Iwaki America, Inc.
Dental Reimbursement Arrangement (DRA) 105 Plan

January 1 Through December 31

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ATTACHMENT ONE A-1

PREAMBLE

The Employer identified in the Appendix has established the Dental Reimbursement Arrangement 105 plan (the "Plan") for its Employees for purposes of reimbursing eligible Employees of the Employer for the cost of certain Eligible Dental Expenses incurred by them, their Spouses and eligible Dependents. It is intended that the Plan meet the requirements for qualification under Internal Revenue Code Sec. 106, and that benefits paid to employees hereunder be excludable from their gross incomes by virtue of Internal Revenue Code Sec. 105(b).

DENTAL REIMBURSEMENT ARRANGEMENT (DRA) 105 PLAN

ARTICLE I
DEFINITIONS

1.01 "Affiliated Employer" means any employers who, within the context of Code Section 414(b), (c), or (m) of the Code, will be considered with the Employer as a single employer for purposes of Code Section 105.

1.02 "Anniversary Date" means the first day of any Plan Year.

1.03 "Benefits" means any amounts paid to a Participant in the Plan under the terms and conditions set forth herein as reimbursement for Eligible Medical Dental Expenses incurred during a Plan Year by a Participant, his Spouse and/or his Dependents.

1.04 "Board of Directors" means the Board of Directors of the Employer or other governing body. The Board of Directors, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

1.05 "Code" means the Internal Revenue Code of 1986, as amended.

1.06 "Dependent" means any individual who satisfies the conditions set forth in the Summary Plan Description.

1.07 "Effective Date" of this Plan means the effective date set forth in the Summary Plan Description.

1.08 "Eligible Medical Expenses" means those expenses incurred by the Participant, or the Participant's Spouse or Dependents that satisfy the conditions set forth in the Summary Plan Description.

1.09 "Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any leased employee (including, but not limited to, those individuals defined in Code § 414(n)), or an individual classified by the Employer as a contract worker or independent contractor, temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll or any

individual who performs services for the Employer but who is paid by a temporary or other employment agency.

1.10 "Employer" means the Employer specified in the Appendix to the attached Summary Plan Description and any Affiliate of the Employer that adopts the Plan with the consent of the Employer, provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third party administrator, or amendment or termination of the plan) the term "Employer" shall mean only the Employer identified in the Appendix to the attached Summary Plan Description. Affiliates who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

1.11 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.12 "FMLA" means the Family and Medical Leave Act of 1993, as amended from time to time.

1.13 "FMLA Leave" means a leave or absence that the Employer is required to extend to an Employee under the provisions of the FMLA.

1.14 "**Group Dental Plan"** means the group dental plan(s) established by the Employer and identified in the Summary Plan Description.

1.15 "Highly Compensated Individual" means an individual defined under Code Section 105(h), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.16 "Participant" means an Employee who becomes covered by the Plan in accordance with Article II herein.

1.17 "Plan" means this self-insured dental reimbursement plan set forth herein and described in the Summary Plan Description.

1.18 "Plan Administrator" or "Committee" means the person(s) appointed by the Employer with authority and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

1.19 "Plan Year" means the period of coverage for this Plan as specified in the Appendix.

1.20 "Spouse" means an individual who satisfies the definition of a Spouse as set forth in the Summary Plan Description.

1.21 "Summary Plan Description" means the dental Reimbursement Arrangement 105 Plan Summary Plan Description and Appendix adopted by the Employer and attached to this Plan Document as Attachment 1, as amended from time to time. The Summary Plan Description and Appendix are incorporated hereto by reference.

1.22 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

2.01 Eligibility to Participate. Each Employee who satisfies the eligibility conditions set forth in the Summary Plan Description shall be eligible to participate in this Plan.

2.02 Termination of Participation. Participation shall terminate as of the dates set forth in the Summary Plan Description. Except as provided in Article V below, the Participant shall not be entitled to reimbursement for other Eligible Dental Expenses incurred after coverage ceases under this Plan. To the extent required under USERRA and FMLA, participation in the Plan shall resume for a former participant whose coverage ended as a result of a qualified leave under FMLA or USERRA.

2.03 FMLA Leave and USERRA Leave. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA (with respect to leaves of 30 days or less), then to the extent required by the FMLA or USERRA, the Employer will continue to maintain the Participant's coverage under this Plan on the same terms and conditions set forth in the Summary Plan Description as if the Participant were still an active Employee.

ARTICLE III
BENEFITS UNDER THE PLAN

3.01 Annual Benefits Provided by the Plan. The Plan will reimburse Participants each Plan Year for Eligible Dental Expenses up to the maximum annual reimbursement amount set forth in the Summary Plan Description, subject to any other limitations set forth in the Summary Plan Description (such as a monthly reimbursement limitation to the extent permitted under applicable law).

3.02 Direct Benefit Payments. Employer may, in its discretion, pay any or all of the Eligible Dental Expenses directly to the dental care provider in lieu of making reimbursement thereof. In such event, Employer shall be relieved of all further responsibility with respect to that particular medical expense.

3.03 Cost of Coverage. The Employer shall fund coverage provided hereunder from its general assets.

ARTICLE IV
PAYMENT OF BENEFITS

4.01 Claim For Benefits. No benefit shall be paid hereunder unless a Participant has first submitted a written claim for benefits in accordance with the procedures set forth in Section 4.02 and Article VII herein. Upon receipt of a properly documented claim, the Employer shall reimburse the Participant in accordance with the terms of this Plan.

4.02 Required Documentation. Any Participant applying for reimbursement under this Plan shall submit to the Claims Administrator all documentation required to be provided as set forth in the Summary Plan Description. A failure to comply with such requirements may, at the discretion of Plan Administrator, terminate any such participant's right to reimbursement.

4.03 Limitation on Benefits. Reimbursement under this plan shall be made by the Employer only in the event and to the extent that such reimbursement or payment is for an Eligible Dental Expense and has not been reimbursed from or is not otherwise reimbursable from any other source. In the event that there is another source that will provide for reimbursement or payment in whole or in part, then the Employer shall be relieved of any liability hereunder to the extent of coverage under such other source.

4.04 Coordination of Benefits. The Plan is intended to pay benefits solely for otherwise unreimbursed Eligible Dental Expenses. To the extent the otherwise Eligible Dental Expense is payable or reimbursable from another source, the other source shall pay or reimburse prior to payment or reimbursement from this Plan. Notwithstanding the preceding sentence, the Plan Administrator may require that a Dental Flexible Spending Arrangement or “Dental FSA” (as defined in the proposed Code Section 125 regulations) contributed to solely with employee pre-tax salary reductions to reimburse or pay prior to reimbursement or payment under this Plan with respect to Eligible Dental Expenses covered both by this Plan and the Dental FSA. If a Dental FSA is required to pay or reimburse before payment or reimbursement from this Plan, it will be set forth in the Summary Plan Description.

ARTICLE V
CONTINUATION COVERAGE UNDER COBRA and USERRA

The following provisions shall be applicable to the Plan. The intent of this Article is to extend continuation rights required by COBRA and by USERRA with respect to certain military leaves of absence. To the extent greater rights are required by USERRA and/or COBRA, this article is void.

5.01 Continuation Coverage after Termination of Normal Participation. During any Plan Year during which the Employer is subject to Code Section 4980B (COBRA) or 38 U.S.C. Section 4301 et seq. (USERRA), each person who is a Qualified Beneficiary described in Section 5.02 herein shall have the right to elect to continue coverage under the Plan upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage hereunder. Such extended coverage under the plan is known as "Continuation Coverage."

5.02 Qualified Beneficiary. A "Qualified Beneficiary" is any person who is covered by the Plan immediately preceding a Qualifying Event described in Section 5.04 herein and is (a) an Employee of the Employer (such persons are called "Covered Employees"), (b) the Spouse of the Covered Employee, or (c) a Dependent child of the Covered Employee. A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours of the Covered Employee's employment. A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment will be treated as a "Qualified Beneficiary".

5.03 Qualifying Event. Any of the following shall be considered as a "Qualifying Event":

(a) death of a Covered Employee;

(b) termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment;

(c) divorce or legal separation of a Covered Employee from the employee's Spouse;

(d) a Covered Employee's becoming eligible to receive Medicare benefits under Title XVIII of the Social Security Act;

(e) a dependent child of a Covered Employee ceasing to be a Dependent; or

(f) commencing a military leave of absence qualified under USERRA that is expected to continue longer than 30 days.

5.04 Benefit Available under Continuation Coverage. Each person who is eligible to elect to continue coverage in accordance with this Article V shall have the right to continue the level of coverage in effect on the day before the Qualifying Event; however, in the event that such coverage is modified for all similarly situated non-COBRA Participants prior to the date Continuation Coverage is elected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly situated non-COBRA Participants. At the beginning of each Plan Year, the Qualified Beneficiary shall be eligible for the maximum annual reimbursement amount (plus any unused reimbursement amounts from the previous year to the extent set forth in the attached Summary Plan Description) that is made available to similarly situated non-COBRA beneficiaries (described in Section 2.01 herein) provided that you pay the applicable premium. A premium for Continuation Coverage shall be charged to Employees and Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by applicable law.

5.05 Notice Requirements.

(a) When an Employee becomes covered under this Plan, the Plan Administrator must inform the Participant (and spouse, if any) in writing of the rights to continued coverage, as described in Article XI.

(b) The Employer shall give the Plan Administrator (if different from the Employer) written notice of a Qualifying Event within thirty (30) days of the occurrence thereof.

(c) Within fourteen (14) days of receipt of the Employer's notice, the Plan Administrator shall furnish each Qualifying Beneficiary with written notification of the termination of regular coverage under the Plan (or any other group dental plan subject to COBRA), as well as a recital of the rights of any such Beneficiary to elect Continuation Coverage, as required by Code Sec. 4980B and ERISA § 601, in accordance with the terms of this Plan.

(d) In the case of a Qualifying Event described in Section 5.04(c) or (e), a Covered Employee or a Qualified Beneficiary who is a Spouse or Dependent of such Employee must notify the Plan Administrator within sixty (60) days of the occurrence thereof or the date coverage under the Plan is lost as a result of the event, whichever is later. The Plan Administrator shall give written notification of Continuation Coverage rights to any other affected Qualified Beneficiaries within fourteen (14) days of receipt of the notice described in this Section 5.06(d).

Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a spouse of a Covered Employee is treated as notification to all other Qualified Beneficiaries residing with the Spouse at the time notification is made.

5.06 Election. Any Qualified Beneficiary entitled to Continuation Coverage shall have 60 days from the later of the date of the notice required by Section 5.05 or the date coverage is lost as a result of the Qualifying Event in which to return a signed election form to the Plan Administrator (or the Plan Administrator's designee) indicating the choice to continue benefits under this Plan. To the extent set forth in the Summary Plan Description, a Qualified Beneficiary may be required to elect continuation coverage under the Group Dental Plan in order to obtain continuation coverage under this Plan.

5.07 Duration of Continuation Coverage. Except as otherwise provided in this Plan, Continuation Coverage shall extend for a period of 18 months after the date that regular coverage ceased due to occurrence of the initial Qualifying Event described in Section 5.04(b) and (f), unless during such 18-month period a subsequent Qualifying Event occurs, in which case, another 18 months shall be available to the Beneficiary provided notice of a Qualifying Event described in Section 5.03(c) or (e) is provided to the Plan Administrator prior to the end of the initial 18-month period. Except as otherwise provided in this Section, in the case of a Qualifying Event not described in Section 5.03(b) and (f), Continuation Coverage shall extend for a period of 36 months after the date that regular coverage ceased due to the occurrence of the Qualifying

Event. In the case of a Qualified Beneficiary who is determined, under title II or XVI of the Social Security Act to have been disabled at the time of a Qualifying Event described in Section 5.03(b) or within 60 days of such Qualifying Event, Continuation Coverage with respect to such event shall extend for all Qualified Beneficiaries who elected coverage for a period of 29 months after the date that regular coverage ceased due to the occurrence of the Qualifying Event if notice of such determination is provided to the Plan Administrator within sixty (60) days after the date of such determination and before the end of the initial 18 month Continuation Coverage period. In the event a Covered Employee becomes entitled to Medicare coverage, the period of Continuation Coverage for a Qualified Beneficiary, other than the Covered Employee for such Qualifying Event or any subsequent Qualifying Event, shall not terminate for a period of 36 months from the date the Covered Employee becomes entitled to Medicare benefits. In no event, however, shall Continuation Coverage extend more than 36 months beyond the date of the original Qualifying Event.

5.08 Automatic Termination of Continuation Coverage. Continuation Coverage shall automatically cease if (a) the Employer no longer offers the particular group dental plan to any of its employees, (b) the required premium for Continuation Coverage is not paid within 30 days of the date due or within 45 days after the initial election of Continuation Coverage made pursuant to Section 5.06, (c) an electing Qualified Beneficiary becomes covered under another group dental plan after electing Continuation Coverage to the extent that the Qualified Beneficiary is not subject to a pre-existing condition exclusion or limitation under the other group dental plan (except during the 18 month period following a Qualifying Event described in 5.03(f)), (d) an electing Qualified Beneficiary becomes eligible to receive benefits under Medicare (except during the 18 month period following a Qualifying Event described in 5.03(f)), (e) with respect to a Qualifying Event described in 5.03(f), the date the covered employee fails to return to work in accordance with USERRA.

ARTICLE VI
PLAN ADMINISTRATION

6.01 Allocation of Authority. The Board of Directors (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator may be one individual or a Committee. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;

(d) To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer, insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;

(e) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan;

(f) To keep records of all acts and determinations, and to keep all such records, books of account, data and other documents as may be necessary for the proper administration of the Plan;

(g) To prepare and distribute to all Employees information concerning the Plan and their rights under the Plan;

(h) To do all things necessary to operate and administer the Plan in accordance with its provisions.

6.02 Provision for Third-Party Plan Service Providers. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan and to rely upon all tables, valuations, certificates, reports and opinions furnished thereby. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

6.03 Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

6.04 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an employee of the Employer shall serve without compensation for services rendered in such capacity, but the Employer shall pay all reasonable expenses incurred in the performance of their duties.

6.05 Bonding. Unless otherwise determined by the Employer, or unless required by any Federal or State law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

6.06 Payment of Administrative Expenses. The Employer currently pays all reasonable expenses incurred in administering the Plan.

6.07 Funding Policy. Benefits under the Plan shall be paid from the general assets of the Employer. The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and shall be retained by the Employer.

ARTICLE VII
CLAIMS PROCEDURES

7.01 Denial of Claim. Once a claim has been submitted to the Claims Administrator in accordance with Section 4.01 herein, the Claims Administrator will review it. If the Claims Administrator wholly or partially denies a claim, the Claimant (or his duly authorized representative) will be furnished a notice written in a manner to be understood by the claimant setting forth:

(a) the specific reason or reasons for the denial;

(b) specific reference to pertinent Plan provisions on which the denial is based;

ARTICLE VIII
AMENDMENT OR TERMINATION OF PLAN

8.01 Permanency. While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 8.02 and 8.03, below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

8.02 Employer's Right to Amend. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Plan Administrator in accordance with its normal procedures for transacting business or, if a Committee, by written consent of all Committee members. Such amendments may apply retroactively or prospectively. Any amendment adopted in accordance with Section 8.02 herein shall be deemed to be approved and adopted by any Affiliated Employer.

8.03 Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

8.04 Determination of Effective Date of Amendment or Termination. Any such amendment, discontinuance or termination shall be effective as of such date as the Employer shall determine.

ARTICLE IX
GENERAL PROVISIONS

9.01 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

9.02 Applicable Laws. The provisions of the Plan shall be construed, administered and enforced according to applicable Federal law and the laws of the state of incorporation of the Employer to the extent not preempted.

9.03 Post-Mortem Payments. Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving spouse (if any), otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

9.04 Non alienation of Benefits. Except as expressly provided by the Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

9.05 Mental or Physical Incompetency. Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

9.06 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person under the Plan because he cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited after 90 days after the date any such payment first became due.

9.07 Requirement for Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

9.08 Source of Payments. The Employer and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from

time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

9.09 Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

9.10 Tax Effects. Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any Pre-tax Premiums made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof.

9.11 Gender and Number. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

9.12 Headings. The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

9.13 Incorporation by Reference. The actual terms and conditions of the Group Dental Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

9.14 Severability. Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

9.15 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

9.16 HIPAA Privacy with Respect to Dental Care Reimbursement

(a) The Plan will use protected dental information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Dental Insurance Portability

and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to dental care treatment, payment for dental care as defined in the Privacy Notice distributed to Plan Participants.

The Plan will disclose PHI to the Employer only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions in Subsection b below.

(b) With Respect to PHI, the Employer agrees to certain conditions.
The Employer agrees to:

- Not use or disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- Report to the Plan any PHI use or disclosures provided 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 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 Employer 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).

(c) Adequate separation will be maintained between the Plan and the Employer. Only the individuals identified in the Privacy Notice distributed to Participants in accordance with HIPAA. The persons described in the Privacy Notice may only use and disclose PHI for Plan administration functions that the Employer performs for the Plan. If the persons described herein do not comply with the Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

IN WITNESS WHEREOF, the Employer has executed this Plan as of the Effective Date.

Employer
Iwaki America, Inc.

By:____

Title:____

Date:____

ATTACHMENT ONE
IWAKI AMERICA, INC.

DENTAL REIMBURSEMENT ARRANGEMENT

Summary Plan Description

January 1, 2011 Through January 1, 2012

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INTRODUCTION

Iwaki America, Inc. (the "Employer") is pleased to sponsor this Dental Reimbursement Arrangement (the “DRA”). The purpose of this DRA is to reimburse Participants for certain unreimbursed Dental expenses (“Eligible Dental Expenses”) incurred by the Participant and their Covered Dependents. This DRA is intended to qualify as a self-insured dental reimbursement plan for purposes of Section 105 and 106 of the Internal Revenue Code (“Code”).

This Summary Plan Description, or “SPD”, describes the basic features of the DRA, including the rights and responsibilities of covered individuals, the Employer, and the Plan Administrator. Attached to this SPD is a Plan Information Appendix that provides important information specifically related to this DRA (e.g. the name of the sponsoring employer and plan administrator, the plan number, and the maximum level of reimbursement available under this particular DRA). If you do not have a Plan Information Appendix for this SPD, you should contact the Employer. The Plan Information Appendix may be replaced from time to time to reflect changes made in the plan. You should check your Plan Information Appendix to ensure that you have the most recent Plan Information Appendix. You may contact the Employer if you have concerns that the Plan Information Appendix that you have is outdated. Other appendices may be attached to this SPD to the extent referenced in the SPD. The Plan Information Appendix and any other appendices referenced in this SPD should be considered a part of the SPD (i.e. the SPD, the Plan Information Appendix and any other applicable appendices together constitute the entire SPD).

This DRA has been established and is operated in accordance with both this SPD and the official plan document. This SPD (including the applicable appendices) has been incorporated into and made a part of the official plan document (i.e. the official plan document and this SPD together constitute the plan document for this DRA). Although the SPD has been incorporated into and made a part of the plan document, the terms of the official plan document will control if there is a conflict between this SPD and the official plan document.

This DRA is considered a component of the Employer’s dental plan (Component Dental Plan) identified in the Plan Information Appendix. Both the DRA and the Component Dental Plan should be considered a single employee benefit plan even though they are described in separate documents. The governing documents for this DRA are not intended to replace, supercede, modify or revise the governing documents of the Component Dental Plan. For purposes of this SPD, the Component Dental Plan and this DRA are collectively referred to as the “Plan”.

PART I:
General Information about the Plan

*****_You will notice that certain terms and/or phrases are capitalized throughout this SPD. These terms and/or phrases are important and you should remember them. The capitalized terms and phrases are defined either in this SPD or in the official plan document._

Q-1. What is the DRA?

Generally, the DRA is an employer provided reimbursement account. The DRA works as follows.

- You do not have to pay for your DRA coverage as an active employee.

Q-2. Who can participate in the DRA?

You are eligible to participate in this DRA if you are an Employee of the Employer (including any Adopting Employer) _and_ you elect to participant in the Component Dental Plan. For a detailed description of the eligibility and enrollment rules of the Component Dental Plan, please refer to the governing documents for the Component Dental Plan. Eligible employees who become covered under this DRA are called "Participants".

Q-3 Are my dependents covered under the DRA?

If you become a Participant, you may also be reimbursed for Eligible Dental Expenses incurred by your Covered Dependents. A "Covered Dependent" is any individual who is covered under the Component Dental Plan as your legal spouse or a dependent. For a detailed description of dependent eligibility and enrollment rules (including special enrollment rules) under the Component Dental Plan, please refer to the governing documents for the Component Plan. You are required to provide proof of dependent status upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay in coverage under this DRA.

Q-4. What is the effective date of coverage under this DRA?

Coverage under this DRA for an Eligible Employee and Eligible Dependent(s) begins on the applicable date identified in the "Effective Date of Coverage" section of the Plan Information Appendix. In no event will the coverage under this DRA begin before the effective date of this DRA. The effective date of this DRA is identified in the Plan Information Appendix.

Q-5. When does coverage under this DRA end?

Coverage for a Participant and/or Covered Dependent ends on the same date that coverage under the Component Dental Plan ends. However, you, your covered spouse, and/or your covered child(ren) may be eligible to continue coverage under this DRA beyond the date that coverage would otherwise end if coverage is lost for certain reasons. Your continuation of coverage rights and responsibilities are described in Q-13 below.

Q-6. What happens to my DRA coverage if I take a leave of absence from the Employer?

Your coverage under this DRA during a paid or unpaid leave of absence will be treated in the same manner that coverage under the Component Dental Plan is treated during a leave of absence. For a detailed summary of the continuation rights under the Component Dental Plan during a leave of absence, please refer to the governing documents of the Component Dental Plan and/or your Employee Guidelines.

Q-7. What is an "Eligible Dental Expense"?

"Eligible Dental Expenses" are Dental care expenses *incurred* by you or your Covered Dependents that satisfy all of the conditions described in the "Eligible Dental Expense" section of the Plan Information Appendix. All expenses that are not within the scope of "Eligible Dental Expenses" described in the Plan Information Appendix are excluded. "Incurred" means the date the service or treatment is provided; not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a Dentist) will not be reimbursed until the services or treatment giving rise to the expense have been provided. Also, an otherwise Eligible Dental Expense will not be reimbursed unless the requirements described in Q-10 below have been satisfied.

In no event will the following expenses be eligible for reimbursement:

a) any expense that is not a Code Section 213(d) expense

b) expenses incurred *prior to the date* that coverage under this DRA becomes effective

c) expenses incurred *after the date* that coverage under this DRA ends.

Q-8. What is a Dental Reimbursement Account?

Generally, a DRA is an employer provided reimbursement account. Once you become a Participant, the Employer will handle all reimbursements. The participant must submit their invoice or bill to Human Resources. Human Resources will authorize payment and forward documentation to Accounts Payable for processing. You have no property rights in the Reimbursement Account.

Q-9. Who contributes to my Reimbursement Account?

While you are an active employee, only the Employer contributes to your Reimbursement Account (with DRA Dollars). In fact, federal laws prohibit you from contributing to your Reimbursement Account with any portion of a pre-tax salary reduction made under a Code Section 125 cafeteria plan. You may, however, be required to pay the "applicable premium" for continuation of DRA coverage under COBRA (please refer to Q-13 below for more information regarding COBRA continuation coverage).

Q-10. What is the maximum amount of reimbursement that I may receive under the DRA?

The following dental expenses are eligible for reimbursement under this Plan (provided all other terms and conditions of the DRA have been satisfied):

Dental Dental Insurance will cover the first $2000 of <u>covered</u> claims per member.
Iwaki America, Inc. will pay 50 % of the next $4,000 of covered claims per member in a calendar year.

Q-11. Can I change my level of coverage under the DRA during the Plan Year?

If you change your level of coverage under the Component Dental Plan during the Plan Year (e.g. single to family/family to single or part-time to full-time/full-time to part-time) and there is a different DRA Dollar allocation associated with the new level of coverage, your annual DRA Dollar allocation may be adjusted to the extent described in the "Changing Coverage" section of the Plan Information Appendix. All adjustments (if any) will be applied prospectively only.

Q-12. How do I receive reimbursement under the DRA?

You may submit your bill for reimbursement of Eligible expenses incurred during the coverage period at any time prior to the end plan year described in the Plan Information Appendix. The documentation you submit must contain the following: a) the name of the patient, b) the date service or treatment was provided, c) a description of the covered service or treatment; d) an explanation of benefits summary demonstrating your maximum dental

coverage has been reached; and e) the amount incurred. Submit your detailed invoice or bill to Human Resources. Human Resources will then authorize payment and forward documentation to Accounts Payable for processing.

Q-13. What is "Continuation Coverage" and how does it work?

A federal law called "COBRA" requires most employers sponsoring group dental plans to offer covered employees and certain covered family members the opportunity for a temporary extension of dental care coverage (called "Continuation Coverage") in certain instances where coverage under the group dentall plan would otherwise end. These rules apply to the Plan (including the DRA) unless the Employer is a small employer as defined under applicable law. The Plan Administrator will tell you whether the Plan is subject to these rules. Below is a description of your rights and responsibilities under COBRA.

When Coverage May Be Continued Under COBRA

If you are a Participant or a Covered Dependent under the DRA, then you may continue your coverage under the DRA if you elect COBRA continuation coverage under the Component Dental Plan.

You must elect COBRA continuation coverage under the Component Dental Plan in order to be eligible to continue coverage under the DRA. See the Component Dental Plan Summary Plan Description for more information regarding your right to elect COBRA continuation coverage.

Type of Coverage

If you choose continuation coverage, you are entitled to the level of coverage under the DRA in effect for you immediately preceding the qualifying event.

Cost

For the period of continuation coverage, the cost of such coverage will not exceed 102% of the "applicable premium", as determined by the Plan Administrator, or 150% of the "applicable premium" during any disability extension to which you may be entitled, as determined by the Social Security Administration. The Plan Administrator will notify you of the applicable premium. The notice you receive will describe the premium payment requirements under the Plan (e.g., who you pay the premium to, etc.).

When Continuation Coverage Ends

Continuation coverage under this DRA will continue for as long as continuation coverage continues under the Component Dental Plan. See the Component Dental Plan Summary Plan Description or certificate of coverage for a description of duration of COBRA continuation coverage.

Q-14. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. All modifications/terminations effectuated by the Employer will be applied to all Participants and Covered Dependents except as otherwise stated.

Q-15. Does the Plan coordinate benefits with other Component Dental Plans? No.

Q-16. Who do I contact if I have questions about the DRA?

If you have any questions about the DRA, you should contact the Plan Administrator. Contact information for the Plan Administrator is provided in the Plan Information Appendix.

PART II

ERISA RIGHTS

This DRA may be a welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA). If it is an employee welfare benefit plan subject to ERISA, ERISA provides that you, as a Plan Participant, will be entitled to:

1. Receive Information about Your Plan and 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, 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 Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply 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.

2. Continue Component Dental Plan Coverage

Continue dental coverage for you, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, you or your dependents 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.
Obtain reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Component Dental Plan, if you have creditable coverage under another plan. You should be provided a certificate of creditable coverage, free of charge, from your Component Dental Plan or Dental insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases (if you requested continuation coverage), before losing coverage (if you requested continuation coverage), or up to 24 months after losing coverage (if you requested continuation coverage). Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. 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 your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. 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 from the Plan, or from exercising your rights under ERISA..

4. Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan 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 Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

5. Assistance with Your Questions

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

PLAN INFORMATION APPENDIX

PLAN INFORMATION APPENDIX TO THE IWAKI AMERICA, INC. DENTAL REIMBURSEMENT ARRANGEMENT SUMMARY PLAN DESCRIPTION

This Appendix provides information specific to the Iwaki America, Inc. Dental Reimbursement Arrangement (DRA).

The effective date of this Plan Information Appendix is October 1, 2010

I. GENERAL PLAN INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:	Iwaki America, Inc. 5 Boynton Road Holliston, MA 01746 (508)429-1110
2. Name, address, and telephone number of the Plan Administrator: The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more committees.	Same as above
3. Address for Service of Legal Process:	Same as above
4. Employer's federal tax identification number:	04-2544696
5. Plan Number	501
6. Original Effective Date of the DRA:	October 1, 2010
7. Plan Year:	October 1 through September 30
8. Adopting Employers participating in the Plan:	Iwaki America, Inc.
9. Third Party Administrator:	N/A
10. Identity of Component Dental Plan(s) under which this DRA is a component.	Delta Dental

II. EFFECTIVE DATE OF COVERAGE

A. The effective date of coverage for Participants is as follows:

Same as Dental Plan

B. The effective date of coverage for Covered Dependents is as follows: Same as above.

III. ELIGIBLE DENTAL EXPENSES

The following dental expenses are eligible for reimbursement under this Plan (provided all other terms and conditions of the DRA have been satisfied):

Iwaki America, Inc. will pay 50% of any covered costs incurred over the $2,000 maximum up to a maximum of $6,000 in dental charges in a calendar year. Delta Dental will pay the first $2,000 and Iwaki America, Inc. will pay 50% (to a maximum of $2,000) of the next $4,000 in a calendar year**.**

IV. DRA Dollars

A. The annual amount of DRA Dollars that may be allocated to a Reimbursement Account is:

Delta Dental will pay the first $2,000 and Iwaki America, Inc. will pay 50% (to a maximum of $2,000) of the next $4,000 in a calendar year.

V. REIMBURSEMENT ACCOUNT (applies only to plans that allow carryover)

The amount in your Reimbursement Account may not exceed the following amount: See item IV (A) above. N/A

VI. CHANGING COVERAGE

Single Coverage to Family Coverage
Family Coverage to Single Coverage

VII. RUN OUT PERIOD

Expenses will not be reimbursed unless they are submitted for reimbursement, in accordance with the SPD, within 0 days.

VIII. UNCLAIMED PAYMENTS

Any unclaimed reimbursement amounts (e.g., failing to cash a reimbursement check) will be forfeited and returned to the Employer if not claimed (or cashed) prior to the employer's plan reconciliation date (which follows the end of a plan year's run out period, which is 0 days).

IX. INTERACTION/COORDINATION WITH DENTAL FSA

To the extent that Eligible Dental Expenses are covered both by this DRA and by an Employer sponsored Dental FSA in which the employee participates, the Eligible Dental Expenses will be paid as follows:

Delta Dental will pay the first $2,000 and Iwaki America, Inc. will pay 50% (to a maximum of $2,000) of the next $4,000 in a calendar year.