

**H & S SWANSONS' TOOL COMPANY  
FLEXIBLE BENEFIT PLAN**

**EFFECTIVE: January 1, 2005**

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## I. ESTABLISHMENT OF PLAN

### *A. Purpose*

This Plan is a voluntary employee benefit plan that affords the Participant the opportunity to take advantage of tax savings currently offered by the federal government. A Participant sets aside a portion of income each pay period before it is taxed for uses described in this Plan Document. Participants must read this entire Plan Document to ensure that all requirements and conditions of the Plan are fully understood.

### *B. Introduction to Plan*

Any Eligible Employee may elect to participate in the H & S Swansons' Tool Company Flexible Benefit Plan. Participation in the Premium Only option is automatic unless waived; participation in any of the other Plan benefit options requires completion of an enrollment form.

### *C. Terms of Participation*

Under federal regulations which govern the Plan, an Employee may change his elections regarding participation once a year during the open enrollment period established by the Employer. Such changes may be made for any reason and will become effective on the first day of the next Plan Year. During the remainder of the Plan Year, an Employee may not change his elections unless he experiences a qualifying change in status that is on account of and consistent with the change as set forth in this document.

Any balance in an Employee's account at the end of a Plan Year must be forfeited. Under IRS rules for Flexible Spending Account plans, that balance cannot be paid to an Employee in cash, carried over to the next Plan Year, nor be made available to an Employee in any way. Forfeited funds may be used to offset costs of the Plan.

By accepting coverage under this Plan, an Employee and his Dependents agree to supply information about medical conditions and records 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.

### *D. Compliance*

This Plan is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. Should any part of this document for any reason be declared invalid, such decision shall not affect the validity of any remaining portion, which remaining portion shall remain in effect as if this document had been executed with the invalid portion thereof eliminated.

## II. PREMIUM ONLY OPTION

For an Employee enrolled in the medical and/or dental plan(s) sponsored by the Employer, payroll deductions for contributions, including any change in the cost of the benefit during a period of coverage under the terms of the Plan, will be taken automatically before income is taxed for federal, applicable state and Social Security purposes, as allowed by law. To have these contributions taken from pay on an after-tax basis, the Employee must sign a waiver. The Employee's election (automatic pretax deductions or after-tax deductions per signed waiver) for those contributions only will continue year after year unless the Employee makes a change during the open enrollment period, or in the case of a qualified status change.

Information regarding the Employer-sponsored health plan(s) is contained in the plan documents and/or insurance contracts for those plans. Coverage and claims procedures for such health benefits are governed by said documents.

### III. HEALTH CARE FLEXIBLE SPENDING ACCOUNT OPTION

#### ***A. Contributions***

The maximum an Employee may contribute to his Health Care Flexible Spending Account during the 12-month Plan Year is \$3,000.

#### ***B. Eligible Expenses***

In general, Health Care expenses for an Employee and his Dependents are eligible for reimbursement from his Health Care Flexible Spending Account if they meet all of the following requirements:

- The expenses were Incurred on or after the effective date of the Employee's participation in the Plan;
- They would qualify as medical expenses for federal income tax purposes under Section 213 of the Code;
- They have not been and will not be paid by the Employee's health benefit plan(s) or by another employer's group health benefit plan or by any other insurance policy or program; and,
- They have not and will not be deducted on the Employee's tax return.

Eligible reimbursable expenses under this Plan include, but are not limited to, out-of-pocket expenses for:

- Deductibles and copayments for hospital, physician, prescription drug, dental and vision care;
- Uncovered health services such as hearing aids, vision care, routine physicals and well baby care, counseling therapy and long-term rehabilitation services (alcoholism and drug abuse); and
- Fees in excess of plan limits, including those for orthodontia and psychiatric services.

Under current laws the contributions a Spouse makes for health insurance, and the expenses for elective cosmetic surgery are expenses which are not eligible for reimbursement from the Employee's Health Care Flexible Spending Account. The above are just two examples of ineligible expenses. Further information on the types of health care expenses eligible for reimbursement from an Employee's Health Care Flexible Spending Account is available from the IRS in Publication 502. (Call 1-800-TAXFORM.) *However, Publication 502 provides information relating to tax-deductible expenses on the federal income tax return and; therefore, includes some provisions that conflict with this Plan. For purposes of filing a claim for reimbursement, all other terms and conditions of this Plan shall apply in determining the benefits available to a Participant.*

### ***C. Over-the-Counter Drugs***

Notwithstanding the eligible expense requirements set forth above, Over-the-Counter (“OTC”) Health Care expenses for an Employee and his Dependents are eligible for reimbursement from his Health Care Flexible Spending Account if they are medicines or drugs that are used for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. Applicable sales tax and shipping charges related to the purchase of qualified OTC medical expenses are also eligible for reimbursement. Items that are used to promote the general good health of an individual or items that are not medicines or drugs are not eligible for reimbursement. OTC medical expenses must be properly substantiated when filing a claim for reimbursement. Different levels of substantiation may be required depending on the facts and circumstances of the claim.

### ***D. Estimating Eligible Health Care Expenses***

To determine how much an Employee should contribute, the Employee should estimate the unreimbursed Health Care expenses that are expected to be Incurred in the Plan Year ahead. Careful consideration should include anticipated medical, dental and vision care out-of-pocket expenses. Any balance in an Employee's account at the end of a Plan Year must be forfeited. Under IRS rules for Flexible Spending Account plans, that balance cannot be paid to an Employee in cash, carried over to the next Plan Year, nor be made available to an Employee in any way. Forfeited funds may be used to offset costs of the Plan.

## IV. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT OPTION

### *A. Contributions and Limitations*

Contributions to an Employee's Dependent Care Flexible Spending Account are limited by federal regulations. An Employee may elect to contribute a maximum to a Dependent Care Flexible Spending Account during the Plan Year (or calendar year) that is the **lesser of:**

- 1) **\$5,000** if the Participant is single and files an individual tax return or if the Participant is married and files a joint tax return;
- 2) **\$2,500** if the Participant is married and files a separate tax return; **or**
- 3) The Participant's taxable income or the Spouse's taxable income, whichever is less. (For example, if the Employee earns \$25,000 per year and his Spouse earns \$3,000, then the Employee's contribution to a Dependent Care Flexible Spending Account can be no more than \$3,000 for the year.)

**Important: Contributions to all employer-sponsored Dependent Care Flexible Spending Account plans cannot exceed \$5,000 on a combined basis in any calendar year.**

If a Participant's Spouse is a full-time student or cannot care for himself, the Spouse may be considered to have an income of **\$250 per month** if there is one qualified Dependent or **\$500 per month** if there are two or more qualified Dependents.

**Note:** The Child Care Tax Credit on a Participant's federal income tax statement provides a dollar-for-dollar write-off against his taxes. The Child Care Tax Credit cannot be used for expenses paid by the Dependent Care Flexible Spending Account. The Tax Credit amount may range from 20% to 35% of child care costs dependent upon the Participant's adjusted gross income. The credit cannot be claimed on more than the amount allowed under current Federal law. Participants should consult a tax advisor for specific questions.

## ***B. Eligible Expenses***

Eligible Dependent Care expenses are work-related expenses Incurred for qualifying individuals (see next subsection). Expenses are for the care of a qualifying person only if their main purpose is the person's well-being and protection, and must be Incurred to enable the Participant (and Spouse, if applicable), to be gainfully employed. These expenses include:

- Work-related babysitting (*i.e.*, not social) and licensed daycare center costs;
- After-school\* day care costs;
- Incidental housekeeping services in the Employee's home included with day care.

\*Expenses for care do not include amounts for education. The IRS provides an example of a 5-year old child who goes to kindergarten in the morning. In the afternoon, the child attends an after-school day care program at the same school. The total cost of sending the child to school is \$3,000, of which \$1,800 is for the after-school day care program. Only the \$1,800 qualifies as non-educational care with the primary purpose of providing for a child's well-being and protection.

Note: Provider name, address, and taxpayer identification are required to be provided on the Employee's tax return. An Employee may not claim an exclusion for reimbursement of Dependent Care expenses unless he provides on his tax return the name, address and taxpayer identification number (TIN) of the service provider. (No TIN is necessary for tax-exempt organizations.) If the caregiver is an individual, the TIN is the individual's social security number.

An Employee may claim reimbursement for payments made to a relative; however, he may not be reimbursed for payments he makes to one of his tax-eligible Dependents or any of his children age eighteen (18) or younger.

## ***C. Ineligible Expenses***

Expenses which are ineligible for reimbursement include, but are not limited to:

- Babysitting for social reasons;
- Expenses incurred on or after a child's 13<sup>th</sup> birthday;
- Overnight camp;
- Education, food or clothing expenses that are not incidental to and inseparably part of the care;

- Costs of transportation;
- Tuition for children in the first grade or above and for kindergarten education; and
- Payments made for care provided by someone eligible to be claimed as a Dependent on the Participant's income tax form (although payment to another relative is permissible) or to any of his children age eighteen (18) or younger.

#### ***D. Qualifying Individuals***

Individuals who qualify as dependents for the purpose of this Plan are:

- The Participant's children who are under the age of 13 and for whom the Participant is entitled to an exemption under Section 151(c) of the Code (*Note: A Dependent Care election may be canceled when a Dependent child turns age 13 in the middle of a Plan Year and is no longer a qualifying individual for purposes of the Dependent Care Flexible Spending Account rules*); and
- A Spouse or Dependent of the Employee who is physically or mentally incapable of caring for himself.

For purposes of Dependent Care Flexible Spending Account provisions, including contribution limits, eligible Dependents shall not include an individual legally separated from the Employee under a divorce or separate maintenance decree, nor shall it include an individual who, although married to the Employee, files a separate federal income tax return, maintains a separate principal residence from the Employee during the last six (6) months of the taxable year and does not furnish more than one-half the cost of maintaining the principal place of residence. However, if an Employee is divorced or legally separated, he can generally have his child's Dependent Care expenses reimbursed if he is the custodial parent (i.e., if he has custody of the child for a longer period of time during the Plan Year than the other parent). The following exceptions would override the custodial parent rule and permit the Employee, as a non-custodial parent, to have his child's Dependent Care expenses eligible for payment from his Dependent Care Flexible Spending Account:

- The custodial parent formally releases claim to the federal income tax Dependent Care exemption for the year; or
- The Employee provides over half the support of the child under a multiple support agreement.

### ***E. Federal Reporting Requirement***

An Employee is required to report on his federal income tax return, the name(s) and tax identification number(s) or Social Security number(s) of his providers of dependent care services.

Note: The tax identification number is not required if the provider of dependent care services is a tax-exempt organization (i.e., a church-sponsored nursery school or a county daycare center).

### ***F. Understanding Dependent Care Benefit Options with the Spending Account and the Federal Income Tax Credit***

The federal government provides an income tax credit for Dependent Care expenses such as those described earlier. While an Employee may take advantage of the tax benefits available under both the Dependent Care Flexible Spending Account and the federal income tax credit, he cannot use both the tax credit and the spending account for the same Dependent Care expenses, and expenses eligible for the tax credit are reduced, on a dollar-for-dollar basis, by the amount he contributes to a Dependent Care Flexible Spending Account.

The practical effect of contributing dollars to a Dependent Care Flexible Spending Account which he would otherwise receive in his salary is that the income which he reports for federal, applicable state and FICA (Social Security) taxes is reduced, as may be allowed by applicable law. The amount of this contribution will not be reported on the Employee's W-2 form as part of his earnings. There will be no taxes due on this amount.

The amount which an Employee can save in taxes depends on the amount of his contribution and his taxable income with and without the contribution. He can approximate this amount of savings by determining his marginal, i.e., top, tax rate. The higher his marginal tax rate, the greater amount he can save in taxes with this spending account.

In deciding whether to use the Dependent Care Flexible Spending Account or the federal tax credit, an Employee needs to evaluate which will be more advantageous to him. In most cases, the spending account will provide him the greater tax savings.

Since the spending account advantage may change as revisions are made in the tax rules, an Employee will want to monitor his personal situation and may also wish to consult a tax advisor.

## V. ELIGIBILITY AND PARTICIPATION

### *A. Eligibility Provisions*

Any Employee of the Employer who is regularly scheduled to work a minimum of thirty (30) hours per week will be eligible to participate in this Plan, subject to the provisions stated in this Article.

### *B. Participation*

If an Eligible Employee wishes to open a Flexible Spending Account and contribute a portion of his salary to such an account to pay for eligible costs which will be Incurred during a Plan Year, an Employee must make such an election by completing an election form and processing it as directed by the Plan Administrator or its authorized representative. This election must initially be made prior to the effective date, (which is the first of the month following the completion of the thirty (30) day waiting period).

Subsequent elections may be made annually during the open enrollment period in December. Such open enrollment elections will become effective on the first day of the next Plan Year.

If an Employee does not complete the election form on a timely basis, he will be considered to have elected not to participate in the Flexible Spending Account Option(s) of this Plan.

If an Eligible Employee wishes to participate in the Premium Only Option offered in this Plan, he must complete the required enrollment or election process as described in Article II of this document.

### *C. Change in Elections*

Under federal regulations which govern the Plan, an Employee may change his elections regarding participation once a year during the open enrollment period established by the Employer. Such changes may be made for any reason and will become effective on the first day of the next Plan Year.

During the remainder of the Plan Year, an Employee may not change his elections unless he experiences a qualifying change in his status that is on account of and consistent with the change, as discussed below under Section D, "Consistency Rule."

The following events are changes in status:

#### **LEGAL MARITAL STATUS.**

Events that change an Employee's legal marital status, including the following: marriage; death of Spouse; divorce; legal separation; and annulment.

**NUMBER OF DEPENDENTS.**

Events that change an Employee's number of Dependents, including the following: birth; death; adoption; and placement for adoption; and court ordered change in custody or Qualified Medical Child Support Order (QMCSO).

**EMPLOYMENT STATUS.**

Any of the following events that change the employment status of the Employee, the Employee's Spouse, or the Employee's Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the cafeteria plan or other employee benefit plan of the employer of the Employee, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under that plan, then that change constitutes a change in employment (e.g., if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan, then that change constitutes a change in employment status).

**DEPENDENT SATISFIES OR CEASES TO SATISFY ELIGIBILITY REQUIREMENTS.**

Events that cause an Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of age, student status, or any similar circumstance.

**RESIDENCE.**

A change in the place of residence of the Employee, Spouse, or Dependent.

***D. Consistency Rule***

An election change satisfies the consistency rule only if the election change is **on account of and corresponds with a change in status** that affects eligibility for coverage under an employer's plan.

If an Employee experiences a change in status, he will be permitted to change his election in a manner that is consistent with the change in his status, provided that he does so within thirty-one (31) days. Any such change will become effective on the date of the occurrence, the date that the change of election is received or the first of the month following the date of the change in election, as permissible by law.

### ***E. Special Application of Consistency Rule to Dependent Care***

IRS regulations provide that the consistency rule is satisfied for a Dependent Care Flexible Spending Account if the election change is on account of and corresponds with a change in status that affects eligibility of Dependent Care expenses for tax exclusions. The following examples illustrate the effect of change in status and consistency rule requirements for a Dependent Care Flexible Spending Account change in elections:

- A Dependent child's turning age 13 would affect eligibility for Dependent Care expenses. Therefore, a Dependent Care election may be canceled when a Dependent child turns age 13 in the middle of a Plan Year and is no longer a qualifying individual for purposes of the Dependent Care Flexible Spending Account rules.
- An Employee's or Spouse's leave of absence (paid or unpaid) or change in employment status (part-time to full-time or vice versa) would also represent a special application of the consistency rule under a Dependent Care Flexible Spending Account. A change in the number of hours of work performed by the Employee or the Employee's Spouse is a change in coverage. Thus, the Dependent Care election may be changed to correspond with the change in coverage.
- Another special application of the consistency rule under a Dependent Care Flexible Spending Account provides that significant changes in the cost for the services of the child care provider represent a change in status that will permit a corresponding change in the Dependent Care election. However, no change based on a significant increase or decrease in cost can be made to a Dependent Care Flexible Spending Account when the cost increase for Dependent Care is imposed by a Dependent Care provider who is a relative of the Employee.

### ***F. Medicare or Medicaid Entitlement***

If the Employee, the Employee's Spouse or qualified Dependent becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Employee may prospectively reduce or cancel his election. Likewise, if the Employee, the Employee's Spouse or qualified Dependent loses eligibility to Medicare or Medicaid coverage, then the Employee may prospectively elect to commence or increase his election.

## ***G. Significant Cost or Coverage Changes***

***(Not Applicable for Health Care Flexible Spending Account Option)***

If an Employee's cost for coverage under the Employer-Sponsored health plan changes significantly during a Plan Year, the Employee may choose to revoke his election under the Premium Only Option and in its place receive on a prospective basis coverage under another plan providing similar coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and whether a substitute plan provides similar coverage. If the change in cost is deemed to be insignificant, each Employee's election shall be prospectively decreased or increased to reflect the change. Similarly, if a change in cost is significant but the Employee chooses not to revoke his election, that Employee's election shall be changed accordingly.

Furthermore, an Employee may revoke his election or make a prospective election change during the Plan Year if the change corresponds with an open enrollment period change made by the Employee's Spouse or qualified Dependent, provided that the Employee's election change is consistent with the changes made under the other group benefits plan and the other group benefits plan permits such an election change. Similarly, the Plan Administrator (in its sole discretion) will determine, based upon prevailing IRS guidance, whether the requested change is on account of and corresponds with a change made under the group benefits plan of the Spouse or qualified Dependent.

Finally, an Employee may revoke his election or make a prospective election change during the Plan Year if the coverage under his Employer-sponsored health plan is significantly curtailed or ceases during a period of coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether coverage has been significantly curtailed.

## VI. FILING A CLAIM

### ***A. Claims under the Health Care Flexible Spending Account***

Claim forms for expenses covered under the Health Care Flexible Spending Account Plan should be accompanied by:

- (1) A written, dated statement from an independent third party stating the Health Care expense has been Incurred and the amount of the expense. (This means that an Employee is required to submit an explanation of benefits (EOB); or, if the expense is totally ineligible for reimbursement, a statement from the service provider rather than just a proof of payment, such as a canceled check.) The following information must be set forth on the claim for reimbursement:
  - patient's name
  - nature of Incurred expense
  - amount of requested reimbursement
  - date of service
- (2) A written statement that the Health Care expense has not been reimbursed under any other health plan coverage (included on claim form).

The minimum claim amount is \$25.

Claims should be sent to the Claims Administrator.

### ***B. Claims under the Dependent Care Flexible Spending Account***

Claim forms for expenses covered under the Dependent Care Flexible Spending Account Plan should be accompanied by:

- (1) A written, dated statement from an independent third party stating the Dependent Care expense has been Incurred and the amount of the expense. (This means that an Employee is required to submit a statement from the service provider rather than just a proof of payment, such as a canceled check.) The following information must be set forth on the claim for reimbursement:
  - Dependent's name
  - nature of Incurred expense
  - amount of requested reimbursement
  - date of service

- provider's name
  - provider's tax identification number or social security number
- (2) A written statement that the Dependent Care expense has not been reimbursed under any other Dependent Care Flexible Spending Account plan (included on claim form).

The minimum claim amount is \$25.

Claims should be sent to the Claims Administrator.

### ***C. Receiving Reimbursement***

All payments for claims will be made directly to the Employee and not to a provider of a service. Checks will generally be drawn within two weeks of receipt of the reimbursement request.

### ***D. Claims in Excess of the Employee's Account***

If an Employee submits a claim for more than the current balance of his applicable Health Care Flexible Spending Account, his claim will be paid up to the total he elected for the Plan Year minus any prior payments for the Plan Year.

If an Employee submits a claim for more than the current balance of his applicable Dependent Care Flexible Spending Account, his claim will be paid up to the balance in his account, and the remainder of the claim will automatically be paid as additional contributions are made to the account. Claims do not need to be resubmitted.

### ***E. Claims at the End of the Plan Year***

To enable an Employee to use his Flexible Spending Account for expenses incurred and provided before the end of the Plan Year, he may continue to submit claims until March 1<sup>st</sup> following the close of the Plan Year. Those claims must be for expenses incurred and provided during the appropriate Plan Year or coverage period.

## VII. RIGHTS OF EMPLOYEES PARTICIPATING IN THE PLAN

### *A. Nondiscrimination*

In connection with the administration of this Plan, the Plan Administrator or representatives of the Plan Administrator will not discriminate unfairly between similarly situated individuals. The Plan Administrator shall have the authority to adjust contributions to avoid discrimination.

### *B. Appeal*

#### **EXPLANATION OF DENIAL**

The written explanation of a claim denial shall set forth, in a manner calculated to be understood by the Participant, the following information:

- The reason(s) for denial.
- If the claim is denied because the Plan needs more information to make a decision, a description of any additional information necessary for the Participant to perfect the claim and explanation of why such information is necessary.
- A statement that the claim and its denial shall be reviewed upon submission of a written request.
- A statement that the Participant, the Participant's attorney or other duly authorized representative shall have, as part of the review procedure, a reasonable opportunity to examine pertinent Plan documents and records and to submit written comments on issues.
- A statement that failure to submit a written request for review within 180 days after the receipt of the written explanation of the claim denial shall make the Plan's decision final.

#### **PROVIDING ADDITIONAL INFORMATION**

As part of the review procedure, the Participant or the Participant's duly authorized representative shall have a reasonable opportunity to examine pertinent Plan documents and records and to submit written comments on the issues. Furthermore, the Participant also has the right to obtain applicable determination procedures used to ascertain coverage under a Qualified Medical Child Support Order free of charge from the Plan Administrator.

### **DECISION ON REVIEW**

The Plan shall process a claim in accordance with its reasonable claims procedures. The Plan has a right to secure independent medical advice and to require such other evidence as it deems necessary to decide the claim. If the Plan requires more than 30 days to process a claim, the claimant will be notified of the delay, the reason for the delay, and the expected date a decision will be made. If the claim is wholly or partially denied, the Plan shall furnish the Participant a written explanation for the denial. A claim and its denial shall be reviewed if a written request for appeal is filed within 180 days after receipt of the written explanation of the claim denial by the Participant. Otherwise, the initial decision shall be the final decision of the Plan. The Plan shall review the request for appeal information and comments submitted by the Participant or the Participant's duly authorized representative. The Plan shall furnish the Participant with a written explanation of its decision with respect to the appeal within 60 days following receipt of the written appeal.

### **EXPLANATION OF DECISION ON REVIEW**

The written explanation of the appeal decision shall set forth, in a manner calculated to be understood by the Participant, the following information:

- The specific reason(s) for the decision, including a response to the information and comments, if any, submitted by the Participant and his duly authorized representative.
- Specific reference to pertinent Plan provisions and records, if any, on which the decision is based.

### **LIMITATION**

No action at law or in equity can be brought to recover on this Plan before exhausting the appeals procedure described above. No action at law or in equity can be brought to recover after the expiration of two years after the time when written proof of loss is required to be furnished to the Plan.

## ***C. Health Insurance Portability And Accountability Act Privacy Rules***

### **PLAN SPONSOR CERTIFICATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**

With respect to the Health Care Flexible Spending Account benefit option, the Plan will use protected health information (PHI) to the extent of 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 certifies that in accordance with HIPAA, 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.

With an authorization, the Plan will disclose PHI for the purposes granted, and to the parties specified in the authorization.

### **WITH RESPECT TO PHI, THE PLAN SPONSOR AGREES TO CERTAIN CONDITIONS**

The Plan Sponsor agrees to:

- 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.
- 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;

- 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;
- 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;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA, and;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

#### ***D. ERISA Rights Guaranteed to Participants***

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 the Plan and its Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, 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 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.

#### 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 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.

## VIII. PLAN ADMINISTRATION, AMENDMENT AND TERMINATION

### *A. Rights of the Plan Administrator*

Any duly authorized officer of the Employer may exercise any authority or responsibility allocated or reserved to the Employer under this Plan.

The Plan Administrator shall have the right to hire all persons providing services to the Plan and to appoint a Claims Administrator to receive, review, and process claims for benefits.

The Plan Administrator shall have the authority and responsibility to call and attend the meetings at which this Plan's funding policy and method are reestablished and reviewed.

The Plan Administrator shall have the discretionary authority and responsibility to construe and interpret terms of this Plan; to make factual determinations, including all questions of eligibility; to establish the policies, interpretations, practices, and procedures of this Plan; to adopt and implement procedures; and to render final decisions on review of claims as described in this Plan Document. Furthermore, the Plan Administrator has the authority to delegate certain duties and responsibilities to a claims fiduciary. All interpretations under the Plan, and all determinations of fact made in good faith by the Plan Administrator will be final and binding on the Participants and beneficiaries and all other interested parties.

Furthermore, the Plan Administrator shall have the right to determine the amount, manner, and time of payment of any benefits under this Plan and to change contribution rates for Participants at any time and from time to time.

The Plan Administrator has a duty to maintain records and to file reports required by law. This duty shall include complying with ERISA's reporting and disclosure statements, if applicable.

The Plan Administrator shall forward applications to the Claims Administrator and notify the Claims Administrator in writing of changes with respect to Participants and other facts necessary for determining Plan coverages and for processing claims for Plan benefits.

The Plan Administrator or any duly authorized representative of the Plan Administrator will have the right to examine any claim for benefits under this Plan.

The Plan Administrator shall perform all other responsibilities allocated to the Plan Administrator.

### ***B. Right To Amend***

The Employer shall have the unlimited right to amend this Plan in any and all respects at any time and from time to time without prior notice to any Participant. Any such amendment shall be documented in writing by an authorized representative of the Employer and shall become effective as of the date specified in said amendment. Any such amendment 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 by amendment 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 amendment must be endorsed by the Plan Administrator or the duly authorized representative of the Plan Administrator and attached to this Plan Document.

### ***C. Retroactive Amendments***

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.

### ***D. Misstatement of Facts***

No agent or representative of the Plan will have the authority to legally change this document or waive any of its provisions, either purposely or inadvertently. Any change must be made as stated above. If any relevant facts pertaining to any person's eligibility for benefits under this Plan are found to be misstated, an equitable adjustment of any benefits paid will be made. If such misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan, and in what amount.

### ***E. Right To Terminate or Merge the Plan***

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Employer reserves the unlimited right to terminate or merge the Plan at any time without prior written notice to any Participant. Such termination shall be evidenced by appropriate documentation by an authorized representative of the Employer that has the authority to terminate or merge the Plan. The date of the merger or termination will be the date specified in the enabling written pronouncement. Termination of the Plan shall apply to all Employees and Dependents (including those on continuation coverage). Additionally, the Employer reserves the right to determine from time to time the level of contribution required from Participants or Dependents for Plan coverage.

## **IX. MISCELLANEOUS**

### ***A. State Law***

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws to the extent such laws are not preempted by federal law.

### ***B. Status of Employment Relations***

The adoption and maintenance of this Plan shall not be deemed to constitute a contract between the Employer and the Employees or to be consideration for, or an inducement or condition of, the employment of an Employee. Nothing in this Plan shall be deemed to:

- Affect the right of the Employer to discipline or discharge any Employee at any time.
- Affect the right of any Employee to terminate his employment at any time.
- Give to the Employer the right to require any Employee to remain in its employ.
- Give to any Employee the right to be retained in the employ of the Employer.

### ***C. Word Usage***

Whenever words are used in this document in the singular or masculine form, they shall where appropriate be construed so as to include the plural, feminine, or neuter form.

### ***D. Titles are Reference Only***

The titles are for reference only. In the event of a conflict between a title and the content of a section, the content of the section shall control.

### ***E. Information in Document***

Every effort has been made to make this document as complete and accurate as possible. If any conflict should arise between any other document and this Plan, the terms of this Plan shall control.

### ***F. Counterparts***

This Plan may be executed in any number of counterparts each of which shall be deemed to be an original, but all of which together constitute an instrument which may be sufficiently evidenced by any counterpart.

## X. GENERAL RULES AND INFORMATION

### ***A. Plan Year***

The Plan Year will be a period of twelve (12) consecutive months, commencing January 1<sup>st</sup> and ending December 31<sup>st</sup>.

### ***B. Contributions***

An Eligible Employee may elect to contribute a portion of his salary to pay for eligible costs that will be incurred during a Plan Year.

### ***C. Excess Expenses***

Expenses incurred in excess of an Employee's Flexible Spending Account balance(s) at the end of a Plan Year cannot be reimbursed or carried forward for reimbursement in the next Plan Year.

### ***D. Use It or Lose It Rule***

Any balance in an Employee's Flexible Spending Account(s) at the end of a Plan Year must be forfeited. Under IRS rules for Flexible Spending Account plans, that balance cannot be paid to an Employee in cash, carried over to the next Plan Year, nor be made available to an Employee in any way. Forfeited funds may be used to offset administrative expenses of the Plan.

### ***E. Leave of Absence***

If a Participant takes a leave of absence, paid or unpaid, he may still participate in the Plan. Options for continuing, suspending, or revoking participation in the Premium Only, Health Care and Dependent Care Flexible Spending Account Plans will vary according to the leave status as FMLA or non-FMLA. The Participant should contact Human Resources in advance of the leave for more information.

### ***F. Termination of Participation***

A Participant will cease to be a Participant in this Plan upon the earliest of:

- The expiration of the Plan Year for which the Employee has elected to participate (unless during the open enrollment period for the next Plan Year the Employee elects to continue participating);
- The termination of this Plan;
- The date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Employee eligible to participate; or

- The date the Participant revokes his election to participate under a circumstance which such change is permitted under the terms of this Plan.

### ***G. Termination of Employment***

If an Employee terminates employment during a Plan Year, all contributions to this Plan will cease as of the date of termination. An Employee will be entitled to submit claims until March 1st after the close of the Plan Year following the date of termination for expenses Incurred prior to his termination. Employees participating in the Plan may elect to continue to participate as described below under Continuation Rights.

### ***H. Continuation of Coverage under COBRA***

Note: Only Participants in the Health Care Flexible Spending Account Option of the Plan are eligible to continue such coverage under COBRA.

Limited continuation of group health coverage for the balance of the Plan Year is required by federal law for Health Care Flexible Spending Account Participants who have underspent their accounts as of the qualifying event date, and it is the intent of this Plan to comply with federal law.

If an Employee participating in the Health Care Flexible Spending Account Option of the Plan terminates his employment or becomes ineligible because of reduced hours, he may continue to participate in a Health Care Flexible Spending Account on an after-tax basis by electing continuation of coverage under COBRA. Continued participation will allow an Employee to submit, for reimbursement, expenses eligible for reimbursement through the Plan according to the provisions of the Plan. Continued participation will provide that an Employee be allowed the rights and privileges of similarly situated Employees, except that open enrollment will not be offered for another Plan Year.

Qualified beneficiaries may also include the employee's spouse and/or the employee's dependents. Qualifying events for non-employees include the death of the employee; the divorce or legal separation of the employee from his spouse; the employee's becoming entitled to medicare, and as a result the loss of eligibility for coverage under the plan by him and his dependents; and the loss of dependent status by a dependent child under the terms of this plan. Written notice regarding the right to COBRA must be provided to 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). Employees and dependents who elect to continue coverage must pay the full cost of the plan, not to exceed 102% of the employer's cost.

COBRA coverage is not available for Participants who have overspent their Health Care Flexible Spending Account as of the qualifying event date. 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.

### ***I. Rehire***

A terminated Employee who is rehired within the same Plan Year must reinstate his elections if he is rehired within thirty (30) days of his termination and may make new elections if he is rehired after thirty (30) days of his termination date upon eligibility as a new hire.

### ***J. The Effect of the Plan on Other Benefits***

Salary dollars contributed by an Employee to his Flexible Spending Account are not subject to federal income taxes or FICA (Social Security) taxes, and will not be included in the taxable income reported on the Employee's W-2 form.

Under present law, an Employee's earnings, for the purpose of determining his FICA earnings and his eventual Social Security benefits, do not include salary reduction contributions made to the Plan. This means that if an Employee earns less than the Social Security wage base, his eventual Social Security benefits will be slightly reduced. The value of the FICA and federal (and state, if applicable) income tax savings to the Employee will normally exceed any reduction in his eventual Social Security benefit.

### ***K. Clerical Errors***

No clerical errors made 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.

## **XI. DEFINITIONS**

### **CLAIMS ADMINISTRATOR**

The Claims Administrator is the entity, if any, designated by the Plan Administrator to provide claims administration services on behalf of the Plan Administrator. Currently, the Claims Administrator is the Employer.

### **CODE**

Code shall mean the United States Internal Revenue Code of 1986, as amended.

### **DEPENDENT**

For purposes of the Premium Only Option, Dependent shall mean a Dependent as defined by the Employer-sponsored health plan(s).

For purposes of the Health Care Spending Account, Dependent shall mean the Employee's Spouse and any person who satisfies the definition of Dependent within the meaning of Section 152 of the Code.

For purposes of the Dependent Care Flexible Spending Account, a Dependent includes the Participant's children who are under the age of 13 and for whom the Participant is entitled to an exemption under Section 151(c) of the Code; and a Spouse or Dependent of the Employee who is physically or mentally incapable of caring for himself or herself, but for purposes of Dependent Care Flexible Spending Account provisions, shall not include an individual legally separated from the Employee under a divorce or separate maintenance decree, nor shall it include an individual who, although married to the Employee, files a separate federal income tax return, maintains a separate principal residence from the Employee during the last six (6) months of the taxable year and does not furnish more than one-half the cost of maintaining the principal place of residence.

### **ELIGIBLE EMPLOYEE**

Any Employee of the Employer who is regularly scheduled to work a minimum of thirty (30) hours per week will be eligible to participate in this Plan.

### **EMPLOYEE**

An Employee means an individual whom the Employer compensates for personal services performed on a regular and continuous basis and for whom the Employer pays employment taxes as required by the Code. "Employee" excludes self-employed individuals, independent contractors, partners in a partnership, and 2% shareholders of a Subchapter S corporation.

### **EMPLOYER**

Employer shall mean H & S Swansons' Tool Company.

**ERISA**

ERISA is the Employee Retirement Income Security Act of 1974, as presently enacted and as it may be amended from time to time, together with its related rules and regulations. References to any section of ERISA shall include any successor provision.

**FAMILY AND MEDICAL LEAVE ACT (FMLA)**

Under the Family and Medical Leave Act of 1993, eligible Employees may take up to twelve (12) weeks of unpaid leave in any twelve (12) month period in the following circumstances:

- The birth, adoption, placement for adoption or foster care placement of a child. The leave must be completed within twelve (12) months of the birth, adoption or placement;
- The serious health condition of a Spouse, a child under age eighteen (18) or an adult child who cannot care for himself, or a parent of the Employee (not a parent-in-law);
- The Employee's own serious health condition that prevents him from performing the functions of his job.

**INCURRED**

Expenses are treated as having been incurred when the Participant is provided with the Dependent Care service or the Health Care that gives rise to the expenses, and not when the Participant is formally billed or charged for, or pays for the service or care.

**PARTICIPANT**

Participant shall mean an Employee who satisfies the eligibility and participation requirements specified in this document and is enrolled in the Plan.

**PLAN**

Plan shall mean H & S Swansons' Tool Company Flexible Benefit Plan as set forth in this document.

**PLAN YEAR**

Plan Year shall mean a period of twelve (12) consecutive months, commencing January 1<sup>st</sup> and ending December 31<sup>st</sup>.

**SPOUSE**

Spouse shall mean the legally recognized marital partner of an Employee.

**SUMMARY PLAN DESCRIPTION**

Summary Plan Description shall mean this written description of benefits provided through the Employer's Flexible Benefit Plan.

## XII. PLAN IDENTIFICATION

Name of Plan: H & S Swansons' Tool Company  
Flexible Benefit Plan

Name and Address of Plan Sponsor: H & S Swansons' Tool Company  
9000 68 Street N.  
Pinellas Park, FL 33782  
Telephone: 727-388-0704

Claims Administrator: H & S Swansons' Tool Company  
9000 68 Street N.  
Pinellas Park, FL 33782  
Telephone: 727-388-0704

Sponsor Identification Number: 36-2248023

Plan Number: 501

Type of Plan: The Plan is a cafeteria (fringe benefit plan) as  
defined by IRC Section 125 and a health (welfare  
benefit plan) under ERISA.

Type of Plan Administration: Self-Funded & Self-Administered

Plan Administrator/  
Agent for Legal Process/  
Named Fiduciary: H & S Swansons' Tool Company

Funding of Plan: Contributions are made by the Plan Sponsor  
in accordance with the elections of the  
Eligible Employees.

End of Plan's Fiscal Year: June 30<sup>th</sup>