

H & S Swanson's Tool Company Benefit Plan

Amended & Restated: July 1, 2005

This document, together with the applicable certificate of insurance booklets issued by the Company constitutes the Summary Plan Description required by ERISA §102.

Additionally, this document together with the applicable group insurance contracts and benefits booklets, constitute the written plan document for the H & S Swanson's Tool Company Benefit Plan required by ERISA §402.

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1. Introduction

H & S Swanson’s Tool Company (“Company”) maintains the H & S Swanson’s Tool Company Benefit Plan (the “Plan”) for the exclusive benefit of eligible Employees and their eligible dependents. Currently, these benefits are provided under various insurance contracts entered into by the Company for the Plan. The Plan benefits are summarized in the certificate of insurance booklets issued by the applicable insurance companies. This document, together with the certificate of insurance and benefits booklets constitutes the Summary Plan Description required by ERISA §102. Participants should read this entire Plan document, including all exhibits and/or attachments to ensure that all requirements and conditions of the Plan are fully understood.

2. General Information About the Plan

Plan Name: H & S Swanson’s Tool Company Benefit Plan

Type of Plan: Welfare benefits plan

Plan Year: January 1st – December 31st

Fiscal Year: July 1st – June 30th

Plan Number: 502

Funding Medium and Type of Administration: This Plan provides fully insured benefits to Eligible Employees and their Dependents. Benefits are provided under a group insurance contracts entered into between the Company and the insurance companies identified in this document. Claims for benefits are to be sent to the appropriate insurance company. That insurance company is responsible for paying claims, not the Company. Note that the insurance companies and the Company share responsibility for administering the plan.

Plan Sponsor & Plan Administrator: H & S Swanson’s Tool Company
9000 68th Street N.
Pinellas Park, FL 33782
Telephone: 727-388-0704

Plan Sponsor’s Employer Identification Number: 36-2248023

Medical Insurance Company: Humana
101 E. Main Street
Louisville, KY 40201
Telephone: 800-872-7207

Dental Insurance Company: CompBenefits
100 Mansell Court East, Suite 400
Rosewell, GA 30076
Telephone: 800-342-5209

LTD, STD & Life Insurance Company: UNUM
2211 Congress St.
Portland, ME 04122
Telephone: 800-421-0344

Named Fiduciary: H & S Swanson's Tool Company
9000 68th Street N.
Pinellas Park, FL 33782
Telephone: 727-388-0704
Attn: George Lawston

Agent for Service of Legal Process: Fisher & Sauls
100 2nd Ave., Suite 701
City Center Building
St. Petersburg, FL 33701
Telephone: 727-822-2033

Service for legal process may also be made upon the Plan Administrator.

The written plan document required by ERISA §402 consists of this document, together with group insurance contract(s) entered into between the Company and the insurance companies.

Important Disclaimer: The fully insured benefits hereunder are provided pursuant to Insurance Contracts between the Plan Sponsor and the applicable insurance companies. If the terms of this document conflict with terms of the applicable Insurance Contract, the terms of the Insurance Contract will control, unless superseded by applicable law.

3. Eligibility and Participation Requirements

To determine whether you and your dependents are eligible to participate in the various benefit options offered by the Plan, please read the eligibility information contained in the attached certificates of insurance and benefits booklets. Eligible Employees must complete an application form to enroll and pay the required premium, if applicable.

4. HIPAA Rights for Health Care Benefits

Under HIPAA (the Health Insurance Portability and Accountability Act of 1996), if you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

The Plan shall issue a Certificate of Creditable Coverage, automatically and without charge, under the following circumstances:

- (a) For an individual who is a Qualified Beneficiary entitled to elect COBRA coverage, the Certificate of Creditable Coverage shall be issued with the COBRA notice sent after the Qualifying Event.
- (b) For an individual who loses coverage under the Plan, but is not entitled to COBRA coverage, the Certificate of Creditable Coverage shall be issued as soon as reasonably possible after coverage ceases.
- (c) For an individual who is a Qualified Beneficiary and has elected COBRA coverage, the Certificate of Creditable Coverage shall be issued within a reasonable time after the cessation of COBRA coverage or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.

The Plan shall also issue a Certificate of Creditable Coverage at any time within twenty-four (24) months after coverage ceases, provided that the Plan receives a written request for the Certificate of Creditable Coverage by the former Plan Participant (or by another person authorized by the former Plan Participant).

The Certificate of Creditable Coverage shall be in the form required by HIPAA. Also upon written request, the Plan shall provide a copy of the Plan Document and other information as outlined in the model form established by HIPAA to provide additional information on categories of benefits for plans that use the Alternative Method of counting Creditable Coverage. The Plan shall charge the requesting entity or individual a fee to cover the reasonable cost of providing this information.

5. COBRA

Federal Legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA) requires that an Employee and/or Dependent may elect to continue coverage up to the length of time specified below after the occurrence of any of the following events which would normally result in termination of coverage under the Plan, provided they pay the full cost of Plan coverage, not to exceed 102% of the total cost (employer and employee) or 150% of the total cost during the 11-month extension for disability. Each Qualified Beneficiary, including the Employee, Spouse or any Dependent covered under the regular Plan, may make an independent election for Continuation Coverage.

Coverage may be continued up to 18 months for an Employee and/or Dependent in the qualifying event of the termination of employment (other than by reason of gross misconduct) or the reduction of hours of an Employee. Continuation coverage may be extended from 18 months to 36 months for Dependent(s) who are qualified beneficiaries if during the 18-month period a second qualifying event occurs, such as the Employee dies, enrolls in Medicare, or divorces or legally separates from his Spouse. This extension may also apply upon the loss of Dependent status by a Dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

Continuation coverage may extend from 18 months to 29 months for you and/or your Dependent if one of you becomes totally disabled (as determined by the Social Security Administration under Title 2 or Title 16) at any time during the first 60 days of COBRA continuation coverage. However, you and/or your Dependent must give notice of the disability within 60 days of the Social Security determination and must request to extend the continuation period before the end of the first 18 months. If during the continuation coverage the Social Security Administration determines that the individual is no longer disabled, the individual must inform the Plan of this redetermination within 30 days of the date it is made.

Coverage may be continued for up to 36 months for a Dependent in the event of:

- (a) Your death;
- (b) Your divorce or legal separation from your Spouse;
- (c) Your becoming entitled to Medicare, and as a result the loss of eligibility for coverage under the Plan by yourself and your Dependents;
- (d) The loss of Dependent status by a Dependent child under the terms of this Plan.

Coverage will be continued only for you and/or your Dependents who were covered under the Plan on the day immediately preceding termination. However, if a child is born to you or placed for adoption with you during the period of COBRA continuation coverage, your child is entitled to receive COBRA continuation coverage with independent COBRA rights.

Coverage will not be continued beyond the earliest of the following dates:

- (a) The date ending the period for which any required contribution has been paid;

- (b) The date you and/or your Dependent first become entitled to Medicare, or first become covered under another group health plan without being subject to that plan's preexisting limitations;
- (c) The date your employer ceases to provide any group health plan.

If any provision of this section is contrary to the Consolidated Omnibus Reconciliation Act of 1985 (as amended), the provision is changed to comply with the law.

Note: All Plan Participants must notify the Plan in writing within sixty (60) days of

- (a) Divorce or legal separation
- (b) Covered Dependent child ceasing to qualify as a Dependent
- (c) Acceptance of Medicare or coverage under another employer's group health plan (whether or not as an Employee), if that plan does not limit coverage for Preexisting Conditions.
- (d) Second qualifying event
- (e) Qualified Beneficiary's disability or cessation of disability
- (f) Death of the Employee

Written notice must be provided to the Claims Administrator or the designated COBRA Claims Administrator, if applicable. The notice must include the name of the Employee with identification number, Plan Name and Number, date and type of the qualifying event and name(s) of the applicable Dependent(s).

FAILURE TO NOTIFY THE PLAN IN A TIMELY MANNER WILL RESULT IN LOSS OF ELIGIBILITY FOR COBRA CONTINUATION COVERAGE.

6. Summary of Plan Benefits

The Plan provides Eligible Employees and their Dependents, if applicable, with medical, dental, long-term disability, short-term disability and life insurance benefits. The insured benefits are provided under group insurance contracts entered into between the Company and the insurance companies. A summary of the benefits provided under the Plan is set forth in the attached certificate of insurance booklets and schedules of benefits.

This Plan shall provide benefits in accordance with the applicable requirements of Federal laws, such as COBRA, and the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act.

This Plan will also provide benefits as required by any qualified medical child support order, as defined in ERISA § 609(a). A copy of the procedures governing qualified medical child support orders (QMCSOs) may be obtained without charge from the Plan Administrator. This Plan will also provide benefits to Dependent children placed with Participants or beneficiaries for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of Participants or beneficiaries, in accordance with ERISA § 609(c).

Under the federal law entitled Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group insurance coverage generally may not 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 normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (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) or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

The federal law entitled the Women's Health and Cancer Rights Act requires coverage for reconstructive surgery following mastectomies. Accordingly, this Plan shall provide, in a case of a Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction with such mastectomy, coverage for:

- (a) reconstruction of the breast on which the mastectomy has been performed;
- (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (c) prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and benefit percentage provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan.

7. How the Plan is Administered

The administration of the Plan is under the supervision of the Plan Administrator, the Company and the duly authorized person(s) who acts on behalf of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. Any duly authorized officer of the Plan Administrator may exercise any authority or responsibility allocated or reserved to the Plan Administrator under this Plan. The Plan Administrator shall have the right to hire all persons providing services to the Plan and to appoint a claims fiduciary to receive, review, and process claims for benefits. The Company bears the incidental costs of administering the Plan.

This Plan provides fully insured benefits that are provided under a group insurance contract entered into between the Company and the applicable insurance companies. Claims for the insured benefits are to be sent to the appropriate insurance company. That insurance company is responsible for paying claims, not the Company.

The applicable insurance company or claims administration firm is responsible for:

- (a) Determining eligibility for and the amount of any benefits payable under the Plan.
- (b) Prescribing claims procedures to be followed and the claims forms to be used by Employees pursuant to the Plan.

Those entities also have the authority to require Employees to furnish them with such information deemed necessary for the proper administration of the Plan. If you have questions concerning eligibility for and/or the amount of any benefits payable under the Plan, please contact the applicable insurance company or claims administration firm.

8. Circumstances Which May Affect Benefits

Your eligibility for Plan benefits terminates on the day that you terminate from employment with the Employer. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, or if you submit false claims. (See the certificate of insurance booklet and/or schedules of benefits for more information.) Coverage for your spouse and Dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the certificate of insurance booklet and/or schedules of benefits, such as divorce, child attains age limit, child gets married, etc. Benefits will also cease for Employees, spouses and Dependents upon termination of the Plan.

Depending on the reason why coverage was terminated, you and your covered spouse and Dependents might have the right to continue coverage temporarily under COBRA. See Section 5 above for information about COBRA rights.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions due to pre-existing conditions, and exclusions for certain medical procedures) are described in the certificate of insurance and benefits booklets. Please read the booklets carefully. See also any Plan notices and other important information about the exclusions due to pre-existing conditions and special enrollment rights you may have, copies of which may have been previously furnished to you. Please contact the Plan Administrator if you need another copy.

9. Right to Receive Medical Information Necessary to Determine Benefits

By accepting coverage under this Plan, Eligible Employees and their Dependents agree to supply information about medical conditions and records or other coverage when requested by the Plan. All private health information will be kept confidential and will be used on a need only basis for purposes of administering Plan benefits.

10. Amendment or Termination of the Plan

The Plan Administrator shall have the unlimited right to amend, terminate, or merge the Plan at any time without prior written notice to any Participant. Any such amendment, termination, or merger shall be documented in writing by an authorized representative of the Employer and shall become effective as of the date specified in the appropriate documentation. Any such amendment, termination or merger shall be binding upon all Employees and Dependents (including those Participants on continuation coverage). However, the responsibilities of the named fiduciaries and their delegates shall not be increased or changed without their written consent.

No change in this Plan will be valid unless it is approved by the Plan Administrator or the duly authorized representative of the Plan Administrator. Any such change must be endorsed by the Plan Administrator or the duly authorized representative of the Plan Administrator and attached to this Plan Document. An amendment to this Plan may be retroactively effective, but shall not adversely affect the rights of a Participant under this Plan for benefits provided after the effective date of the amendment but before the amendment is adopted.

Additionally, the Employer reserves the right to determine from time to time the level of contribution required from Participants for Plan coverage.

11. No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

12. Claim Procedures

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence, as it deems necessary in order to decide your claim. If the insurance company denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

See the certificate of insurance or booklets for more information about how to file a claim and for details regarding the claims procedures of the applicable insurance company.

13. Statement of ERISA Rights

A Participant of this Plan is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and 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 (EBSA).

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

The Employee and qualified beneficiaries may continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. COBRA participants may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

If there is creditable coverage from another plan, reduction or elimination of exclusionary periods of coverage for Preexisting Conditions, if applicable, shall be allowed under this group health plan. Participants should be provided a certificate of creditable coverage, free of charge, from their group health plan or health insurance issuer when they lose coverage under the plan, when they become entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if requested before losing coverage, or if requested up to 24 months after losing coverage. Without evidence of creditable coverage, Participants may be subject to a Preexisting Condition exclusion for 12 months (18 months for Late Enrollees) after the enrollment date for coverage.

Prudent Actions by Plan Fiduciaries

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

Enforcement of Rights

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

Under ERISA, there are steps that may be taken to enforce the above rights. For instance, if a copy of plan documents or the latest annual report from the Plan is requested and not received within 30 days, a suit may be filed in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If there is a claim for benefits which is denied or ignored, in whole or in part, a suit may be filed in a state or Federal court. In addition, if there is disagreement with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, a suit may be filed in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the suit is successful, the court may order the person sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If there are any questions about this Plan, contact the Plan Administrator. If there are 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 (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, 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 EBSA.

14. Summary and Protected Health Information

This provision shall only apply to benefits that are subject to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and its implementing regulations, issued under the Privacy Regulations at 45 C.F.R. Parts 160 and 164.

Disclosure of Summary Health Information

This Plan shall disclose to the Plan Sponsor summary health information (information that does not and could not be used to identify an individual) if the Plan Sponsor requests such information for the purpose of:

- obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- modifying, amending, or terminating this Plan.

Disclosure of Protected Health Information (PHI)

The Plan will disclose PHI (information that identifies or could identify an individual) to the Plan Sponsor only in accordance with HIPAA Privacy laws. The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The Plan Sponsor hereby acknowledges and agrees to the following provisions in this document:

- a. Not to use or further disclose PHI other than as permitted or required by the plan document or as required by law; and to ensure that the separation between the plan and plan sponsor required under the privacy rules is supported by reasonable and appropriate security measures.

- b. To ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI; and to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- c. Not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- d. To report to the Plan any security incident or any PHI use or disclosure that it becomes aware is inconsistent with the uses or disclosures for which provision is made;
- e. To make available protected health information in accordance with 45 CFR §164.524;
- f. To make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR §164.526;
- g. To make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- h. To make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request;
- i. If feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible; and
- j. To ensure that adequate separation between the Plan and the Employer, as required by 45 CFR §164.504(f), is established and maintained.

Limitations of PHI Access and Compliance

Access to PHI information may be given only to the Plan Sponsor and staff of the Plan Sponsor who receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business in carrying out Plan administration functions that the Plan Sponsor performs for the Plan. The access and use of PHI by the Plan Sponsor and staff described above is limited to purposes of the administration functions that the Plan Sponsor performs for the Plan. If the Plan Sponsor and said staff do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

15. Legal Compliance/Conformity

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws of the Employer's principal place of business to the extent such laws are not preempted by federal law. If any provision of the Plan Document or Employer's Plan is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

No clerical errors made by the Employer, Plan Administrator, or the Claims Administrator in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made. If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

16. Definitions

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Eligible Dependent means an individual who meets the requirements for such status as defined by the applicable certificates of insurance.

Eligible Employee means a person who is an Employee of the Employer, regularly scheduled to work sufficient hours for the Employer in an Employer/Employee relationship and who meets the requirements for such status as defined by the applicable certificates of insurance.

Employer is H & S Swanson's Tool Company.

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

Medicare is the Health Insurance for the Aged and Disabled program under Title XL of the Social Security Act, as amended.

Participant is a person covered under this Plan or the legal representative or guardian of a minor or incompetent person covered under this Plan.

Plan means the H & S Swanson's Tool Company Benefit Plan, which is a benefit plan for certain Employees of Employer.

Plan Year is the twelve-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year that is a short Plan Year.

NOTE: This document, together with the applicable certificate of insurance booklets issued by the Company constitutes the Summary Plan Description required by ERISA §102.