ERISA SUPPLEMENTAL SUMMARY PLAN DESCRIPTION (SPD) WRAP DOCUMENT

This document, together with the documents incorporated by reference herein shall constitute your Plan Document and Summary Plan Description (SPD) for the Cyclone Drilling Inc. Employee Benefit Plan (the "Plan"), as required by the Employee Retirement Security Act of 1974 ("ERISA"). For ease of reference this document shall refer to itself throughout as "SPD" but has been drafted to operate as both documents. It is intended that this document satisfy the requirements of Section 402 of ERISA. This SPD should be read in connection with the incorporated documents listed, which include all related plan documents, insurance policies, health maintenance organization contracts, communications documents, and other documents. To the extent any terms or provisions of this SPD differ from any of the documents listed, such other document, policy or contract shall control, unless an applicable law or regulations requires otherwise. The Plan will provide benefits in accordance with applicable federal laws.

All benefit plans are summarized in this SPD and in the documents listed herein. This SPD supersedes and replaces all prior plan documents and summary plan descriptions for such Plan benefits.

For additional information regarding the benefits provided under the "Plan," please contact the Plan Administrator identified below.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Notice" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of Labor Reg. § 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to a Claimant or his Authorized Representative. The term is synonymous with "Notification."

PLAN NAME: Cyclone Drilling Inc. Employee Benefit Plan

PLAN NUMBER: 501
Medical
Prescription Drugs
Dental
Vision
Life / AD&D

TAX ID NUMBER: 83-0222580

EMPLOYER INFORMATION
Cyclone Drilling Inc.
PO Box 908
Gillette, WY 82717
(307) 682-4161

PLAN ADMINISTRATOR / PLAN SPONSOR
Cyclone Drilling Inc.
PO Box 908
Gillette, WY 82717
(307) 682-4161

AGENT FOR SERVICE OF LEGAL PROCESS
Cyclone Drilling Inc.
PO Box 908
Gillette, WY 82717

NAMED FIDUCIARY
Cyclone Drilling Inc.
PO Box 908
Gillette, WY 82717

AFFILIATED GROUPS – ADDITIONAL PARTICIPATING EMPLOYERS
Cyclone Trucking 83-0312349
Squaw Valley Apartments 83-0287981
PP&J (disregarded entity wholly owned by Cyclone Drilling) 20-0141994

Plan benefits, including information about eligibility, are summarized in the Summary Plan Descriptions (SPDs) and Certificates of Coverage, Member Payment Summary, and Provider & Facility Directories, copies of which are available from your Human Resources Department, free of charge. These documents together with this document constitute the Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act ("ERISA"). Capitalized terms not otherwise defined in this document are defined in the SPDs and Certificates of Coverage.

The Plan provides benefits in accordance with the applicable requirements of federal laws, such as Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability Accountability Act (HIPAA), Newborns' and Mothers' Health Protection Act (NMHPA), Patient Protection and Affordable Care Act (PPACA), and the Women's Health and Cancer Rights Act (WHCRA).

The Plans are not to be construed as a contract for or of employment.

"Plan Year" means the twelve (12) month accounting period of the Plan, effective October 1, 2001, which begins on October 1 and ends on September 30.

TYPE OF ADMINISTRATION

The Medical/Rx Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured. All benefits paid under this Plan shall be paid in cash from the general assets of the Company. No employee shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that the Company may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Company and an Employee or any other person. Neither an employee nor a beneficiary of an Employee shall acquire any interest greater than that of an unsecured creditor. Benefits are paid directly from the Plan through the Claims Administrator.

The other Welfare Benefit Plans are fully-insured and the administration is provided through the Insurance Providers. The funding for the benefits is derived from contributions made by covered Employees. No employee shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that the Company may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Company and an Employee or any other person. Neither an employee nor a beneficiary of an Employee shall acquire any interest greater than that of an unsecured creditor. Benefits are paid directly through the Insurance Providers.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plans as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Waiver and estoppel. No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Participant or Eligible Beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.
Effect on other benefit plans. Amounts credited or paid under this Plan shall not be considered to be compensation for the purposes of a qualified pension plan maintained by the Company. The treatment of the amounts paid under this Plan under other employee benefit plans shall be determined under the provisions of the applicable employee benefit plan.
Nonvested benefits. Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any Participant or Eligible Dependent except with respect to claims that have actually been incurred by any such person that would otherwise be eligible for payment under the Plan, as it is in effect when the expense is incurred.
Interests not transferable. The interests of the Participants and their Eligible Dependents under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, assigned, alienated, or encumbered without the written consent of the Plan Administrator.
Severability. If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Company shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

Can the Plans be amended or terminated?
The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend or discontinue the Plan at any time and for any reason, without prior notice.

Changes in the Plans may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility, and the like. Proper notice of any material changes will be given as required under HIPAA and the ACA.

If the Plans are terminated, the rights of the Plan Participants are limited to expenses incurred before termination. Such termination shall be evidenced by a written resolution of a majority of the Board of Directors of the Company, a certified copy of which shall be filed with the Plan Administrator, the Trustees, and any outside provider of plan administration services.

Termination by dissolution, insolvency, bankruptcy, merger, etc. These Plans shall automatically terminate if the Company (1) is legally dissolved; (2) makes any general assignment for the benefit of its creditors; (3) files for liquidation under the Bankruptcy Code; (4) merges or consolidates with any other entity and it is not the surviving entity; (5) sells or transfers substantially all of its assets; or (6) goes out of business, unless the Company's successor in interest agrees to assume the liabilities under the Plans as to the Participants and Eligible Dependents.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator means the person appointed by the Company who has the authority and responsibility to manage and direct the operation and administration of the Plan. The Plan Administrator is also called the Plan Sponsor. The Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Cyclone Drilling Inc. to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies, or is otherwise removed from the position, Cyclone Drilling Inc. shall appoint a new Plan Administrator as soon as reasonably possible.
The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for

benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.
Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate.

Compensation of Plan Administrator.
Unless otherwise agreed to by the Board of Directors, the Plan Administrator shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by the Employer. Unless required by ERISA, by the Board of Directors, or by any other federal or state law, neither the Plan Administrator nor any of the Plan Administrator's delegates shall be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

Delegation by the Plan Administrator.
The Plan Administrator, subject to approval of the Board of Directors, may employ the services of such persons (including an insurance company) as it may deem necessary or desirable in connection with the administration of claims or other operations of the Plan. The Plan Administrator may also appoint a Benefit Committee consisting of not less than three (3) persons, each of whom shall either be an Employee or Director of the Company to assist the Plan Administrator either generally or specifically in reviewing claims for benefits, subject to the right of the Board of Directors to replace any or all of the members of the Committee, or to eliminate the Committee entirely.
The Plan Administrator also shall have the power and duty to retain the services of one or more Health Care Professionals, for the purpose of reviewing Benefit Claims that are under appeal for reasons based on medical judgment, such as medical necessity or experimental treatments.
The Plan Administrator, the Company (and any person to whom any duty or power in connection with the operation of the Plan is delegated), may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including Employees who are actuaries or accountants), consultant, third-party administration service provider, legal counsel, or other specialist, and the Plan Administrator, Company, or such delegate shall be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.

Indemnification and exculpation.
The Plan Administrator and the members of any Committee appointed by the Plan Administrator to assist in administering the Plan, its agents, and officers, directors, and employees of the Company

shall be indemnified and held harmless by the Company against and from any and all loss, cost, liability, or expense that may be imposed upon or reasonably incurred by them in connection with or resulting from any claim, action, suit, or proceeding to which they may be a party or in which they may be involved by reason of any action taken or failure to act under this Plan and against and from any and all amounts paid by them in settlement (with the Company's written approval) or paid by them in satisfaction of a judgment in any such action, suit, or proceeding. Indemnification under this section shall not be applicable to any person if the loss, cost, liability, or expense is due to the person's gross negligence or willful misconduct.

Fiduciary. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary, or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

CLAIMS PROCEDURES

Claims procedures are fully described in the Summary Plan Description and Certificates of Coverage. These include procedures for obtaining pre-authorizations, approvals, utilization review decisions, procedures for filing claims, notification of benefit determinations, grievance procedures for the review and appeal of denied claims.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS.

Certain members of the Employer's workforce perform services in connection with the administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) General. The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) Permitted Uses and Disclosures. Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training, or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management, and general administrative activities.

(3) Authorized Employees. The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) Updates Required. The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) Use and Disclosure Restricted. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) Resolution of Issues of Noncompliance. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f) (2) (iii) of the Privacy Standards.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS.

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the Employer creates, maintains, or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

"Electronic Notice" means a Notice or Notification given by the Plan to a Claimant or his Authorized Representative by electronic mail ("e-mail") or through an interactive Intranet site on the World Wide Web (the "Internet"), provided that:

(a) the Plan Administrator shall assure that the electronic-based system for furnishing documents results in actual receipt by Claimants or their Authorized Representatives of transmitted information and documents by the return-receipt feature (in the case of e-mail), or conduct periodic reviews or surveys to confirm receipt of transmitted information;

(b) each participant is provided notice, through electronic means or in writing, apprising the participant of the document(s) to be furnished electronically, the significance of the document (e.g., the document describes changes in the benefits provided by your plan) and the participant's right to request and receive, free of charge, a paper copy of each such document; and

(c) each Claimant or his Authorized Representative participant is provided upon request a paper copy of the document delivered to the to the Claimant or Authorized Representative participant through electronic media.

This Plan will comply with all applicable requirements of final Regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act, and any provisions of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with such guidance. The Plan Administrator will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

ELIGIBILITY

Who can participate in the plan?
Employees who actually participate in the Plan are called participants. You continue to participate in the Plan until you are no longer employed by the Company, or your Continuation Coverage (as described in the "Continuation Coverage" section) is no longer in effect. You are eligible to participate in the Plan if you meet all the requirements as described by the Employer.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

To determine whether you and your spouse and/or dependents are eligible to participate in the Plan, please read the eligibility information contained in the attached Summary Plan Description and Certificate of Insurance booklets.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

Participants shall make such contributions as required by schedules provided by the Employer for coverage of the Participant and of Eligible Dependents. However, no Employee shall be required to contribute to the Plan as a condition of employment with the Employer.

Special Eligibility Rules
Full-Time Employee Determinations

Due to federal health reform ("PPACA"), specific eligibility rules may apply to the medical coverage available under the Plan.

For the Plan Years in which the employer mandate under PPACA is in effect with respect to the Employer, the Employer intends to determine eligibility and offer medical and dental coverage based on the guidelines in effect for the relevant plan year. All provisions herein shall be interpreted such that the Employer shall be in compliance with then-existing rules and guidelines.

To participate in medical coverage under the Plan, an employee must be characterized by the Employer as a common law employee who is either:

- Reasonably expected to work Full-Time, or,
- Determined under such procedures as are established by the Employer to have been working Full-Time.

Subject to applicable law changes. "Full-Time" is defined as thirty (30) or more hours of service a week on average in a month. On a reasonable and consistent basis, an Employer may treat one hundred thirty (130) hours of service in a calendar month as the monthly equivalent of thirty (30) hours of service per week.

An Employer may determine each employee's Full-Time status for a calendar month by counting the employee's hours of service for that month. Alternatively, the Employer can opt to count the employee's hours of service for a specific period (the "Measurement Period") to determine whether the employee is Full-Time and must be offered medical coverage for a subsequent period (the "Stability Period").

Subject to any permissible transition rule, the Measurement Period shall be between three (3) and twelve (12) months long followed by a Stability Period of at least six (6) consecutive months but no shorter than the Measurement Period. To the extent permitted under federal law, the Employer may select different periods for various groups of employees. The Measurement Period and Stability Period may be separated by an Administrative Period of up to ninety (90) days.

The Employer shall track the hours of service for each part-time employee, variable hour employee and seasonal employee. An hour of service refers to each hour for which the employee is paid, or entitled to payment, from the Employer for the performance of duties and non-worked hours for which payment is made or due for vacation, holiday, illness, incapacity, layoff, jury duty, military duty, or leave of absence (other than compensation that constitutes income from sources outside of the United States). In the case of employees who are not paid on an hourly basis, the Employer may calculate hours of service using a days-worked equivalency (eight hours of service for each day for which the employee is entitled to pay for worked or non-worked time) or a weeks-worked equivalency (40 hours of service per week for each week for which the employee is entitled to pay for worked or non-worked time), unless the use of the equivalency would substantially understate the employee's hours of service.

If an employee's total number of hours of service for a Measurement Period, divided by the number of months in the Measurement Period, equals at least 130, then the employee was full-time during the Measurement Period and must be considered Full-Time during the Stability Period that follows.

Permitted Election Changes

Under the Affordable Care Act Safe Harbors, an employee can drop coverage due to a reduction in hours during a stability period that leads to an inability to pay the monthly employee premium contribution. As an employer, if an employee's payment is late, Cyclone Drilling Inc. must provide the employee with a 30-day grace period in order to make the payment. If the employee does not make the payment within the grace period, Cyclone Drilling Inc. is not required to provide coverage for the period for which the premium is not timely paid and may terminate coverage.

The employee's revocation of the election of coverage under the group health plan must correspond to the intended enrollment of the employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

A cafeteria plan may rely on the reasonable representation of an employee who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the employee and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan

The employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through the Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual enrollment period; and

The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee and any related individuals who cease coverage due to the revocation in a Qualifying Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

A cafeteria plan may rely on the reasonable representation on an employee who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the employee and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Special Enrollment

(a) If an Employee does not enroll for coverage for the Employee and/or the Employee's Dependents within thirty (30) days after becoming eligible for coverage and subsequently wishes to elect such coverage, in appropriate circumstances the Employee may do so under the Plan's Special Enrollment rules. For medical, dental and vision benefits, no evidence of insurability will be required in these circumstances.

(b) An Employee may enroll for coverage for the Employee and all Eligible Dependents at any time provided that (1) the Employee is eligible for coverage under the Plan but is not currently enrolled; (2) the Employee declined coverage under the Plan when it was offered previously and gave the existence of alternative health coverage as the reason for "Waiver of Group Health Coverage" on the Employee's original card; and (3) the alternative coverage has terminated, because either (i) it was COBRA continuation coverage that has been exhausted, or (ii) eligibility for the alternative coverage was lost (for reasons other than the individual's failure to pay premiums or for cause) or employer contributions toward the cost of the coverage terminated. In

this case, the Employee must submit a completed enrollment form within 30 days after the date on which (1) COBRA continuation coverage was exhausted, or (2) the coverage terminated because of loss of eligibility for coverage or the termination of employer contributions toward the cost of the coverage. The effective date under the Plan will be the 1st of the month following receipt of a substantially complete application

(c) In addition, an Employee may enroll for coverage for the Employee and all Eligible Dependents at any time provided that (1) the Employee is eligible for coverage under the Plan but is not currently enrolled; (2) the Employee declined coverage under the Plan when it was offered previously; and (3) another individual (a Spouse or child) has become a Dependent of the Employee through marriage, birth, adoption, or placement for adoption. In this case, the Employee must submit a completed enrollment form within 30 days of the marriage, birth, adoption, or placement for adoption. Enrollment in the Plan will be effective the date of the qualifying event as long as the enrollment form is submitted in a timely fashion as described above.

In the case of marriage, eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins.

(d) At the time each Employee is offered the initial opportunity to enroll in this Plan, he also will be given notice of these Special Enrollment rights.

How much do I have to pay toward the insurance premium?
Specific information about the amount you must pay toward your health insurance premium will be provided to you before you enroll in the Plan, whether you enroll during your initial enrollment period, during annual enrollment, or under the special enrollment rules.

Tax Issues and Family Coverage
The Employer is required to tax benefits under the Plan in accordance with federal law. The value of any health coverage provided under the Plan for an employee's family member who is not a "tax code dependent" (i.e., a dependent as defined in Internal Revenue Code § 152, as modified by Code Section 105(b), IRS Notice 2004-79, and current IRS interpretations) shall be included in gross income (subject to federal income tax withholding and employment taxes) and reported on the employee's Form W-2, unless such coverage is paid by the employee on an after-tax basis. Under certain state tax laws, a child over a certain age does not qualify as the employee's tax dependent. The value of such a child's health coverage will also be included in the employee's income for state tax purposes. This includes any portion of the premium that the employer pays toward that health coverage. The employee's share of the contribution that covers such a child will be paid using after-tax payroll deductions. An employee should consult his or her own tax advisor as to the impact of providing coverage and benefits under the various Plan options, and the application of Internal Revenue Code Section 152.

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

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Cyclone Drilling Inc., PO Box 908, (307) 682-4161. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Any Employee (and Eligible Dependents of the Employee) whose coverage under the Plan ended due to a period of the Employee's absence for duty in the Uniformed Services for more than 31 days shall again become covered by the Plan without imposition of the waiting period as soon as the Employee returns to full-time employment, provided that Employee returns to, or reapplies for, reemployment within 90 days of completion of such period of duty.

Qualified medical child support orders.

A Qualified Medical Child Support Order (QMCSO) is an order by a court for one parent to provide a child or children with health insurance. If the plan administrator receives a QMCSO for your child or children, the plan administrator will contact you concerning the plan procedures for such an order.

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (“QMCSO”) or a National Medical Support Notice (“NMSN”) if such an individual is not already covered by the Plan as an Eligible Dependent once the Administrator has determined that such order meets the standards for qualification set out below.

The following definitions shall apply for these purposes:

(i) “Alternate Recipient” means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

(ii) “Medical Child Support Order” means any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that (1) provides for child support with respect to a Participant's child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law), or (2) enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

(iii) “Qualified Medical Child Support Order” is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such an order to be a QMCSO, it must clearly specify (1) the name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order; (2) a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; (3) the period of coverage to which the order pertains; and (4) the name of this Plan. However, such an order need not be recognized as “qualified” if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants and Eligible Beneficiaries without regard to this Section 3.09, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

(iv) “National Medical Support Notice” is a notice issued by an appropriate agency of a state or local government similar in form, content, and legal effect to a Qualified Medical Child Support Order that directs the Plan Administrator to effectuate coverage for an Alternate Recipient as the dependent child of the noncustodial parent who is (or will become) a Participant in this Plan pursuant to a domestic relations order that includes a provision for health care coverage.

(v) Upon receiving a Medical Child Support Order or National Medical Support Notice, the Plan Administrator shall—as soon as administratively possible— (1) notify the Participant and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan's procedures for determining whether the order qualifies as a QMCSO, and (2) make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination. To give effect to this requirement, the Plan Administrator shall (1) establish reasonable, written procedures for determining the qualified status of a Medical Child Support order; and (2) permit any Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to the order.

(vi) Within twenty (20) business days after the date of the NMSN, the Company shall provide the Plan Administrator with the notice. Within forty (40) business days of the date of the notice, the Plan Administrator shall: (I) notify the state or local agency issuing the NMSN whether coverage is available to the child who is the subject of the notice and, if so, whether the child is covered under the plan, and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by an official of the issuing agency) to effectuate coverage, and (II) provide to the custodial parent (or official of the governmental agency involved in the notice) a description of the coverage available and any forms or documents necessary to effectuate the coverage.

What if I take leave under the Family and Medical Leave Act?
If you use your leave under the Family and Medical Leave Act (FMLA), you may choose to continue coverage during your leave of absence, or you may choose to suspend coverage during your leave. If you continue coverage during your leave, then you are required to pay the employee's portion of the health insurance coverage. If you voluntarily terminate your employment for reasons outside your control, you may be required to reimburse the Company for the employer portion of the health insurance premium. If you decide to take an FMLA absence, contact the Plan Administrator for further information and election forms.

If the Participant chooses not to participate while on an FMLA leave, but subsequently returns to active working status on or before the expiration of the leave, the Participant and all Eligible Dependents shall immediately become covered under the Plan without being required to give evidence of insurability, and the provisions for excluding benefits for preexisting conditions shall not apply to any medical condition of the Participant or Dependents that has arisen during the FMLA leave.

Contributions during FMLA leave.

(1) While a Participant is on an FMLA leave, the Company shall continue to make the same contributions to this Plan on behalf of the Participant and his covered Dependents that it would have made had the Participant not taken such leave of absence. The Company shall continue to do so until the earlier of the date that (i) the Participant fails to return to work on expiration of the FMLA leave, or (ii) the Participant voluntarily gives notice of his intent to terminate his employment. For these purposes, a Participant is considered to "terminate his employment" when the participant gives oral or written notice of his intent not to return to work due to reasons within the Participant's control either to his immediate supervisor or to the Human Resources Department, and other forms of notice (such as word-of-mouth) shall not be effective.

(2) If the Participant voluntarily terminates his employment due to reasons within his control at or before the end of the FMLA leave, the Company shall have the right to be reimbursed by the Participant for any and all contributions the Company has made on behalf of the Participant and the Participant's covered Dependents during the leave. In this regard, the Company shall have the right to obtain reimbursement from any funds that the Company might otherwise owe the Participant following the Participant's voluntary termination, including (but not limited to) (i) any regular or overtime wages, commissions, salary, or bonuses; (ii) accrued vacation pay or sick leave pay; or (iii) benefits payable under this Plan or any other employee benefit plan under which the Participant is otherwise entitled to payment. In addition, the Company shall have the right to pursue reimbursement in a court of law. However, in pursuing reimbursement, the Company shall not resort to any method that violates any state or federal wage payment or other law.

(3) Regardless of whether or not the Participant returns from an FMLA leave, the Company shall be entitled to recover from the Participant any required employee contributions the Company has made on behalf of the Participant and his Eligible Dependents during an unpaid FMLA leave to ensure continuity of coverage.

(4) The Company may not recover any of its regular Company contributions made on behalf of the Participant for the time the participant has been on an FMLA leave if the Participant's failure to return to employment at the expiration or exhaustion of such leave is due to (i) the continuation, recurrence, or onset of a serious health condition that would entitle the Participant to an FMLA leave; or (ii) other circumstances beyond the Participant's control. Situations "beyond the Participant's control" include (but are not limited to) unexpected transfer of the Participant's spouse to a job location that is more than 75 miles from the Participant's work site; a relative or individual other than an immediate family member has a serious health condition and the Participant is needed to provide care; the Employee is laid off while on leave; or the Participant is a "key employee" who decides not to return to work after being notified of the Company's intention to deny restoration of such Participant to his former position (or the equivalent) because of substantial economic injury to the Company. For this purpose, a "Key Employee" is a salaried FMLA-eligible Participant who is among the highest paid 10% of all the Employees—both salaried and nonsalaried, regardless of eligibility for participation in this Plan—employed by the Company within 75 miles of the Participant's work site. However, a situation is not considered to be "beyond the Participant's control" if the Participant fails to return to work following an FMLA leave because the Participant desires to remain with a parent in a distant city even though the parent no longer requires the Participant's care, or the Participant-parent decides to remain at home with a newborn or newly-adopted child, or other newly-acquired dependent.

As soon as administratively feasible after a Participant qualifies for an FMLA leave, the Plan Administrator shall give the Participant the opportunity to choose in writing between continued coverage during the leave of absence, or of suspending coverage for the leave's duration. If the Participant chooses ongoing coverage, the Participant must continue to make the same premium payments or contributions that he was making immediately before the leave took effect. The written election form given to the Participant must reflect that if the Participant elects to continue active

participation, he will be able to make these payments in any combination of the following methods at his option:

(i) Advance withholding from the Participant's last paycheck before any unpaid FMLA leave takes effect.

(ii) Withholding from any salary continuation check for a paid leave of absence that is considered as part of the Participant's FMLA leave.

(iii) Monthly payment by the Participant to the Company from the Participant's own funds either at the same time as it would be made if by payroll deduction or on the same schedule as payments are made for COBRA continuation coverage, as provided in Article V.

(iv) Payment through any cafeteria plan under Code Sec. 125 if such plan makes provision for medical benefits.

(v) By any other method mutually agreeable to the Participant and the Company, including (where the leave is foreseeable) increased withholding from one or more of the Participant's regular paychecks preceding the leave to pay in advance the required premiums during the leave.

The Company's obligation to provide ongoing coverage under this Plan for a Participant on an FMLA ceases if the Participant is more than thirty (30) days late on making a required premium payment, provided, however, that the Company may—at its option—cover a Participant's missed payments so that coverage will be uninterrupted. In this event, the Company's advances may be recovered under the terms of Section 10.03(a) (2) in the event the Participant voluntarily terminates his or her employment under circumstances within the Participant's control.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women s Health and Cancer Rights Act of 1998, benefits under this Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema). If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following Covered Charges, as you determine appropriate with your attending Physician: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and treatment of physical complications of the mastectomy, including lymph edema. The amount you must pay for such Covered Charge (including Copayments and any Deductible) are the same as are required for any other Covered Charge. Limitations on benefits are the same as for any other Covered Charge.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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 mothers or newborns 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).

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Among other safeguards, GINA prohibits an employer from discriminating against employees on the basis of genetic information and limits a Plan's ability to acquire or monitor genetic information

except as expressly provided in the Act. As with other compliance duties, the Plan and Employer will satisfy all applicable laws and regulations related to GINA requirements.

DISCRIMINATION AGAINST OLDER PARTICIPANTS IS PROHIBITED.

This Plan shall provide benefits for any Participant age 65 or older or for any Eligible Dependent age 65 or older under the same terms and conditions that apply to a Participant who is under age 65 or Eligible Dependent who is under 65.

Plan charges covered by Medicaid.
This Plan shall not reduce or deny benefits for any Participant or Eligible Dependent to reflect the fact that such an individual is eligible to receive medical assistance under a state Medicaid plan.

Medicare and Medicaid reimbursements.
The Plan shall reimburse the U.S. Health Care Financing Administration ("HCFA") for the cost of any items and services provided by Medicare for any Participant or Eligible Dependent that should have been borne by this Plan. Similarly, the Plan shall reimburse any state Medicaid program for the cost of items and services provided under the state plan that should have been paid for by this Plan.

How do Medicare and the Plan settle claims?
The Plan is the primary payor and Medicare is the secondary payor, for those services that would otherwise have been provided by Medicare in the case of:

- you or your spouse who is covered under this Plan by reason of your current employment and who is entitled to Medicare benefits
- a disabled individual covered under the Plan, who is entitled to Medicare, but is still participating in this Plan
- you or your dependent who is entitled to Medicare benefits solely on the basis of having end-stage renal disease. The Plan will follow procedures as set out under CMS for coordination of benefits.

SPECIAL ENROLLMENT OPPORTUNITIES - CHIP

A Special Enrollment Period will apply to you or your Dependent if:

Your Medicaid or Children's Health Insurance Program (CHIP) terminates as a result of loss of eligibility and your request for enrollment is made within 60 days after the date of termination; or
You become eligible for premium assistance subsidy under Medicaid or CHIP and your request enrollment is made within 60 days after the date you become eligible for the premium assistance.

PLAN PARTICIPANTS RIGHTS UNDER ERISA

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

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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.

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

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

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

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

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Applicable Law. (Only if fully insured)
The Plans shall be governed and construed in accordance with Title I of ERISA and the laws of the State of Wyoming to the extent not preempted by ERISA.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If a clerical error or other mistake occurs, that error will not deprive you of benefits under the policy nor will it create a right to benefits.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement 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 your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.