Health Care Expense Reimbursement Plan

With Rollover of Benefits

Summary Plan Description

Prepared For

LTX, INC.

A Long Term Health Care Cost Containment Strategy

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INTRODUCTION

LTX, Inc. (hereinafter referred to as the "Company") has adopted a health reimbursement arrangement known as the LTX, Inc. Medical Care Expense Reimbursement Plan (hereinafter referred to as the “Plan" and/or “medical reimbursement plan”) on January 1, 2009. The Company has its principal place of business and corporate offices at 1515 Industrial Drive NW, Rochester, MN 55901. The Company intends the Plan to qualify as a medical reimbursement plan within the meaning of IRC Sections 104, 105, 106, 3401, 3301 and 3121 and any other applicable provisions of the Internal Revenue Code of 1986, as amended (hereinafter referred to as the "Code") and to meet the applicable requirements of the Employee Retirement Income Security Act of 1974, as amended (hereinafter referred to as "ERISA"). The Plan has an effective date of January 1, 2009 and each Plan year ends on December 31.

I. DEFINITIONS

Whenever used in the Plan, the following words and phrases shall have the meanings set forth below, unless the context plainly requires a different meaning.

Administrator: Unless otherwise expressly provided by a duly authorized resolution, the Plan Administrator is the Employer. The Administrator shall have all the rights duties and obligations of a Fiduciary under the provisions of ERISA. The Administrator shall act as the Plan’s agent for service of process.

Anniversary Date: Anniversary Date shall mean the day and month chosen by the Plan Administrator to begin a new Plan Year and the same day and month of each succeeding year thereafter.

Benefits: Benefits means the amounts paid to reimburse Claims for Qualified Expenses up to the Employer Contribution.

Change in Status: A Change in Status shall occur upon any one or more of the following events:

(a) A Participant's marriage or divorce;

(b) Birth or adoption of a child of a Participant;

(c) Death of a spouse or dependent of a Participant;

(d) Termination of a Participant's employment with the Employer;

(e) Commencement or termination of employment of a Participant's spouse with the Employer;

(f) Change by a Participant or a Participant's spouse from full-time to part-time work status or vice-versa with the Employer;

(g) Taking of an unpaid leave of absence from employment with the Employer by a Participant or a Participant's spouse.

Claim: Claim shall mean an application filed for a reimbursable amount paid by a Participant or an eligible beneficiary for benefits provided by the Plan.

Claimant: A Claimant is a Participant or Eligible Dependent who files a Claim**.**

COBRA: The applicable provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) appear in Section VII.

Code: Code shall mean the Internal Revenue Code of 1986, as amended, or any successor statute(s) thereto.

Compensation: Compensation shall mean a Participant's total salary, wages, bonuses, pay for overtime, vacation pay, sick pay, pay for shift differentials and other cash compensation paid by the Employer to a Participant but excluding reimbursed expenses, credits, or benefits under any plan of deferred compensation to which the Employer contributes and any additional compensation in a form other than cash.

Dependent: Dependent shall mean the same as identified in the LTX, Incorporated Medical Benefit Plan Summary Plan Description (SPD).

Eligible Dependent: Eligible Dependent shall mean the same as identified in the LTX, Incorporated Medical Benefit Plan Summary Plan Description (SPD).

Employee: Employee means any individual working for the Employer as follows:

a. A full-time Employee of the Employer is an individual who completes a year of service within the Plan Year or who has completed 90 days of service before the Effective Date.

b. A part-time or seasonal Employee of the Employer is an individual who does not complete a year of service within the Plan Year.

Employer: Employer shall mean LTX, Inc. and those entity(ies) under common ownership with the Employer within the meaning of Section 414 of the Code, as amended, or any successor, or those additional entity(ies) listed in the Plan Adoption Agreement. For purposes of the Plan, successor means any transferee of the Employer's business who elects to continue the Plan.

Employer Contribution: Employer Contribution means the amount of Plan Benefits payable for Claims for Qualified Expenses, which the Employer establishes at the beginning of each Plan Year for each Participating Employee classification.

Entry Date: Entry Date shall mean the Effective Date and the first funding date an Employee becomes eligible for Benefits.

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

Fiduciary: Fiduciary shall have the meaning assigned to it by ERISA, as amended, and by applicable regulations and judicial precedent.

FMLA: The Family Medical Leave Act (FMLA) shall apply under certain conditions, more fully set forth herein, upon a leave of absence by the Employee.

Hour of Service: Hour of service shall mean each hour for which the Employer directly or indirectly compensates an individual for performing duties for the Employer and for reasons other than the performance of duties. "Hour of service" also, shall include any

hour for which the Employer is awarding or agreeing to back pay. An individual will not receive credit for more than five hundred and one (501) hours of service for any single continuous period during which the individual receives compensation from the Employer, but is not performing duties for the Employer due to vacation, holiday, illness, incapacity, layoff, jury duty, military duty or leave of absence. Notwithstanding the preceding provisions, an individual shall not receive credit for any hour of service attributable to payments from a plan for workmen's compensation, unemployment compensation, disability benefits or medical reimbursements.

Participant: Participant shall mean an individual who is an Employee on or after the Effective Date and who satisfies the eligibility and participation requirements of Articles II and III.

Plan: Plan means the LTX, Inc. Medical Care Expense Reimbursement Plan set forth in this Summary Description, as amended from time to time.

Plan Year: A Plan Year is the one-year period from one Anniversary Date to the next. The initial Plan Year can also be a Short Plan Year. The normal full one-year Plan Year shall mean the period beginning on January 1 and ending on December 31 of each year.

Qualified Expenses. Qualified Expenses are the "Medical Care" expenses defined by Section 213(d) of the Code that are incurred by Participating Employee and Participating Dependents, except that Qualified Expenses do not include: (i) premium (or premium-equivalent) paid pre-tax pursuant to a salary reduction election under Section 125 of the Code or otherwise is not a Qualified Expense; (ii) amounts to which the Participating Employee is otherwise entitled; (iii) amounts that could be and have been reimbursed by any other employer-sponsored accident and health plan; (iv) amounts determined not to meet the definition of medical care expenses under Section 213(d); and (v) amount in excess of the actual amount determined to be Qualified Expenses, as provided for in Treasury Regulation 1.105-2.

"Medical Care" as defined by section (213)(d) of the Code means amounts paid—

a. for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, and

b. for transportation primarily for and essential to medical care referred to in subparagraph (a), and

c. for insurance … covering medical care referred to in subparagraphs (a), the premium (or premium-equivalent) for which is not paid pre-tax pursuant to a salary reduction election under Section 125 of the Code or otherwise.

QMCSO: The Plan Administrator shall comply with all Qualified Medical Child Support Orders (QMCSO) as more fully set forth herein.

Regulations: Regulations shall mean the written determinations of the Secretary of the United States Treasury Department pursuant to Section 7805 of the Code or of the Secretary of the United States Department of Labor pursuant to ERISA.

Year of Service: Year of Service means a consecutive twelve (12) month period ending on December 31, during which an Employee has not less than the company specified number hours of service with the Employer.

II. ELIGIBILITY

Eligibility of the Plan is the same as identified in the LTX, Incorporated Medical Benefit Plan Summary Plan Description (SPD).

III. PARTICIPATION

Each Employee who meets the requirements to be an Eligible Employee shall become a Participant. The Employer shall give written notice to the Employee of his/her participation in the Plan and of the Benefits provided hereunder. Status as a Participant automatically entitles his/her eligible dependent(s) to participate under the Plan. Each eligible full time Employee hired after the Effective Date shall become a Participant on the first Entry Date after he/she has met the eligibility requirements with the Employer. The Plan Administrator shall furnish a Participant with a Summary Plan Description (SPD) containing the information required by ERISA within ninety (90) days after he/she becomes a Participant in the Plan.

Participation in the Plan shall cease upon an Employee's termination of employment with the Employer for any reason, unless continuation of coverage under COBRA is elected. Upon termination of a Participant's employment with the Employer or any other change in status, the Plan Administrator shall determine the extent, if any, to which a change in Benefits shall occur. Except as otherwise provided in the Plan, if a Participant shall terminate his/her employment with the Employer, such Participant (and/or his/her Eligible Dependent(s)) shall forfeit all rights to Benefits, unless any one or more of such eligible beneficiary(ies) shall remain a Participant in the Plan. If a cessation of Benefits shall occur upon a change in status, such Participant (and his/her Eligible Dependent(s)), however, shall retain the right to reimbursement for Claims incurred prior to the termination of the Participant's employment with the Employer. For this purpose, a Claim will arise upon the rendition of the products or services relating to such Claim.

As an eligible Participant in the Plan, you will be provided with a medical reimbursement for the sole purpose of reimbursing eligible out of pocket health care related expenses that you and your eligible Dependents have incurred and have not been reimbursed from any other source. It is your responsibility to notify the Plan Administrator if you do not utilize the reimbursement for the stated purpose.

IV. CONTRIBUTIONS

Employer Contributions: The Employer will make sufficient contributions to the Plan from time to time to meet the Benefits as provided in Article V and as otherwise provided hereunder. The contributions will comply with the requirements of ERISA, the Code, applicable regulations and judicial precedent. Amounts vary based on your Employee / Participant classification. Amounts are established at the beginning of each Plan Year and may change year to year. Please see your Plan Administrator for amounts applicable to your specific Employee / Participant classification.

Payment: The Employer shall make its contributions during or after the close of its taxable year, but in no event beyond such time as the Code, as amended, or any successive statute or applicable treasury regulations thereunder may allow qualifying such contributions for deduction by the Employer under the provisions of the Code.

Liability: Except as provided herein, any other party providing services to or for the Employer or Plan Administrator shall have no liability for the payment of Benefits hereunder, and the Participants and their Eligible Dependent(s) must look solely to the unencumbered assets of the Employer for their Benefits under the Plan. The Employer shall satisfy all Claims, certified by the Plan Administrator, to Plan Benefits in the order of their receipt.

V. BENEFITS

Reimbursement: Except as otherwise provided herein, the Employer shall pay to each Participant and/or his/her Eligible Dependent(s) such amounts as he or she has expended for health care related expenses for himself or herself subject to the applicable provisions of this Summary Plan Description. However, the Plan shall not pay, reimburse or otherwise duplicate any Claim for Benefits under any insurance policy or other plan that covers a Participant or his/her Eligible Dependent(s).

As an eligible Participant in the Plan, you will be provided with a medical reimbursement for the sole purpose of reimbursing eligible out of pocket health care related expenses that you and your Eligible Dependents have incurred and have not been reimbursed from any other source. It is your responsibility to notify the Plan Administrator if you do not utilize the reimbursement for the stated purpose. Unused amounts in your account will accrue from year to year. Your Employer's intention is to leave any unused funds at year end in your account in total but these amounts are legally susceptible to the Employer's sole discretion and may be revised prior to the commencement of each new Plan Year. Qualified Expenses incurred but not paid from prior years may be eligible for reimbursement at the employer's sole discretion and may be revised prior to the commencement of each new Plan Year. No interest may be earned on unused balances.

Coverage: For purposes of the Plan, Benefits shall be available for reimbursement of the following:

a. Amounts for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, and

b. For hospitalization, medical and dental bills, prescription drugs and eyeglasses; and

c. For transportation primarily for and essential to medical care and

d. For insurance … covering medical care referred to in subparagraphs (a), the premium (or premium-equivalent) for which is not paid pre-tax pursuant to a salary reduction election under Section 125 of the Code or otherwise.

NOTE: This Plan will not reimburse for insurance premiums you paid towards your group health care coverage on a pre-tax basis.

Limitation: No Participant and/or his/her Eligible Dependent(s) shall receive in the aggregate more than the maximum amount of reimbursement as defined on a year to year basis by the Plan Administrator / Plan Sponsor under this Plan except if stated in a separate Addendum.

Payment of Benefits in Conjunction with Flexible Spending Accounts: If you are currently enrolled in a flexible spending account under your Employer Cafeteria Plan, your medical care claims will be paid from funds available in your Flexible Spending Account first. Once your flexible spending account funds have been exhausted any portion of your remaining unpaid claims will be paid from funds made available from the Plan in your account.

QMCSO: If a court of competent jurisdiction or administrative agency issues a judgment, decree or order which provides for child support or health benefit coverage pursuant to a state's domestic relations law or other statute, the Plan Administrator shall comply with such holding as long as the QMSCO does not require the Plan to provide any type or form of benefit, or any option, not otherwise expressly provided in the Plan except to the extent necessary to comply with federal law. The Plan Administrator shall provide all interested parties with its written procedures for determining and administering a QMCSO promptly under receipt of any QMCSO.

VI. ADMINISTRATION OF THE PLAN

The Employer currently acts as the Plan Administrator. The Employer may appoint a third party as Plan Administrator to administer the Plan. The Plan Administrator shall act also as the Plan's agent for service of legal process. The Plan Administrator and any other agents appointed by the Employer shall keep the books and records of the Plan on the accrual method of accounting.

The Plan Administrator will maintain its principal address at 1515 Industrial Drive NW, Rochester, MN 55901 with a business telephone number of (800) 328-7224. The laws of the State of Minnesota shall control the interpretation of the provisions of the Plan except to the extent that the laws of the United States preempt the state laws.

The establishment or maintenance of the Plan shall not create any rights and interests in any Participant or Dependent(s) against the Employer beyond the contributions actually paid or payable by the Employer. The Plan shall not be liable for the debts of any Participant or Dependent. No Participant or Dependent can assign or otherwise encumber voluntarily or involuntarily any Benefits due to him/her under the Plan.

The Plan Administrator will adopt rules and employ agents to assist it in its duties. Its duties include but are not limited to:

a. Interpreting and enforcing the provisions of the Plan for the exclusive benefit of the Participants and without discrimination among similarly situated Participants.

b. Determining all questions relating to Qualified Expenses, Benefits and other Plan rights of Participants and Eligible Dependent(s).

c. Establishing rules for the administration of the Plan and to prescribe any forms required to administer the Plan.

d. Determining the eligibility of employees to participate in the Plan.

e. Notifying eligible employees of their right to participate in the Plan.

f. Filing all necessary government reports.

g. Complying with a QMCSO.

h. Performing all other acts necessary to satisfy its obligations under the Plan.

All decisions and determinations of the Plan Administrator that are not consistent with the specific provisions of this Plan shall be binding and conclusive on all persons, firms, associations and corporations.

VII. CLAIMS PROCEDURE

Claim Submission: A Claimant may submit a Claim to the Plan Administrator at any time by the following methods:

a. Electronically via the internet: The Claimant may submit a claim paid via his/her Employer provided debit card account. These amounts will be automatically deducted from the Claimant's account.

b. Manually via Expense Reimbursement Request Form: The Claimant may submit a manual claim form provided by the Plan Administrator along with any other evidence and supporting documents the Plan Administrator may require to substantiate the Claim.

In order for a claim to be considered for payment the Claim must be submitted to the Plan Administrator no later than 30 days following the end of the Plan Year. Claims incurred during the previous Plan Year can be considered for reimbursement based on the available roll over balances of the employee account.

No Participating Employee and/or his/her Eligible Dependent(s) shall receive more than the aggregate Employer Contribution for Claims for Qualified Expenses incurred and paid within any one Plan Year plus the remaining carryover balance from prior years contributions. If the Plan Year is a short Plan Year (less then twelve (12) months) then the maximum benefits payable for Qualified Expenses are limited to the Employers prorated Contribution for the proportionate part of a full Plan Year plus any carryover balances of the employee account.

You as the Participating Employee are solely responsible for using the Benefits provided to you to pay for Qualified Expenses for yourself and your Eligible Dependent(s).

You as the Participating Employee are solely responsible for obtaining, maintaining and submitting third party verification of the dates, amounts and name of providers of Qualified Expenses that you and or your Eligible Dependent(s) have incurred.

The Plan Administrator shall furnish to you written notice as to the disposition of your Claim within thirty (30) days after the filing of your Claim application with the Plan Administrator. If the Plan Administrator determines that an extension of time is needed in order to properly give you notice of the disposition of your claim due to matters beyond the control of the Plan, the Plan Administrator can extend the reporting period by fifteen (15) days.

The Plan Administrator must notify you of the circumstances requiring the extension of time and provide you with a date by which the Plan expects to render a decision.

If such an extension results from your failure to submit the necessary information that is required in order to decide if the expenses you incurred are Qualified Expenses eligible to be paid as a Claim for Benefits, the notice given to you shall describe specifically the required information that is needed and you shall have forty five (45) days from your receipt of such notice within which to provide the information requested.

Denial of Claim: Any party denied a Claim/Benefit shall receive an appeal of the denial of his Claim upon a written request to the Plan Administrator. If the Claimant wishes further consideration of his position, he may file a written statement of his position with the Plan Administrator no later than one hundred eighty (180) days after receipt of the written notification of the Plan Administrator's disposition of the Claim for Benefits under the Plan. During this review procedure, the Plan Administrator shall provide the Claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Claimant's request for Benefits. The Plan Administrator shall schedule an opportunity for a full and fair hearing of the issue within thirty (30) days of the receipt of the written request for the hearing. A Plan Fiduciary (other than the Plan Administrator) shall make a decision within thirty (30) days of the hearing and shall communicate its decision in writing to the Claimant. This rehearing shall consider all relevant information whether the Claimant submitted such information or the Plan Administrator considered such information in the initial benefit determination. The rehearing shall identify any rules, guidelines or similar criterion or any medical or vocational experts whose advice the Plan obtained or relied upon in connection with a Claimant's adverse Benefit determination. If the rehearing still results in an adverse benefit determination, Claimant may have the right to bring an action in Federal Court pursuant to Section 502(a) of ERISA.

Reconciliation of Non-Qualified Expenses and Excess Reimbursement(s): If the Plan Administrator determines that any amount(s) paid to a Participant or his/her Eligible Dependent(s) were for non-Qualified Expenses and/or were in excess of Qualified Expenses, then the Employee is obligated to repay the Plan the erroneous or excess amounts the earlier of:

a. 90 days after the end of the Plan Year in which the Claim was incurred, or

b. The termination of employment

The Plan Administrator shall take the following steps to obtain repayment to the Plan in the amount of the erroneous or excessive reimbursement(s) to the Plan:

a. Make a written demand of the Employee to repay the Plan with cash or the equivalent of cash.

b. If the Employee fails to do so, withhold the repayment from the Employee’s compensation to the extent consistent with applicable law.

c. If it is impossible to withhold repayment from compensation, use the amount of future Claims for Qualified Expenses to offset the amount until repayment is made.

d. If all of the foregoing efforts prove unsuccessful or are otherwise unavailable, the amount will be treated as any other business indebtedness.

VIII. COBRA COVERAGE

Coverage: COBRA Coverage is only available to Employees of a Company with more then 20 full time employees. If your Employer has more then 20 full time employees then this Plan must also include COBRA coverage for your benefit.

Qualifying Events: The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides that when a Participant (a) terminates employment for any reason other than gross misconduct with the Employer; (b) dies, divorces or legally separates; (c) changes from full-time to part-time work or vice-versa with the Employer; (d) loses a dependency; (e) qualifies for medicare; or (f) takes an unpaid leave of absence from employment with the Employer (hereinafter individually and collectively a qualifying event(s)), the Participant, his spouse and/or dependent child(ren) may elect to continue in the Plan for eighteen (18) months after the qualifying event(s) by paying timely in monthly installments the Employer's cost of coverage plus an administrative fee for the continuation of benefits under the Plan.

The following schedule delineates the events that would cause the loss of the Benefits of the Plan and the individuals who qualify for the COBRA benefits upon such events:

Qualifying Event	Employee	Spouse	Dependent Child(ren)
(a) Voluntary or involuntary termination of employment for reasons other than gross misconduct	X	X	X
(b) Reduction in the hours of employment	X	X	X
(c) Covered employee's entitlement to Medicare	X	X	
(d) Divorce or legal separation of a covered employee	X	X	
(e) Death of a covered employee	X	X	
(f) Loss of status as a dependent child			X

Election: The election period will not end any sooner than sixty (60) days after the later of (1) the date upon which the Participant could lose coverage on account of the qualifying event(s); or (2) the date of the notice from the Plan Administrator to the Participant of his/her right to elect COBRA continuation coverage. The election will take effect on the date that the Participant sends it to the Plan Administrator. In general, the employer must determine when a qualifying event has occurred. However, each Eligible Employee or Dependent must notify the Plan Administrator of a divorce, legal separation or cessation of dependency within sixty (60) days of any such qualifying event(s).

Contributions During COBRA Continuation: If during the continuation period, the Employer makes contributions on behalf of similarly situated Employees who have not experienced a qualifying event, contributions shall be required to be made to the account of an Employee electing COBRA coverage. Contributions will be made at the same

times as they are made for similarly situated Employees who have not experienced a qualifying event.

If during the continuation period, the employer makes no contributions on behalf of similarly situated Employees who have not experienced a qualifying event, no contributions shall be required to be made to the account of an Employee electing COBRA coverage.

Example: If contributions are available only if covered by a particular group health plan (i.e., a high deductible major medical plan) and the Employee elects not to continue coverage under the group health plan, no contributions would be made to similarly situated employees and, therefore, no contributions would be made for the Employee electing COBRA.

COBRA Premiums: The Employee and other Eligible Dependent(s) electing COBRA coverage (hereinafter referred to collectively as the "COBRA participants") shall be jointly responsible for paying an aggregate monthly premium. The premium shall be an estimate of the cost of providing coverage to participants that have not experienced a qualifying event, plus a 2% administrative fee.

The monthly premium will be calculated as follows:

a. Estimate the contributions to the Plan and administrative costs to the Plan on a per-participant basis for the determination period (i.e., the Plan Year) and divide by twelve; and

b. Add the 2% administrative fee to the estimated monthly cost.

If the COBRA premium payment is not made, in whole or in part, COBRA coverage for all COBRA participants, with respect to both the receipt of contributions and access to the account, shall, in accordance with the requirements of COBRA, terminate effective the date through which the last premium was paid.

If no ongoing contributions are to be made during the COBRA continuation period (in accordance with paragraph two under Contributions During COBRA Continuation above) then no premium shall be charged to the COBRA participants.

Access to the HRA Account: The maximum reimbursement available to any COBRA participant shall be the balance of the participant's account at the time the claim is processed for payment. The balance of the account will be adjusted from time to time for ongoing contributions, if any, accepted claims of any COBRA participant and administrative fees chargeable to the participant's account, if any.

Eligible expenses shall continue to include Qualified Expenses incurred by the Participant, the Participant's spouse and Eligible Dependent(s) regardless of whether the spouse and dependents have elected COBRA continuation coverage. Where the definition of Qualified Expense depends on the Participant's employment, the more generous definition of Qualified Expense, typically the definition for former employees, shall apply.

Coverage in Lieu of COBRA Coverage: In accordance with the HRA guidance issued by the Internal Revenue Service, as an alternative to and in lieu of COBRA coverage, the Participant and each other Eligible Dependent(s) may elect to continue to participate for

the sole purpose of spending down the Participant's HRA account. For the Participant, such access shall be provided until the earlier of: (1) the date account balance reaches zero, (2) the date of the Participant's death. For a spouse of a Participant, such access shall be provided until the earlier of: (1) the date account balance reaches zero, (2) the date of the Participant's death, or (3) the date of the entry of a valid divorce decree. For an Eligible Dependent of the Participant, such access shall be provided until the earlier of: (1) the date account balance reaches zero, (2) the date of the Participant's death, or (3) the date the dependent ceases to be a dependent under the terms of the Plan.

Unless specifically included as part of the alternative to COBRA coverage, no additional contributions will be made to the Participant's account during the period of coverage provided in lieu of COBRA.

Eligible expenses shall continue to include Qualified Expenses incurred by the Participant, the Participant's spouse and Eligible Dependent(s) regardless of whether the spouse and dependents elect COBRA continuation coverage or the coverage in lieu of COBRA. Where the definition of Qualified Expense depends on the participant's employment, the more generous definition of Qualified Expense, typically the definition for former employees, shall apply.

If a second qualifying event occurs during the coverage in lieu of COBRA (i.e., the Participant's death, a divorce or a child ceasing to be an Eligible Dependent), COBRA coverage with respect to the coverage in lieu of COBRA will be offered to the Participant's spouse and/or Eligible Dependents measured from the date of the second qualifying event.

If some Eligible Dependents elect COBRA coverage and others elect coverage in lieu of COBRA, the COBRA participants shall be charged the aggregate COBRA premium, if any, and all covered individuals (the COBRA participants and those electing coverage in lieu of COBRA) shall be entitled to access the Participant's account, including ongoing contributions, if any, on an aggregate basis.

Termination of COBRA: COBRA coverage will cease prior to the scheduled termination date upon any one of the following events: (a) the Participant's failure to make timely notification or to make payments for COBRA coverage; (b) the termination of the Plan; (c) the Participant's enrollment in another employer's group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such Participant; or (d) the Participant's entitlement to Medicare benefits. Notwithstanding the preceding provisions, if a Participant, eligible for COBRA coverage, obtains coverage under Medicare or any other group health plan prior to the COBRA election, the Plan may not discontinue the COBRA coverage. An Eligible Participant or Dependent can revoke a waiver of COBRA coverage before the end of the election period. If an Eligible Participant or Dependent does not elect COBRA coverage, any other eligible individual may elect COBRA coverage nonetheless.

Contact your Plan Administrator for additional details regarding your rights under COBRA.

IX. FMLA COVERAGE

Certain Participants on an unpaid or paid leave of absence qualify for continued coverage under the Plan pursuant to the Family Medical Leave Act (FMLA). The Employer may not change any administrative fee for FMLA coverage. If a Participant, eligible for FMLA coverage, terminates his/her employment with the Employer during or after his/her FMLA leave, COBRA coverage may apply to said Participant.

FMLA applies to any Employee of any Employer with at least fifty (50) employees during at least twenty (20) calendar weeks in the current or preceding calendar year, as long as the Employee has worked for the Employer for at least twelve (12) months and as long as the Employee works at a location within no more than seventy five (75) miles of the Employer's other Employees, and as long as the Employee has worked at least one thousand two hundred fifty (1,250) hours during the twelve (12) months prior to the start of the FMLA leave.

Contact your Plan Administrator for additional details regarding your rights under FMLA.

X. AMENDMENT AND TERMINATION

The Employer can make amendments retroactively, unless the amendments directly or indirectly give the Employer any prohibited interest in the Plan or adversely affect employee benefits. The Employer nonetheless shall make any amendments required by the Code or ERISA. The Employer will make no amendments which result in a diversion of income or corpus from the participants or beneficiaries. If any modification to the Plan would result in a material reduction in covered services or Benefits, the Plan Administrator shall furnish to each Participant, a summary of any such modification, or change within sixty (60) days after the date of adoption of the modification or change. A "material reduction in covered services or Benefits" means any modification to the Plan or change in the Plan's Summary Description that, independently or in conjunction with other contemporaneous modifications or changes, would constitute an important reduction in covered services or Benefits to the average Participant under the Plan.

While the Employer expects to continue the Plan, it reserves the right to terminate the Plan at any time by a duly authorized resolution. The Plan will terminate on the earliest of the following dates:

a. The date of a judicial declaration of the bankruptcy or insolvency of the Employer;

b. The date of permanent discontinuance by the Employer of its contributions under the Plan; or

c. The date of a dissolution, merger, consolidation, reorganization or sale of all or substantially all of the Employer's assets. Subject to the provisions of the Plan, the successor or purchaser may provide for the continuation of the Plan and replace the Employer under the Plan.

The Employer can terminate the Plan by a written notice to the Plan Administrator and the participants. The Plan shall terminate automatically on the liquidation of the Employer, its bankruptcy, discontinuance of its business, merger, consolidation,

reorganization or sale of substantially all the assets of the Employer, unless a successor corporation adopts the Plan. If a successor corporation adopts the Plan, the Participants' Benefits must equal or exceed the Benefits under the existing Plan.

XI. RIGHTS AND PROTECTIONS

As a Participant in the Plan, ERISA provides you with certain rights and protections. ERISA provides that all Plan Participants shall receive information about the Plan and its benefits, including the right to:

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including any insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series, if applicable) filed by the Plan with the U.S.Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series, if applicable) and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.

c. Receive a summary of the Plan's annual financial report. ERISA requires the Plan Administrator to furnish each Participant with a copy of this summary annual report.

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

If the Plan Administrator ignores or denies your Claim for a medical reimbursement, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan denies or ignores your Claim for Benefits in whole or in part, you may file suit in a state or Federal court. If the Plan's Fiduciaries misuse the Plan’s money or if the Plan discriminates against you 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 you are successful, the court may order the person that you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Employer's health reimbursement arrangement, 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 Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

This document summarizes the most important provisions of the Plan. The provisions of the Plan supersede this Summary Description to the extent of any inconsistencies. Employees may inspect a complete copy of the Plan in the Employer's offices at 1515 Industrial Drive NW, Rochester, MN 55901 from 9:00 A.M. to 5:00 P.M. on any working day. A representative of the Employer will provide additional information to any Participant upon request. The Employer's federal identification number is 41-0908878.