification of any adverse benefit determination. The notice will set forth the reason or reasons for the adverse determination, refer to the Plan provisions on which the determination is based, and describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. The notice will also describe the Plan's review procedures and related time limits and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA (a federal law) following an adverse benefit determination on review.

If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a statement will be included that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will contain a statement that such an explanation will be provided free of charge to the claimant upon request.

Appeal of Denial

The claimant may request a review of an adverse benefit determination regarding a health or disability claim by submitting a written application to the Plan within 180 days following the denial of the claim. However, in the case of an adverse benefit determination regarding a welfare benefit claim such as group term life or AD&D insurance, the time deadline is 60 days rather than 180 days. The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the claimant will be provided, upon request and free of charge, reasonable access to and copies of all documents,

records and other information relevant to the claimant's claim for benefits. For this purpose, a document, record or other information will be considered relevant if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The appeal procedure will provide for a review that does not rely on the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor is a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involving the judgment. The health care professional engaged for purposes of reviewing the appeal will be an individual who is neither an individual who is consulted in connection with the initial adverse benefit determination nor a subordinate of such an individual. The Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination without regard to whether the advice was relied upon.

In the case of an appeal of an adverse benefit determination regarding an urgent care health claim, a request for an expedited appeal may be made orally or in writing and all necessary information including the Plan's determination on review may be transmitted between the Plan and the claimant by telephone, facsimile or any other available similarly-expeditious method.

Final Decision

The Plan will make a decision regarding a request for review as follows:

Urgent Care Health Claims

The claimant will be notified of the Plan's determination on review regarding an urgent care health claim within 72 hours after the Plan's receipt of the claimant's request for a review of an adverse benefit determination.

Pre-Service Health Claims

There will be one or two levels of appeal for pre-service health claims. In either case, the appeal process must be completed within 30 days and notification must be provided to the claimant.

Post-Service Health Claims

There will be one or two levels of appeal for post-service health claims. In either case, the appeal process must be completed within 60 days and notification must

be provided to the claimant. There will be one level of appeal regarding denied claims for dental benefits.

Disability Claims

The claimant will be notified of the Plan's determination on review regarding a disability claim within 45 days after the Plan's receipt of the claimant's request for a review of an adverse benefit determination unless the Plan determines that special circumstances require an extension of time for processing the appeal. If the Plan determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 45-day period. In no event will such an extension exceed a period of 45 days from the end of the initial period. The notice will indicate the special circumstance requiring an extension and the date by which a decision is expected to be made.

Other Welfare Claims

The claimant will be notified of the Plan's determination on review regarding a welfare benefit claim such as group term life or AD&D insurance within 60 days after the Plan's receipt of the claimant's request for a review of an adverse benefit determination unless the Plan determines its special circumstances require an extension of time for processing the appeal. If the Plan determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 60-day period. In no event will an extension exceed a period of 60 days from the end of the initial period. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected to be made.

Legal Actions

No legal action may be brought to recover benefits under the Plan until the participant has exhausted the claim review procedure. Further, with respect to the self-insured dental benefit under the Plan, no legal action may be brought after the expiration of one year after the participant has been provided with a written notice denying the final level of Plan appeal concerning a claim.

ADMINISTRATION

Employer is the plan administrator. The plan administrator is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan. With respect to the self-insured benefits, the plan administrator has the discretionary authority to decide all questions of eligibility for participation and coverage and the discretionary authority to construe and interpret the terms of the Plan. However, with respect to the fully insured benefits, the insurer has the ultimate discretion and authority to determine all questions of eligibility for

participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy.

AMENDMENT OR TERMINATION

Although Employer intends to maintain the Plan indefinitely, Employer has the authority to amend or terminate the Plan or any Sub-Plan at any time. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits. You will be informed of any material amendment affecting your coverages or changing the operation of the Plan.

YOUR RIGHTS AS A PLAN PARTICIPANT

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

Information About the Plan and its Benefits

ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the plan administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefit Administration).

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, any updated Summary Plan Description and, if 100 or more participants, a copy of the latest annual report (Form 5500 Series). The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report if there are 100 or more participants in the Plan and the Plan is not funded solely through Employer's general assets. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review the rules governing your COBRA continuation coverage rights described elsewhere in this Summary Plan Description.

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

Plan Fiduciaries

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

Enforcement of Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 the participant's claim is frivolous.

Assistance with Questions

If you have any questions about the Plan, you should contact the plan administrator. If you have any questions about this statement ("YOUR RIGHTS AS A PLAN

PARTICIPANT") or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or viewing its website at www.dol.gov/ebsa.

PATIENT PROTECTIONS PLAN NOTICE

Aggressive Tooling, Inc. generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the health insurance carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Aggressive Tooling, Inc. at (616) 754-1404.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Aggressive Tooling, Inc. at (616) 754-1404.

OTHER BASIC INFORMATION ABOUT THE PLAN

Name of Plan:	Aggressive Tooling, Inc. Group Insurance Plan
Sub-Plans:	Aggressive Tooling, Inc. Medical/Prescription Drug Insurance Plan Aggressive Tooling, Inc. Group Term Life Insurance Plan Aggressive Tooling, Inc. Short-Term Disability Benefit Plan Aggressive Tooling, Inc. Long-Term Disability Benefit Plan Aggressive Tooling, Inc. Dental Plan Aggressive Tooling, Inc. Vision Plan
Name, Address, Telephone Number and Taxpayer Identification Number of Employer/Plan Sponsor:	Aggressive Tooling, Inc. 608 Industrial Park Drive Greenville, MI 48838 (616) 754-1404 38-2876187
Plan Number:	501
Type of Plan:	Employee benefit plan providing group health and welfare benefits.
Type of Administration:	The Plan is administered by the plan administrator.
Plan Administrator:	Employer/Plan Sponsor
Agent for Service of Legal Process:	President Aggressive Tooling, Inc. 608 Industrial Park Drive Greenville, MI 48838 Service of legal process may also be made on the plan administrator.

Insurers:	See the applicable insurance booklet or certificate for the address and telephone number of each of the Insurers.
Plan Fiscal Year End:	November 30 for the following plans: Aggressive Tooling, Inc. Group Term Life Insurance Plan Aggressive Tooling, Inc. Short-Term Disability Benefit Plan Aggressive Tooling, Inc. Long-Term Disability Benefit Plan Aggressive Tooling, Inc. Medical/Prescription Drug Insurance Plan Aggressive Tooling, Inc. Vision Plan December 31st for the following plan: Aggressive Tooling, Inc. Dental Plan