This document may create legally binding obligations and should be reviewed by counsel prior to distribution

EMPLOYEE RETIREMENT INCOME SECURITY ACT DISCLOSURES

INTRODUCTION

This document gives you the information required to be provided to participants in welfare benefit plans which are governed by the Employee Income Retirement Security Act of 1974 ("ERISA"). This document should be kept in your personal records with the booklet provided by the insurance carriers that describes the benefits in detail.

The information in this document may duplicate the information in your benefits booklet. If there is a conflict between the information contained in this document and the information contained in the benefits booklet, the benefits booklet will control.

PLAN ADMINISTRATION INFORMATION

1. The name of the Plan is: The Paragon Systems, Inc. Dental Plan

2. The name and address of the employer whose employees are covered by the Plan is:

   Sponsoring Employer: Paragon Systems, Inc.
   14160 Newbrook Drive, Suite 150
   Chantilly, VA 20151

   Participating Employer: Southeastern Paragon
   14160 Newbrook Drive, Suite 150
   Chantilly, VA 20151

3. The federal employer identification number of the plan sponsor is: 63-0937443

4. The plan number assigned by the plan sponsor to the Plan is: 502

5. The Plan is a welfare benefit plan that provides participants with dental benefits.

6. The insurer pays claims directly to participants and health care providers.

7. The name, address and phone number of the Plan Administrator is:

   Megan Bittenbender
   Paragon Systems, Inc.
   14160 Newbrook Drive, Suite 150
   Chantilly, VA 20151
   703-263-7176

8. The name of the person designated as agent for service of legal process and the address to be used for service of process is:

   Megan Bittenbender
   Paragon Systems, Inc.
   14160 Newbrook Drive, Suite 150
   Chantilly, VA 20151
   703-263-7176

9. The term "plan year" refers to each period of 12 months on which the records of the Plan are based. The plan year for the Plan is May 1st through April 30**.**

ELIGIBILITY

An employee who is regularly scheduled to work at least 32 hours per week is eligible to participate in the Plan on the month following 30 days of employment.

BENEFITS AND LIMITATIONS

The Plan provides employees and their dependents with the following types of benefit:

Dental

The benefits booklet provided by the insurance carrier contains detailed information, including schedules of benefits provided under the Plan. Additional copies of these booklets are available, without charge, from the Plan Administrator.

The benefits booklet provided by the insurance carrier also contains information pertaining to the premiums, deductibles, coinsurance and copayment amounts for which participants are financially responsible, annual limits on benefits, lifetime limits on benefits and any other limitations on benefits payable to employees or dependents under the Plan. The benefits booklet may also describe the Plan's requirements for preauthorization requirements or utilization reviews which are required prior to you or your dependents receiving benefits under the Plan.

The benefits booklet describes the circumstances which could result in disqualification, ineligibility, denial, loss, forfeiture, suspension, and reduction of your benefits under the Plans.

The Plan sponsor reserves the right to terminate the Plan at any time, to reduce or eliminate benefits available under the Plan at any time, without prior notice to you and for any reason.

COBRA CONTINUATION COVERAGE

You are receiving this notice because you are covered under Paragon Systems, Inc. Health Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of

coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. For more information about your rights and obligations under the Plan and under federal law, you should get a copy of the Plan document from the Plan Administrator. The Plan Administrator is

Megan Bittenbender
Paragon Systems, Inc.
14160 Newbrook Drive, Suite 150
Chantilly, VA 20151
703-263-7176

COBRA continuation coverage for the Plan is administered by Benefit Design Group, 409 Washington Avenue, Ste. 711, The Mercantile Building, Towson, MD 21204-4903 .

COBRA continuation coverage is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) your hours of employment are reduced, or

(2) your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) your spouse dies;

(2) your spouse's hours of employment are reduced;

(3) your spouse's employment ends for any reason other than his or her gross misconduct;

(4) your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) you become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens: (1) The parent-employee dies; (2) The parent-employee's hours of employment are reduced; (3) The parent-employee's employment ends for any reason other than his or her gross misconduct; (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both); (5) The parents become divorced or legally separated; or (6) The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Megan Bittenbender, Paragon Systems, Inc., 14160 Newbrook Drive, Suite 150, Chantilly, VA 20151, 703-263-7176.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to: Benefit Design Group, 409 Washington Avenue, Ste. 711, The Mercantile Building, Towson, MD 21204-4903

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying even**. **This notice must be sent to** Benefit Design Group, 409 Washington Avenue, Ste. 711, The Mercantile Building, Towson, MD 21204-4903 .

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Megan Bittenbender, Paragon Systems, Inc., 14160 Newbrook Drive, Suite 150, Chantilly, VA 20151, 703-263-7176 or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at http://www.dol.gov/ebsa .

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You also should keep a copy of any notices you send to the Plan Administrator for your records.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

Group health plans must provide benefits in accordance with the applicable requirements of any qualified medical child support order (QMCSO). A child who is the subject of such an order is considered an "alternate recipient" and is treated as a beneficiary under the Plan.

QMCSO requirements. In order to qualify as a QMCSO, a medical support order must:

1. create or recognize the existence of an alternate recipient's right to receive benefits for which the participant or beneficiary is eligible under a group health plan or to assign those rights;

2. clearly specify the name and last known mailing address of the participant and the name and mailing address of each alternate recipient covered by the order;

3. specify a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient or the manner in which the type of coverage is to be determined;

4. specify each plan that the order applies to and the period to which such order applies; and

5. not require a plan to provide any type or form of benefit not otherwise provided under the Plan.

The Plan Administrator is responsible for deciding if the order satisfies the conditions for a QMCSO. If it does, the child is an alternate recipient and considered a beneficiary under the Plan. As an alternate recipient, the child is also considered a participant for reporting and disclosure purposes under ERISA. Reimbursement of benefit payments under a group health plan pursuant to a QMCSO may be made to the alternate recipient or the alternate recipient's custodial parent.

Medicaid eligibility of alternate recipient not considered. A group health plan cannot consider Medicaid eligibility in enrolling an alternate recipient in the Plan. A group health plan must also comply with an alternate recipient's assignment of rights under Medicaid. Finally, where a state has paid for medical services under Medicaid for which the Plan was liable, the state may seek to recover those amounts from the Plan. In other words, ERISA does not preempt state action in this instance.

Plan Administrator's duties. A qualified health plan must establish reasonable written procedures to determine if a medical child support order is a QMCSO. The Plan Administrator must promptly notify the participant and all alternate recipients that such an order has been received and inform them of the Plan's procedures for determining if the order is a QMCSO. Within a reasonable period of time, the Plan Administrator must determine if the order is a QMCSO and notify all parties of the decision. The Plan's written procedures must permit an alternate recipient to designate a representative to receive copies of notices with respect to a medical child support order.

MATERNITY OR NEWBORN INFANT COVERAGE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

FAMILY, MEDICAL AND UNIFORMED ARMED SERVICES LEAVES OF ABSENCE

Subject to certain conditions, the Family and Medical Leave Act ("FMLA") entitles you to take unpaid leaves of absence totaling twelve weeks per rolling 12 month period for specific personal or family health and child care needs. The Plan Administrator can provide you with information as to your rights and benefits under the FMLA.

Additionally, you may be entitled to certain rights and benefits under the Uniformed Service Employment and Reemployment Rights Act of 1994 ("USERRA") if you are absent from work due to duty in the uniformed services. The "uniformed services" are the Armed Forces, the Army National Guard and the Air National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency. The Plan Administrator can provide you with information as to your rights and benefits under USERRA.

Participation During Leaves of Absence. If you are not at work because of an unpaid FMLA leave, or due to an unpaid period of duty in the Uniformed Services lasting more than 31 days, you may elect to continue any or all benefits under the Plan that you had previously elected during the period of absence so long as you continue to make any required contributions. During the absence, you may choose to make these contributions by:

(a) remitting payment to the Plan Sponsor on or before each pay period for which the contributions would have been deducted from your paycheck if leave had not been taken, provided that any delinquent payments must be made within 30 days of their due date; or

(b) at your request, you may prepay the amounts that will become due during the leave out of one or more of your paychecks preceding the leave.

If you are absent for work for any paid leave of absence, you must continue any and all benefits elected under this Plan, and your contributions for those benefits which you choose to continue while on the leave of absence will continue to be deducted from your paychecks during the absence.

CLAIMS PROCEDURE

In most instances, it will not be difficult to determine when, to whom, and how benefits should be paid. However, in some cases an employee or dependent may have questions on some of these issues. Therefore, the Plan provides a claims procedure under which requests for benefits may be made

How your claim is submitted and processed and the time within which the claim will be decided depends on the type of benefit being claimed. Certain benefits, particularly medical benefits, have different varying times within which a claim will be reviewed and processed.

You must follow the claims procedures required under that particular program and set forth in the booklets provided by the insurers.

FUNDING AND EMPLOYEE CONTRIBUTIONS

Termination of Coverage. Your participation in a particular benefit program is determined by the terms and conditions of the contracts, riders, documents and certificates comprising such benefit program. Unless specifically stated in the contracts, riders, documents and certificates of a particular benefit program, your participation in the Plan will automatically terminate on the earliest of the following:

- the date on which your employment with the plan sponsor terminates;
- the date on which the Plan is terminated;
- the date on which you fail to make any required contribution for coverage when due; or
- such other date specifically identified in the contracts, riders, documents and/or certificates comprising the benefit programs under the Plan.

Certain benefit programs may allow you to continue coverage for a period beyond your employment with the plan sponsor. Information with respect to continuation coverage can be obtained from the contracts, riders, documents and/or certificates or from the Human Resources Department.

Although the plan sponsor intends to continue the benefits described herein, it reserves the right to reduce or increase the level of benefits offered under the Plan or to terminate or amend the Plan at any time for any reason without prior notice. Any amendment or termination will be expressed in the form of a written resolution or written action of the governing body of the plan sponsor.

Beneficiary. You may be required to designate a beneficiary under a particular benefit program. You are responsible for designating such beneficiary and may do so by completing the appropriate form available from the Human Resources Department. In the event that you do not name a beneficiary under a particular benefit program, benefits will be payable to your estate.

Funding. The cost of the benefit programs sponsored by the Plan sponsor is determined prior to each annual enrollment period. The Plan sponsor subsidizes a portion of the cost and, to the extent that Employee contributions are required for participation in a benefit program, the amount of the Employee contribution will be determined by the Plan sponsor and communicated to you during the open enrollment period.

MISCELLANEOUS

Participant's Rights Under Federal Law

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that the Plan protect the use and disclosure of your protected health information. Therefore, the Plan will only use your protected health information to the extent of and in accordance with the uses and disclosures permitted by HIPAA – as required for health care treatment, payment for health care and health care operations. Only with your authorization will the Plan will disclose your protected health information to the administrators of the pension plan, retirement plan, and disability

plan sponsored by the Plan sponsor, or any workers' compensation insurance carrier covering the Plan sponsor's employees and only to the extent necessary and for the sole purpose of administering those plans. If you have any questions or concerns about the use and disclosure of your protected health information, you should contact the Plan Administrator.

HIPAA also requires that upon losing coverage (whether regular coverage or COBRA continuation coverage) that you be provided with a Certificate of Coverage. Certificates of Coverage are written documents that show the type of coverage you previously had and how long the coverage lasted and apply both to Plan participants and to dependents. The primary purpose of the certificates is to show the amount of "Creditable Coverage" that you had under this Plan because this can reduce or eliminate the length of time that any preexisting condition clause in a new plan might otherwise apply to you. The Plan will also provide a Certificate for you (or your dependents) upon request if you make the request within two years (24 months) after your coverage terminates. The Plan Administrator can give you forms to make such a request.

As a participant in the 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:

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 and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health 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 request it before losing coverage, or if you request it up to 24 months after losing 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.

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 you and other 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 or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, 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 you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report 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 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, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your 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 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 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 Pension and Welfare Benefits Administration.

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