Aflac Benefit Services • Flex One® • A Service of American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999 • 800.323.5391

SUMMARY PLAN DESCRIPTION
FOR
CLOW STAMPING COMPANY GROUP PLAN
CANCER, INTENSIVE CARE & HOSPITALIZATION
(AFLAC)
AMERICAN FAMILY LIFE ASURANCE COMPANY OF COLUMBUS

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each participant or eligible participant in an employee benefit plan.

When attached to your Certificate of Insurance, this document becomes your Summary Plan Description. Contributions to the plan are made by Clow Stamping Company and by the plan participants. Contributions are based on the amount of insurance premiums necessary to provide the coverage required by the plan. The Plan of Insurance is a welfare benefit plan.

Plan Sponsor Address:

Clow Stamping Company
23103 County Road 3
Merrifield, MN 56465
(218) 765-3111

Plan Name and Identification Number:

The formal name of the plan is the Clow Stamping Company Group AFLAC Plan.

The plan is identified by the following numbers under Internal Revenue Service Rules:

Employer Identification Number: 41-0961650

Plan Number assigned by employer: Account Number OEHX5

Type of Plan:

This employee benefit plan provides the following coverage:

Cancer Insurance or Intensive Care Insurance or Hospitalization Insurance

Plan Administration:

The Plan Administrator is:

Clow Stamping Company
23103 County Road 3
Merrifield, MN 56465
218-765-3111

Employees who have questions about the plan should contact the plan administrator.

Specific questions concerning benefits and individual claims should be directed to:

AFLAC
World Headquarters
1932 Wynnton Road
Columbus, Georgia 31999
(800) 323-5391

Agent for Service of Process:

Process in any legal action may be directed to:

Human Resources Director
Clow Stamping Company
23103 Highway 3
Merrifield, MN 56465

Eligibility to Participate in Plan:

If you are working for Clow Stamping Company at least 30 hours per week as an employee, you are eligible to participate in the plan on the first day of the month following the completion of 30 days of continuous employment. If you are not actively at work on the date you are eligible for the plan, coverage is deferred until the next day you are at work.

Description of Plan Benefits:

The benefits provided under the plan are described in your Certificate of Insurance. If you lose your Certificate of Insurance, contact the plan administrator or AFLAC to obtain a replacement.

Disqualifications of Benefits:

Circumstances which may result in disqualification, ineligibility or denial of benefits are described in your Certificate of Insurance.

Disbursement of Benefits:

The plan provides coverage through insurance issued by AFLAC.

Plan Year:

Records for the plan are kept on a plan year basis beginning on January 1, through the following December 31 for the purpose of accounting and all reports to the United States Department of Labor and other regulatory bodies.

How to Obtain Plan Benefits:

You or your personal representative must obtain a claim form. Claim forms may be obtained from the plan administer or AFLAC

You or your personal representative will complete a portion of the claim form by filling in all information and signing on the line specified. Your personal physician will complete a portion of the form. You or your personal representative will forward the completed form with other requested information to

AFLAC
World Headquarters
1932 Wynnton Road
Columbus, Georgia 31999
(800) 323-5391

for claim payment.

Claim Review Procedures:

If the claim is denied or partly denied, you or your personal representative will receive written notification of the denial, together with the specific reason for the denial, directly from AFLAC. If you or your personal representative needs to provide any additional material, that material will be described in your written notification of the denial. The notification of denial will also explain the plan's claim review procedures.

You or your personal representative may file a written appeal of any denial directly to:

AFLAC
World Headquarters

1932 Wynnton Road
Columbus, Georgia 31999
(800) 323-5391

AFLAC will respond in writing with its decision on your appeal with 30 days of receiving your appeal. The decision of AFLAC on the disposition of the appealed claim is final.

Statement of ERISA Rights:

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office, copies of all documents filed by the plan with the U. S. Department of Labor, such as detailed Annual Reports and plan descriptions.

  However, employers with fewer than 100 employees at the beginning of the plan year are not required to:

  Allow examination of the Annual Report of Plan Description; or furnish copies of the Plan Description, Annual Report, or any Terminal Report.

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

Receive a summary of the plan's annual financial report except as described below. The plan administrator is required by law to furnish each participant with a copy of this Summary of the Annual Report. Employers with fewer than 100 employees at the beginning of the plan year are not required to furnish a copy of the Summary of the Annual Report.

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 you and other plan participants and beneficiaries. No one, including your employer, 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 your claim for a welfare benefit 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 which is denied or ignored, in whole or in part, you may file suite in a state or federal court. If 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 the 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). If you have any questions about your plan, contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, 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 of Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 202210.

Plan Continuance:

Clow Stamping Company, in its sole discretion, reserves the right to revise, amend or terminate the plan at any time including amending or terminating the benefits provided to you in the plan and/or changing the amount of premium the plan participant must pay.

If the plan is revised, amended or terminated, such action will not affect coverage for services provided prior to the effective date of the change.

Master Contract:

The statements in this Summary Plan Description are intended to explain as clearly as possible the essential features of the Plan. The statements are, however, governed in all respects by the terms of the master contract, which will prevail in the case of conflict.

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

PLAN INFORMATION SUMMARY

The Employer named below establishes a Flexible Benefits Plan (the "Plan") as set forth in this Summary Plan Description ("SPD") as of the Effective Date set forth below. The purpose of the Plan is to provide eligible Employees a choice between cash and the specified welfare benefits described in this Plan Information Summary (see "Benefits Provided Under the Plan"). Pre-tax Contribution elections under the Plan are intended to qualify for the exclusion from income provided in Section 125 of the Internal Revenue Code of 1986.

FLEXIBLE BENEFITS PLAN
EMPLOYER INFORMATION

1) Name and Address of Employer: **CLOW STAMPING CO INC**

   Plan Administrator: **TWYLA FLAWS**
   23103 COUNTY ROAD 3
   MERRIFIELD, MN 56465

The Plan Administrator has 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 to construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.

2) Employer's Telephone Number: **(218) 765-3111**
3) Employer's Federal Tax Identification Number: **41-0961650**
4) Plan Number Assigned to Cafeteria Plan (e.g., 501 if this is the first ERISA Plan Number assigned): _____
5) 125 Start Date: **07/01/10**
6) Effective Date of this Plan: **07/01/10**
7) Last Day of the Plan Year: **12/31/10**
   Subsequent Plan Years: **01/01-12/31**
8) Name and Address of FSA Claim Administrator: **SAME**
9) Name and Address of registered agent for service of legal process: **TWYLA FLAWS**

10) Affiliated Employers that will participate in the Plan (affiliates in excess of 30 are listed in Appendix 1):

11) Employer's Type of Business: **CORPORATION**

ELIGIBILITY

All Employees employed by the Employer shall be eligible to participate under the Plan except the following:

An eligible Employee may become a Participant in the Plan:

[ ] Immediately, upon the first day of employment (but not prior to the Effective Date of the Plan).

[ ] On the **day** following commencement of employment.

[**X**] On the first day of the month following **30** days of employment.

[ ] Other: **OTHER**
provided the Employee completes a Salary Redirection Agreement ("SRA"). However, eligibility for coverage under any given Benefit Plan or Policy shall be determined by the terms of that Benefit Plan of Policy, and reductions of the Employee's Compensation to pay Pre-tax or After-tax Contribution(s) shall commence when the Employee becomes covered under the applicable Benefit Plan or Policy.

An eligible Employee may become a Participant in the Dependent Care and/or Medical Expense Reimbursement Plan(s) (if elected below):

[ ] On the same day such Employee is eligible for the Pre-Tax Contribution benefits under the Plan.

[ ] On the day following commencement of employment.

[ ] On the first day of the month following days of employment.

[ ] Other: **OTHER**, provided the Employee completes an SRA selecting such benefits.

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Introduction

Your employer (the "Employer") is pleased to sponsor an employee benefit program known as a "Flexible Benefits Plan" (the "Plan") for you and your fellow employees. Under federal tax laws, it is also known as a "cafeteria plan". It is so called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for them by entering into a salary redirection arrangement instead of receiving a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary redirection. Alternatively, your Employer may allow you to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary attached to the front of this SPD. You will be referred to the Plan Information Summary throughout the SPD. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. If there is a conflict between the official plan document and the SPD, the plan document will govern.

In some cases, the Employer may adopt a Medical Care and/or Dependent Care Reimbursement Plan. If so, they will be listed in the Plan Information Summary as "Benefits Provided under the Plan," and the SPD for each Reimbursement Plan adopted by the Employer will be set forth in Appendix I to this SPD. To the extent that the Employer adopts a Medical Care Reimbursement Plan as indicated in the Plan Information Summary, a summary of your rights and obligations under HIPAA's privacy rules is attached to this SPD as Appendix II.

You may also be able to make pre-tax contributions to a Health Savings Account (as defined in Code Section 223) through this Plan if Health Savings Accounts are identified as an included benefit under "Benefits Provided under the Plan" in the Plan Information Summary. If Health Savings Accounts are identified as a benefit plan option offered under the Plan, your rights and obligations in regard to such contributions will be set forth in the Health Savings Account Contribution Appendix attached hereto.

Questions & Answers about the Flexible Benefits Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to pay for certain benefits offered under the Plan (called "Benefit Plans or Policies") with pre-tax dollars called "Pre-tax Contributions". Pre-tax Contributions are described in more detail in Q-8 of this SPD.

Q-2. What benefits can I purchase on a pre-tax basis through the Plan?

You will be able to choose to participate in the Plan's various pre-tax options by filling out any required enrollment form(s) for the component Benefit Plans or Policies offered under the Plan. The complete list of Benefit Plans or Policies offered under the Plan is located in the Plan Information Summary under "Benefits Offered Under the Plan." NOTE: You may only contribute with Pre-tax Contributions towards the cost of Benefit Plans or Policies that cover you, your legal Spouse, and/or your tax Dependents defined under Internal Revenue Code Section 152. Each Benefit Plan or Policy may define eligible Dependents more narrowly for purposes of coverage under the particular Benefit Plan or Policy.

Q-3. Who can participate in the Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who satisfies the eligibility requirements described in the Plan Information Summary and who is eligible to participate in any of the Benefit Plans or Policies offered under the Plan will be eligible to participate in this Plan as of the date described in the Plan Information Summary (see Q-5 of this SPD for instructions on how to become a Participant). Those employees who actually participate in the Plan are called "Participants." The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Plans or Policies offered under the Plan. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Plans or Policies, please refer to the plan summary for each of the Benefit Plans or Policies listed in the Plan Information Summary.

Only coverage for an Employee and the Employee's Dependents may be paid for under this Plan. A dependent is defined generally as an individual who would be considered the Employee's spouse under the federal income tax code or the Employee's tax dependents as defined in Code Section 152; however, for purposes of health benefits and Dependent Care Reimbursement ("DDC") benefits offered under the Plan, a dependent is defined as (i) for health plan purposes, as set forth in Code Section 105(b) and (ii) for DDC purposes, as any person who meets the requirements to be a "qualifying individual" as defined in the DDC component SPD.

Q-4. When does my participation in the Plan end?

You continue to participate in the Plan until (i) you elect not to participate in accordance with Q-9 of this SPD; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) you terminate employment with the Employer; or (iv) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will **automatically** cease, and you will not be able to make any more

Policy(ies) for each Participant and/or level of coverage is subject to the sole discretion of the Employer, and it may be adjusted upward or downward in the Employer's sole discretion. The Nonelective Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your Dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Nonelective Contribution be disbursed to you in the form of additional, taxable Compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may make available a certain amount of Nonelective Contributions and then allow you to allocate the Nonelective Contributions among the various Benefit Plan(s) or Policy(ies) that you choose (subject to restrictions described in the enrollment material).

Q-9. Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution amounts although your election will terminate if you are no longer working for the Employer or no longer eligible under the terms of the Plan. Otherwise, you may change your elections for Pre-Tax Contributions only during the Annual Enrollment Period, and then, only for the coming Plan Year. There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator (or its designated claims administrator) within 30 days of any of the following events:

1. **Change in Status**. If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

   - a change in your legal marital status (such as marriage, legal separation, annulment, or divorce or death of your Spouse);
   - a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
   - any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit (NOTE: The specific rules governing election changes when you take a leave of absence are described in Q-13 of this SPD);
   - an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student);
   - a change in your, your Spouse's or your Dependent's place of residence.

   If a Change in Status occurs and you want to make a corresponding election change, you must inform the Plan Administrator and complete a new election within 30 days from the date of the event. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator with the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective.

   As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

   - *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage, and Medical Care Reimbursement Plan), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

     Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-Dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike

5. **Change in Cost**. If you are notified that the cost of your Benefit Plan or Policy coverage under the Plan *significantly* increases or decreases during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Plan or Policy that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plans or Policies, however, your Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a Medical Care Reimbursement Plan, to the extent offered under the Plan.)

   Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If you are notified that your Benefit Plan or Policy coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Plan or Policy that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to the Medical Care Reimbursement Plan, to the extent offered under the Plan.)

   Additionally, your election(s), may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-10. 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. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11. What happens if my claim for benefits under this Plan is denied?

This SPD describes the basic features of the Plan. If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedures applicable under the component Benefit Plan or Policy (see the plan summary for each of the Benefit Plans or Policies that you elect). However, if you are denied a benefit under this Plan, the claims procedure under this Plan will apply. You will be notified if your claim under the Plan is denied. The notice of denial will be furnished to you within 30 days after receiving your claim. However, if additional time is needed to process your claim you will be notified before the initial 30-day period has expired. The notice will explain why an extension is necessary and the date a decision is expected to be rendered. In no event will an extension go beyond 15 days after the end of the initial 30-day period. The notice of the denial will include the specific reasons for the denial and the relevant plan provisions on which the denial was based.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim, as set forth in the notice of denial, within 180 days after you receive notice of the denial. If there are two levels of appeal (as indicated in the notice of denial), you will have a reasonable amount of time in which to request a second review and such time period will be identified in the notice of denial. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. Within 60 days after the request for review is received, you will be notified in writing of the decision on review.

The notice of denial will indicate whether there are one or two levels of appeals and will contain the same type of information provided to you in the first notice of denial. If there are two levels of Plan appeals, the decisions on appeal will be made within 30 days after the request for each review is received. The Plan Administrator is the claims fiduciary for making the final decision under the plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-12. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.