NORTHWEST OHIO PLUMBERS AND PIPEFITTERS ACTIVE HEALTH AND WELFARE PLAN

Restated as of January 1, 2014

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NORTHWEST OHIO PLUMBERS & PIPEFITTERS
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WHEREAS, by an Agreement and Declaration of Trust dated March 1, 2006, the Plan was established, pursuant to which the Trustees serving thereunder formulated and adopted this Health & Welfare Plan; and

NOW THEREFORE, the Trustees hereby establish the Northwest Ohio Plumbers & Pipefitters Active Employees Health & Welfare Plan effective May 1, 2010 revised and restated January 1, 2014 to contain the provisions of all prior Plan documents which became a part of this Plan, including all amendments which have been adopted by such Plans as of the effective date.

NOTICE REGARDING PLAN'S GRANDFATHERED STATUS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The Northwest Ohio Plumbers & Pipefitters Active Employees Health & Welfare Plan believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Benesys, at 248-813-9800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ARTICLE I
DEFINITIONS

1.1. Association. Shall mean those Associations that have executed a Collective Bargaining Agreement with the Union, requiring contributions hereto. The term Association includes any new or successor Employer Association that becomes a party to the Trust Agreement by virtue of its execution of an adoption agreement, by which such Association agrees to be bound to the terms and conditions of the Trust Agreement, as amended from time to time.

1.2. Beneficiary. The term "Beneficiary" shall mean any person who, because of relationship to an active or an inactive Participant or Retiree, may be entitled to benefits from the Plan. The term "Designated Beneficiary" shall mean the person or persons designated by a Participant to receive a death benefit from the Plan in the event of his death, or, in the absence of an effective designation, or if such designated person or persons shall have died, the first of the following classes of beneficiaries, in successive preference, then surviving: the Participant's (a) spouse; (b) children; (c) parents; (d) brothers and sisters; (e) estate, pursuant to Section 3.4. The term "children" shall include legally adopted children. Following the entry of a divorce decree, it is presumed that the Participant intended to revoke any designation of his former spouse as the Participant's Designated Beneficiary unless:

(a) The Judgment of Divorce affirmatively states that the divorced spouse will remain Designated Beneficiary, or

(b) A Qualified Domestic Relations Order affirmatively states that the divorced spouse remains the Designated Beneficiary, or

(c) The Participant completes a new designation of Beneficiary form after entry of the Judgment of Divorce, which named the divorced spouse as the Participant's Designated Beneficiary.

1.3. **Benefit Year**. Shall mean the calendar year.

1.4. **Child**. Shall mean any Child of the Employee, including any stepchild or adopted child. In case of divorce, proof of the Participant's obligation to provide coverage for a child or step child shall be required, such as a judgment of divorce, qualified medical child support order, or such other order of a court of competent jurisdiction. Illegitimate children shall be included within this definition, so long as the Participant provides the Plan Administrator proof of paternity, by presenting a registered birth certificate, naming the Participant as the father, order of filiation or adoption order.

1.5. **Claim.** Shall mean a request for a Plan benefit by an eligible Participant or his Dependent.

1.6. **Collective Bargaining Agreemen**. Shall mean any contract, or participation agreement, entered into between the Union and the Association, or any Employer, pursuant to which the Employer has agreed to contribute to this Trust Plan, as well as any renewal or extension thereof.

1.7. **Contribution Hours**. Shall mean those hours worked in covered employment, for which an Employer, pursuant to a Collective Bargaining Agreement, or other written agreement, has actually made fringe benefit contributions. Only hours for which actual contributions are received by the Plan will be deemed Contribution Hours.

1.8. **Covered Employmen**. Shall mean employment with an Employer, for which the Employer has agreed, through a written Collective Bargaining Agreement, or other written agreement, to contribute to this Healthcare Plan.

1.9 **Credit Account**. Means the method of crediting Contribution Hours received on behalf of each Employee to the Employees' individual Credit Account. The cost of benefits plus Plan expenses is deducted from the Employees individual Credit Account.

1.10 **Dependent**. Means your eligible legal spouse, and/or child. An eligible dependent child includes the participant's son, daughter, stepchild, adopted child, child lawfully placed for adoption, or child meeting the definition of a "foster child" under applicable law that is lawfully placed with the Participant by an authorizing placing agency or by court order, and is under the age of 26.

1.11 **Hour Bank**. A notional account where Contribution Hours in excess of those needed to establish or maintain eligibility are stored. The Hour Bank will begin to accumulate for Class I Participants after receipt by the Plan of 2,050 of Contribution Hours.

1.12 **Effective Date.** Shall mean the effective date of this Plan, the effective date of a specific benefit, or the date an Employee or Dependent becomes eligible for benefits. The Effective Date of this Plan shall be January 1, 2014.

1.13 **Employee**. Shall mean any person who is or has been employed by an Employer in Covered Employment, or such other employment for which the Employer is obligated by a Collective Bargaining Agreement, or any other written agreement, to contribute to this Trust Plan.

1.14 **Employer**. Shall mean any of the following:

(a) Any member of an Employer Association and any other individual, partnership, corporation or business entity which is employing the services of individuals performing work that is within the trade jurisdiction of the Union and which has a Collective

Bargaining Agreement, or any other written agreement in effect, requiring contributions to this Plan;

(b) Any other Employer, including a sole proprietor or partnership, engaged in work coming within the trade, craft and geographical jurisdiction of the Union, who is obligated by a Collective Bargaining Agreement, or such other written agreement, to make contributions to this Plan on behalf of its Employees;

(c) The Union, its affiliated Locals or related International bodies, solely to the extent that it acts in the capacity of an Employer of its business representative or its Employees, provided it agrees to make contributions to the Plan on behalf of such Employees;

(d) Any training or other similar program operated in whole or in part by the Union, or with its approval, or in which the Union participates;

(e) Any board of trustees, committee or other agency established to administer or be responsible for fringe benefit Plans, educational or other programs established through collective bargaining by the Union, the members of which maintain a collective bargaining relationship with the Union or one of its constituent Locals;

(f) Any council, committee, or other body composed of representatives of one or more labor organizations of which the Union or one of its constituent Locals is a member and agrees in writing to participate herein; or

(g) Any sponsoring Employer Association, whose members maintain a collective bargaining relationship with the Union, solely in its capacity as an Employer of Employees, on whose behalf it has agreed in writing to make contributions to this Plan.

In the case of an Employer electing to contribute pursuant to the provisions of subsection (d), (e), (f) or (g), contributions must be uniformly made with respect to all Employees of that Employer.

1.15 Employer Contributions. Shall mean those sums required to be paid to the Plan pursuant to the governing Collective Bargaining Agreement between an Employer and the Union. Employer Contributions are plan assets within the meaning of the Employee Retirement Income Security Act ("ERISA") and are assets of this Plan the moment they become due.

1.16 Medical Provider. Shall mean a doctor of medicine, osteopathy, chiropractic, podiatry or optometry, legally qualified and licensed to practice medicine or perform surgery or provide services at the time and place services are performed. The term "Physician" shall also mean a person who is licensed or certified as a psychologist. It shall also mean a person who is a Member or Fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where such person renders service. This definition shall include a Physician's assistant, nurse or person of a similar position working under the direction of the treating Physician. The Plan will provide coverage for services administered by a Physician's Assistant or an otherwise qualified person working under a Physician, however, the Plan reserves the right to seek verification from the treating Physician prior to approving payment for any claims or benefits.

1.17 Participant. Shall mean an Employee who has met the requirements established by the Trustees to be eligible for benefits under this Plan.

1.18 Plan Year. Shall be January 1st through December 31st. The Plan Year shall also be known as the Fiscal Year.

1.19 Qualified Medical Child Support Order (QMCSO). Shall mean a medical support order:

(a) Which creates or recognizes the existence of an alternate recipient's right to receive benefits as a dependent under this Plan, and

(b) Includes:

(1) The name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order;

(2) A reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined (not to exceed the level of coverage offered by the Plan);

(3) The period to which such order applies, and;

(4) The legal name of this Plan.

1.20 Reasonable and Customary or Reasonable Charge. Shall mean charges which do not exceed charges normally made by other hospitals, physicians or service providers in this geographic area. For purposes of foregoing covered charges shall mean the actual cost or charge to an eligible Participant or Dependent, but only to the extent they shall be deemed Reasonable and Customary Charges for necessary medical care and services which are ordered by a legally qualified Physician, but not to exceed the maximums provided in the schedule of benefits.

1.21 Retiree. Shall mean an individual who has retired under a pension program sponsored by the Union and who has continuously maintained eligibility hereunder.

1.22 Retiree Plan. Shall mean the Northwest Ohio Plumbers & Pipefitters Local 50 Retiree Health and Welfare Plan.

1.23 Service. Shall mean services rendered to the eligible Participant or the eligible Dependent by a Physician subsequent to the effective date of the Plan and prior to the termination of eligibility as provided in the eligibility section of the Plan, to the extent and subject to the terms and conditions and definitions set forth in this Plan, except as otherwise limited or excluded herein. "Service" shall also mean all care and procedures rendered by Physicians for diagnosis and/or treatment of disease or injury based on valid medical need, according to accepted standards of medical practice.

1.24 Sickness. Shall include disease, mental, emotional or nervous disorders, and covered pregnancy. A recurrent sickness shall be considered as one sickness. All related sicknesses shall be considered as one sickness. Concurrent sickness shall be deemed to be one sickness unless such sicknesses are totally unrelated.

1.25 Spouse. Shall mean the individual to whom an Employee is legally married. A marriage certificate shall be required as proof of spousal relationship subject to government approval. This definition includes persons of the same-sex who were married in state where same-sex marriage is legal, but are residing in states where such marriage is not legal.

1.26 State Benefits. Shall mean the full amount of unemployment compensation benefits payable to an Employee for a full or partial week of unemployment under the Ohio Unemployment Compensation Act or similar act of any State.

1.27 Union. Shall mean the Northwestern Ohio Plumbers and Pipefitters Local 50, its affiliated Local Unions, or any successor thereto.

1.28 Week of Unemployment. The term "Week of Unemployment" means Sunday through Saturday, or such other periods as may hereinafter be established by the Ohio Unemployment Compensation Act.

ARTICLE II
ELIGIBILITY

2.1. Participation. Every Employee on whose behalf an Employer is required, by a Collective Bargaining Agreement, or such other written agreement to make contributions to this Plan, shall be eligible to become a Participant in this Plan upon satisfying the applicable eligibility requirements, including completing all requested enrollment forms. Participation in any predecessor plan(s) shall not grant any right, title or interest in this Plan, unless specifically provided herein..

2.2. Active Employees (Class I – includes Residential Employees)

(a) **Initial Eligibility.** An Employee working in Covered Employment (Active Participant), shall establish initial eligibility for benefits on the first day of the calendar month following the receipt by the Plan of one hundred and sixty (160) Contribution Hours. Only Employer Contributions actually received by the Plan will be counted toward the requirements for Initial Eligibility.

(b) **Continuing Eligibility**. Upon establishing initial eligibility for benefits, a Participant shall maintain eligibility so long as the Plan receives the appropriate number of Contribution Hours each month on such individual's behalf that are necessary to maintain the selected coverage -- currently 135 Contribution Hours per month. Should a Participant have insufficient Contribution Hours to maintain eligibility, he can continue coverage under the Plan for himself or his Dependents by drawing from his banked hours, or by making self-payments at rates and under conditions established from time to time by the Trustees. The maximum number of consecutive self-payments permitted is fifteen (15).

(c) **Hour Bank**. Upon receipt by the Plan of 2,050 Contribution Hours, each Class I Participant will be eligible to bank excess hours in the Hour Bank up to a maximum of 1,620 hours. In the event that the Participant has not worked sufficient hours to maintain coverage, he may draw upon the hours in the Hour Bank to continue eligibility or to offset the cost of self-payments. Banked hours are not transferable to a Participant's Dependents.

(d) **Self-Pay Eligibility.** When there are insufficient hours in the Hour Bank, the eligible Participant, Spouse or Dependent may self-pay the appropriate premium in order to maintain coverage. Two coverage levels, full and reduced (comprehensive hospital and medical benefits only), will be made available. An irrevocable election of either full or reduced coverage must be made at the time of the first self-payment.

(1) No more than fifteen (15) consecutive months of full self-payments will be permitted for Participants electing Reduced Coverage. Participants electing Full Coverage may make nine (9) consecutive months of self-payments, and then an additional six (6) but with Reduced Coverage. Upon exhaustion of the self-payment option, coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") will be made available. Months in which only a partial self-payment is made will not count be considered self-payment for purposes of the limits set forth in this subsection. Participants who are maintaining eligibility through self-payments must remain available for work and registered on the Union's out of work list.

(2) The amount of the self-payment is the difference between the number of Contribution Hours required for the selected coverage and the balance of Contribution Hours left in the Hour Bank (up to a maximum of 120 for full

coverage and 90 for reduced coverage) multiplied by the then applicable contribution rate. Any self-payments made during a period that a contributing Employer is delinquent shall be refunded to the Participant upon collection.

(e) **Maintenance of Eligibility**. Eligible Participants who are receiving Short Term Disability Benefits will, beginning on the eighth day of their disability, receive contribution credit for each week they are otherwise entitled to draw benefits, up to a maximum total credit of three (3) months.

(f) **Reinstatement of Eligibility.** In the event a Class I Participant's eligibility is terminated, he shall regain eligibility as follows:

(1) **For periods of ineligibility less than 12 months**: Reinstatement shall occur on the first day of the calendar month following the receipt of 160 Contribution Hours within a consecutive two month period.

(2) **For periods of ineligibility greater than 12 months**: Reinstatement shall occur on the first day of the calendar month following the receipt of 600 Contribution Hours within a six month consecutive period.

(g) **Special Rules for Newly-Organized Employers**. Upon approval from the Board of Trustees, employees of newly organized Employers will immediately eligible for coverage under the following terms and conditions:

(1) The Class I participant must have been covered by the Employer's group medical coverage on the date the participant becomes a bargaining-unit employee, and must have worked at least 160 hours for the Employer before becoming eligible immediate coverage;

(2) Coverage will not become effective until the participant loses coverage under the group medical coverage of the newly organized Employer. Until receipt of the first requirement Employer contribution and the posting of a bond by the Employer, claims will not be processed. The participant must provide the Plan Administrator with requested information regarding previous employment, evidence of coverage of the newly organized Employer's group health coverage, and proof that the participant worked 160 hours prior to becoming immediately eligible for coverage;

(3) No credit will be given to the Supplemental Reserve Account during the twelve month (12) period from the date coverage begins.

2.4. Office Employees, Owners & Alumni (Class II Participants)

(a) **Initial Eligibility**. Full time Employees of contributing Employers (those who work at least 40 hours per week) who do not otherwise work in Covered Employment are eligible to participate. A Class II Employee shall establish initial eligibility for benefits on the first day of the calendar month following the completion of one full month's employment and upon execution of all necessary enrollment forms. However, no Class II Employees shall become eligible unless all Class II Employees of the Employer participate in the Plan and such Employer is current in its fringe benefit contributions.

(b) **Continuing Eligibility**. Upon establishing initial eligibility for benefits, a Class II Participant shall maintain eligibility so long as the Plan receives at least one hundred and forty-four (144) Contribution Hours each month from the Employer on such individual's behalf.

(c) **Hour Bank**. No banked hours option is available to a Class II Participant. However, participants who worked in Covered Employment and accumulated a balance in the Hour Bank before becoming a Class II Participant will be permitted to retain hours banked prior to the effective date of the Class II Participant participation agreement. On the date the contribution rate increases, the Hour Bank will be discounted by the percentage of the rate increase.

(d) **Self-Pay Eligibility**. No self-pay option is available to a Class II Participant.

(e) **Reinstatement of Eligibility.** A Class II Employee who loses eligibility for benefits due to a delinquency or voluntary termination of coverage may be reinstated by petitioning the Board of Trustees. Upon approval, coverage will be reinstated within 90 days following the resumption of payment to the Plan by the Employer.

2.5. Surviving Spouse (Class S)

(a) **Eligibility.** Spouses of deceased Participants who maintained eligibility for a period of two consecutive years prior to the date of death will be eligible for benefits in the Retiree Plan on the terms and conditions established by the Trustees of the Retiree Plan.

2.6. Eligibility for Dependents. An eligible Dependent shall mean a Participant's:

(a) Spouse. Provided, however, that a Spouse who is a full-time employee and who is eligible to enroll in employer sponsored coverage must enroll in such coverage as soon as such coverage becomes available to the working spouse. The Plan will apply its coordination of coverage provisions as if the working Spouse had elected the employer-sponsored coverage, unless the working Spouse has family coverage, in which case the normal coordination of benefits provisions will apply. The cost of the working Spouse's coverage may be reimbursed from the Participant's Supplemental Credit Reserve Account.

(b) Son, daughter, stepchild, adopted child, child lawfully placed for adoption, or child meeting the definition of a "foster child" under applicable law that is lawfully placed with the Participant by an authorizing placing agency or by court order, and is under the age of 26. A copy of the order of adoption or placement order must be provided to the Plan Administrator.

(c) Each handicapped Child, who is incapable of self-sustaining employment because of mental or physical handicap, and who is dependent upon the Participant for support and maintenance, shall remain a dependent so long as such incapacity commenced prior to the date such Child's coverage would otherwise terminate under the Plan, and the Participant's coverage remains in force. Proof of the Child's incapacity must be submitted to the Trustees within thirty-one (31) days of the date such Dependent's coverage would have otherwise terminated;

(d) The Plan shall provide benefits otherwise available hereunder, in accordance with any valid order of a court, determined by the Trustees to be a Qualified Medical Child Support Order (QMCSO) under applicable federal law, which creates or recognizes the right of an alternate recipient to benefits as an eligible Dependent under the Plan. A QMCSO must create or recognize an alternative recipient's right to receive benefits for which a Participant or Beneficiary is eligible to receive under this Plan, provide a reasonable description of the benefits of this Plan and the period to which the QMCSO applies is specified. The administrator of this Plan will establish reasonable methods to notify individuals affected by the order, segregate any amounts payable under the order, determine whether the order is qualified and distribute the benefits under the QMCSO. Any payment made by the Plan under a QMCSO or reimbursement for expenses paid by

the Child or the Child's custodial parent or legal guardian must be made either to the Child or the Child's custodial parent or legal guardian.

(e) **Surviving Spouses.** The Surviving Spouse of Class I Participants who maintained eligibility continuously for two years prior to this death will be eligible for benefits under the Retiree Plan under the terms and conditions set forth in the Retiree Plan.

2.7. Continuation of Coverage Under the Family and Medical Leave Act (FMLA). A contributing Employer which is a "covered employer" as that term is defined by the FMLA shall, in order to provide or continue coverage for an eligible Participant, be required to notify the Plan when such "eligible employee" has been granted family or medical leave, in accordance with the terms and conditions established by the Trustees. Both the Employer and the Participant shall be required to provide such notices, information and documentation as may be required by the Trustees and by law. The Plan will continue coverage during the period of any leave for which a Participant is eligible under the provisions of the FMLA. The Employer must remit to the Plan the required amount of Contribution Hours required for eligibility. And the Employer and the Participant must fully comply with all other requirements established by the Trustees.

2.8. Continuation of Coverage Under USERRA. If a Participant leaves Covered Employment to enter service in the Armed Forces, or other uniformed services of the United States, the Contribution Hours accrued in his hour bank, shall be frozen, and he may elect to continue coverage for all benefits under the Plan, except death benefits, accidental death and dismemberment benefits, and Short Term Disability benefits, for a period which is the lesser of:

(a) The twenty-four (24) month period beginning on the last day of Covered Employment; or

(b) The day the Participant fails to apply for or return to Covered Employment.

If a Participant elects to continue coverage, he shall be charged the monthly COBRA premium rate, as described herein, unless his period of service is less than 31 days, in which case coverage shall be provided at no additional cost to the Participant.

The Participant must return to Covered Employment or register on the Union's out-of-work list within ninety (90) days of his discharge under honorable conditions from the services or within twenty-four (24) months of discharge if he is recovering from an illness or injury incurred during or aggravated by his services. Upon his return to Covered Employment or registration on the Union's out-of-work list, the Participant's hour bank, if any, shall be restored. He shall be eligible for coverage without having to reestablish eligibility. However, if the period of military service exceeds five (5) years, the Participant must again establish initial eligibility before his coverage will be reinstated.

2.9. Continuation of Coverage Under Consolidated Omnibus Budget & Reconciliation Act of 1986 (COBRA). COBRA offers Employees and their Dependents the opportunity to temporarily extend their health care coverage at group rates, in certain instances, after coverage under the Plan would normally end. Within the first 90 days of a Participant or Dependent receiving coverage under this Plan, the Plan Administrator will provide each Participant and Dependent a general notice describing COBRA rights. If a qualifying event occurs, the Plan Administrator will provide an election notice to the Participant and his or her Dependents. The election notice describes their COBRA rights and how to elect COBRA coverage. The Plan Administrator must provide this election notice to the Participant and his or her Dependents within 14 days after receiving notice of the qualifying event.

(a) **Participant Eligibility for COBRA Coverage**: A Participant who suffers either a reduction in his hours of employment or is terminated from employment, for reasons other than gross misconduct, is eligible for COBRA continuation coverage.

(b) **Dependent's Eligibility for COBRA Coverage**: A Dependent child or Spouse has the right to elect continuation coverage under COBRA if he or she loses coverage as a result of any of the following qualifying events:

(1) The death of the Participant; or

(2) The termination of the Participant's employment, for reasons other than gross misconduct, or reduction in Participant's hours of employment; or

(3) The Participant's divorce or legal separation; or

(4) Upon the Participant's eligibility for Medicare; or

(5) For a Dependent child, ceases to be an eligible Dependent under this Plan.

(i) A Child born to or placed for adoption with a covered Participant during the COBRA coverage period shall be considered a qualified Beneficiary, entitled to coverage under this Plan.

(c) **Notice Requirements**: A Participant or Dependent who has lost coverage due to divorce, separation or loss of dependency status, must notify the Benefits Office of the qualifying event within sixty days (60) of the occurrence of such event to qualify for COBRA continuation coverage. In all other cases, the Participant's Employer must notify the Benefits Office within thirty days (30) of the qualified events. Failure to elect COBRA continuation coverage within the time specified will result in termination of the Participant or Dependent's group health care coverage, as of the date of the qualifying event.

(d) **Duration of COBRA Continuation Coverage**:

(1) **Active Employee**. An Active Participant who experiences a reduction in hours worked, or is terminated from employment for reasons other than gross misconduct, shall be entitled to maintain COBRA Continuation Coverage for a maximum of eighteen (18 months).

(2) **Spouse or Dependent Child**. Where the qualifying event is a loss of dependency status, i.e. death of an employee, divorce, legal separation, or eligibility for Medicare, the Spouse or Dependent children shall be entitled to coverage to maintain Continuation Coverage for a maximum of thirty-six (36) months.

(e) **Extension of COBRA Continuation Coverage**:

(1) **Disabled Employee**: A Disabled Participant's continuation coverage may be extended to a total period of twenty-nine (29) months if:

(i) The Social Security Administration ("SSA") determines that the Participant was disabled prior to beginning COBRA coverage; or it determines that before the first eighteen (18) months of COBRA coverage have expired, the Participant was disabled within sixty-days (60) of the date that the Participant first began COBRA coverage; and

(ii) The Disabled Participant notifies the Plan Administrator in writing of a Social Security Disability ("SSD") award within the first eighteen months (18) of the COBRA continuation coverage and within sixty days (60) of (a) the date on which SSA issues the disability determination; (b) the date on which the qualifying event occurs; or (c) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event, whichever is later.

(iii) **Loss of SSD Status**. A Disabled Participant must notify the Plan Administrator in writing within thirty-days (30) of a determination by the SSA that the Disabled Participant is no longer disabled.

(2) **Second Qualifying Event**: If a second qualifying event occurs during the first eighteen (18) months of COBRA continuation coverage, the continuation coverage period can be extended an additional eighteen (18) months, for a total coverage period of thirty-six (36) months.

(i) **Notice Required**. The Participant must notify the Plan Administrator in writing of a second qualifying event within sixty days (60) from when the second qualifying event occurred or within sixty days (60) of the date the Participant would lose coverage under the Plan due to the qualifying event, whichever is later.

(f) **Cost of Continuation Coverage**: The Board of Trustees shall determine the cost of COBRA continuation coverage, excluding weekly disability benefits, but shall not exceed 102% of the applicable health insurance premium. The Board of Trustees may charge up to 150% of the applicable health insurance premium to Participants who receive the eleven (11) month extension of COBRA coverage as a result of a disability

2.10 Portability of Coverage. Pursuant to the enactment of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), each Participant and Dependent is entitled to a limited waiver of certain waiting periods associated with pre-existing conditions. To qualify for such waiver, each Participant or Dependent must present a certificate of coverage, evidencing prior coverage, to this Plan. A request for a certificate of coverage from this Plan will issued automatically in the event coverage is terminated, but may also be requested from the Plan by making the request in writing to the Plan Administrator.

2.11. Termination of Eligibility. A Participant's eligibility for benefits shall terminate on the last day of the month for which he has failed to meet the requirement for continuing eligibility under the Plan, unless he makes self-payments, when permitted, in accordance with the provisions of this Plan. If the Participant elects to make self-payments, his eligibility for benefits hereunder shall terminate on the last day of the month preceding the month in which the Participant ceases making self-payments.

2.12 Reinstatement of Eligibility. Surviving Spouses and their Dependents who have failed to maintain continuous coverage shall not have their benefits or eligibility reinstated. Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service will be provided in accordance with Section 414(u) of the Internal Revenue Code, as amended from time to time.

2.13 Reciprocity. The Trustees have entered into reciprocity agreements with other health and welfare Plans covering the industry throughout the country. Pursuant to these reciprocity agreements, contributions made on the Participant's behalf may be transferred from one Plan to another, upon the Participant's request and authorization. The contributions that may be transferred may enable the Participant to meet the continuing eligibility requirements of his home Plan. If the Participant works in another jurisdiction and has Employer Contributions made to another Plan on the Participant's behalf, he may request that such contributions be transferred to this Plan via a reciprocity agreement. Contributions will then be transferred in accordance with the terms of that agreement, which may be pro-rated or at the lesser of the two rates in effect for the particular jurisdictions that are participating in the reciprocity transfer.

ARTICLE III
BENEFITS

This Plan provides coverage to you and your eligible dependents for various benefits that are summarized here and in the schedule of benefits. For some benefits, you must also pay a portion of the expense, known as a co-pay or deductible. For a summary of the benefits provided by the Plan, see Appendix A of this Plan Document.

3.1 Coverage for Class I & II Participants and their Dependents. The Plan has contracted with various service providers to furnish medical, hospital, surgical, and prescription drug benefits to eligible Class I & II Participants and their Dependents. A description of these benefits is set forth in the Schedule of Benefits, found in Appendix A. Different coverage options may be offered with different eligibility and qualification requirements.

3.2. Death Benefit. The Plan provides death benefits to the appropriate Beneficiary upon proof of the eligible Participant's or his eligible Dependent's death. The amount of death benefit is specified in the Schedule of Benefits, attached as Appendix A, and is subject to the provisions thereof. The Plan may purchase such coverage from a life insurance company, which may impose additional requirements for such coverage.

(a) **Beneficiary.** A Participant may, in his application for a death benefit, designate a Beneficiary or Beneficiaries to receive his death benefits.

(b) **Change in Beneficiary**. Subject to any legal restrictions, or to the rights of any irrevocably appointed Beneficiary, the Participant may from time to time change the Beneficiary. Designations of Beneficiary and any changes thereto, must be made in writing, signed by the Participant and filed with the Plan. In the absence of a subsequent appointment or change in Beneficiary, the Beneficiary who is named at the time of the Participant's termination of service, shall remain the Beneficiary for purposes of receiving the death benefit described in the Schedule of Benefits.

(c) **Failure to Designate a Beneficiary**. In the absence of any statutory provision to the contrary, and if the Participant has not designated a Beneficiary or Beneficiaries, the death benefit proceeds shall pass in descending order to the following individuals:

(1) The Participant's surviving Spouse, then to

(2) The Participant's surviving Child or Children, in equal shares; but if there are no survivors, then to

(3) The Participant's surviving Parent or Parents, in equal shares; but if there are no survivors, then to

(4) The Participant's surviving Siblings, in equal shares; but if there are no survivors, then to

(5) The Participant's estate.

(d) **Division of Death Benefit Proceeds**. If a Participant has named two or more Beneficiaries but has not specified a method of sharing the death benefit proceeds, the Beneficiaries who survive the Participant shall be entitled to receive equal shares of the benefit.

(e) **Payment If Beneficiary is Minor**. If any Beneficiary is a minor or otherwise incapable of giving a valid release for any payment due, death benefit proceeds payable to such Beneficiary shall be paid to his duly appointed guardian. Any such payment shall constitute a full discharge of the liability of the Plan or any insurance company.

(f) **Beneficiary Predeceases Participant.** Should any legally designated Beneficiary predecease the Participant, the insurance proceeds so designated shall, unless otherwise specified by the Participant, and in the absence of any statutory provisions to the contrary, be payable equally to the remaining legally designated Beneficiary or Beneficiaries, if any, who survive the Participant.

3.3. Short Term Disability Benefits. Short Term Disability Benefits are payable to Eligible Class I Participants only, according to the Schedule of Benefits attached as Appendix A. An eligible Active

Participant who becomes wholly and continuously disabled by a non-occupational accidental bodily injury or sickness or disease that prevents him from working at his occupation, provided he is under the regular care of a qualified Medical Provider, and provided that such disability occurs while the Participant is eligible for benefits under this Plan, shall be qualified to apply for these benefits. No benefits are payable for any day during which the Participant performs any work, whether for pay or profit, even if during such period the Participant is under the care of a qualified Medical Provider. Any balance of benefits which has not been paid by the end of the disability period, shall be payable, provided that the Participant furnishes the Plan the required medical evidence or certification of disability by the attending Medical Provider.

(a) **Submission of Claims**. Notice must be provided to the Administrator within twenty (20) days of the accident or sickness causing the disability or within a reasonable time if notice cannot practicably be given within that time period. The claimant must then complete the application and return it to the Administrator. Claims review and appeals will be handled in accordance with the relevant provisions of Article V.

(b) **Payment of Short Term Disability Benefits**. Short Term Disability Benefit payments will be made to the Participant during the period of disability, beginning:

(1) With the 1st day of disability due to an accident or injury;

(2) The first day of hospitalization;

(3) The first day of a surgical procedure performed in an outpatient facility; or

(2) With the 8th day of disability due to an illness.

(b) **Maximum Benefits**. Short Term Disability Benefit payments of $450 per week shall be made for a maximum period of twenty-six (26) weeks during any twelve (12) consecutive month period or for any single disability, provided that the Participant remains under the continuous care of a qualified Medical Provider and is deemed unable to work during this time.

(c) **Disability Period**. In determining when one disability ends and a new period begins, all disability absences due to the same or related causes and separated by less than eight (8) weeks of active work will be considered as occurring in a single disability period, unless a new disability period occurs as a result of a cause different from the causes of any prior disability. In addition, no disability will be considered as starting more than three (3) days prior to your first visit to a Medical Provider.

(d) **Return to Active Employment**. Each disabled Participant must notify the Plan Administrator of his active status on the date he returns to work. In the event Weekly Disability Benefits are paid to a Participant based on a certification of disability by the attending Medical Provider, and such Participant returns to active employment without notification to the Plan Administrator, and benefits are paid in error, the Participant must refund such benefits to the Plan within ten (10) days of his return to Covered Employment.

(e) **Limitations**. No Short Term Disability Benefits shall be paid under this provision:

(1) For any period of disability during which such Participant is not under the direct care of a Medical Provider. No disability will be considered as beginning more than three days prior to the Participant's first visit of, or to, a Medical Provider.

(2) For disability due to accidental bodily injuries arising out of and in the course of such Participant's employment.

(3) For disability due to occupational disease. "Occupational disease" shall mean a disease for which the Participant submitting the claim, is entitled to receive benefits under the applicable Workers' Compensation Law, Occupational Disease Law, or similar legislation.

(4) In the event the Participant is disabled as a result of an automobile accident.

(5) For disabilities resulting from alcoholism or drug abuse, except as provided under the Schedule of Benefits, attached as Appendix A.

(6) For expense incurred if the Participant is engaged in any unlawful act.

3.4. Vision Coverage. Vision Coverage is provided as set forth in Appendix A.

3.5. Dental Coverage. Dental Coverage is provided as set forth in Appendix A.

3.6 Health Reimbursement Account: A Health Reimbursement Account, also referred as the Supplemental Credit Reserve Account (SCRA) was established, whereby a portion of Employer Contributions is, for bookkeeping purposes, treated as if it has been set aside into an account in the individual participant's name for eligible Class I Participants to be used exclusively to cover certain medical-related out-of-pocket expenses not otherwise covered by the Plan. New Participants are immediately provided with an SCRA, upon completing all requested enrollment forms. The account may be comingled for investment and other administrative purposes. Residential employees are not eligible for an SCRA.

(a) **Covered Expenses**. Medical expenses eligible for reimbursement from the SCRA include medical, dental, and optical insurance deductibles, co-pays, and medical services otherwise not covered by the Plan, if these expenses meet Internal Revenue Code guidelines for deductibility and are included in the schedule of benefits set forth in Schedule A to this Plan. SCRA balances may also be used to make self-payments of insurance premiums owing under the terms of this Plan.

(b) **Reimbursements.**

(1) Distributions from the SCRA will only be made to reimburse expenditures upon submission of proper documentation under the claims procedure set forth in Section . SCRA cash distributions will not be paid in advance of the covered expenditures. Covered expenses will only be paid from a participant's SCRA to the extent of the balance remaining in that participant's SCRA at the time of the claim.

(2) PrePaid Benefits Card: The Trustees may, within their discretion, provide a pre-paid benefits card to electronically access the balance in the participant's medical reimbursement account for reimbursement at pharmacies and other health care providers that participate in the prepaid benefits program.

(c) **SCRA Transferable**. When a participant is deceased, his SCRA balance is transferable to his eligible surviving spouse. Or if there is no surviving spouse, then his balance is not transferable to his qualified dependent children.

(d) **Balance Forfeitable**. If there is no activity with respect to the SCRA or no Employer Contributions to the SCRA for a period of five (5) or more years, then the balance of the SCRA is forfeited to the Plan.

(e) **Option to Opt-Out**. A Participant may opt-out of the SCRA account and waive all rights to future reimbursements from the SCRA. The Plan shall offer the opt-out opportunity once annually. Upon loss of eligibility, the Participant who has not previously opted out

may permanently opt-out and waive the right to future reimbursements from the SCRA.

ARTICLE IV
EXCLUSIONS AND GENERAL LIMITATIONS

4.1 **Exclusions.** To the extent the exclusions listed below are not the result of an otherwise covered benefit, each exclusion listed below applies to all benefits under this Plan, except life insurance, irrespective of whether the exclusion is repeated in a provision of this Plan describing such benefits. Accordingly, except where required by law, this Plan **will not provide** benefits, as follows:

1. For injury received while working for pay or profit by any Participant or any Dependent including any extra side job, weekend job, a job being performed by a friend or relative on which the Participant or Dependent is assisting (working or viewing).

2. For loss or expense from sickness, or disease, or as a result of any accidental bodily injury which arises out of or in the course of employment, which entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law.

3. For pre-employment or insurance exams.

4. For treatment of injury or illness caused by war.

5. For any hospital confinement, surgery, treatment, service or supply for which the Participant or dependent is not legally obligated to pay.

6. For any period of hospital confinements that occur before the effective date of eligibility, upon becoming eligible however, the Plan will assume coverage.

7. For treatment of injury, resulting from causes other than sickness, accidental injury or disease. Injuries incurred in a "fight", however, injuries sustained in the context of domestic violence will be covered. In case of questionable claims of this type, the Trustees will require a copy of the police report and full details describing the altercation. However, coverage will be extended to victims of domestic violence or where the injury is related to an otherwise covered benefit.

8. For educational or self-help therapy, other than diabetic self-management in a hospital setting.

9. For expense incurred for any type of family planning (other than those associated with contraceptive management).

10. For comprehensive nutritional programs or for visits with specialists in endocrinology and visits when required solely for the purpose of weight loss or for treatment of obesity only or for expense incurred for dietary supplements and nutritional lectures and quick weight loss programs and clinics.

11. For sterilization reversals.

12. For payment of surcharge or nonresident tax levied by community hospitals.

13. For installation of air conditioning units, humidifiers for environmental controls, whirlpools, air filters, bathroom rails, special toilet seats, commodes, chair lifts, or other non-essential home-installed conveniences even when prescribed by a Medical Provider, including ergometers and exercycles, bicycles, etc.

14. For elective surgery, including cosmetic surgeries that are not necessary by reason of sickness, injury or disease or for the protection of the health of the individual.

15. For medical treatment or services, if any, that are not recommended and approved or prescribed by a legally qualified Medical Provider.

16. For treatment of injuries sustained in an automobile accident or motorcycle or other motor vehicle accident or complications resulting from such injuries or accident, unless a subrogation agreement is executed in favor of the Plan.

17. For television, telephone, guest trays or other non-essential personal items and services including take-home prescription drugs and supplies.

18. For expense incurred if the person is engaged in any unlawful act.

19. For immunization injections not otherwise required to be covered by law.

20. Any deductible required by the plan or reimbursement of deductibles under the plan or prescription deductible, if any.

21. For expense incurred (or from complications resulting from) for cosmetic surgery or experimental surgery, except as specifically covered by this Plan.

22. For court ordered hospital confinements and treatment required by court orders, which is the result of an order of any court of law to any eligible Participant or any of his eligible Dependents, even when prescribed by a Medical Provider.

23. For the use of a private room. If used, the average semi-private room rate of that hospital will be paid, except private room accommodations required by the hospital for treatment in quarantine purposes and not for the comfort of the patient.

24. For hospitalization for dental care other than when concurrent hazardous medical condition necessitates hospitalization.

25. For voluntary abortions, except in those cases where such surgery is performed to protect the health of the Participant or eligible Spouse.

26. For radial keratotomies (and/or for Lasik), except as covered under the dental/vision benefit.

27. For purchase of sun lamps required for any cause.

28. For experimental procedures, supplies and devices.

29. For temporomandibular joint (TMJ) services, except surgery to the jaw joint, x-rays (including MRI) and injection procedures, except as covered under the dental/vision benefit. Pre-certification may be required.

30. For custodial care.

31. For prescription drugs that are primarily for elective or cosmetic purpose (i.e., Retin-A).

32. For donor expenses.

4.2 Modifications. The amount of benefits offered by this Plan and the Trustees therefore can modify the eligibility requirements at any time, or such benefits can be eliminated entirely, as the Trustees

deem appropriate. No retroactive claim to benefits will be recognized in case of such modification or elimination of coverage.

4.3 Coordination of Benefits. In general, benefits from this Plan are subject to amounts payable in accordance with coordination of benefits (COB) rules. The purpose of these rules is to avoid duplicate or overlapping payments of benefits resulting in unjust overpayments. The COB rules apply generally to all benefits payable from this Plan other than the Death Benefit and Short Term Disability Benefits.

(a) **Employment**. COB rules are in effect whenever any individual has coverage under this Plan and any other group insurance program, health and welfare Plan, Blue Cross/Blue Shield, Medicare, or other health care plan. If a Participant becomes employed by an employer, who provides a health care plan other than this Plan, then that employer's health insurance program will become the primary insurance carrier once the Participant's eligibility for benefits under this Plan expires.

(b) **Birthday Rule for Dependents**. If both the Participant and his Spouse are entitled to benefits under separate group health insurance programs, and both plans cover the couple's Dependent Children, the Plan which covers the Spouse with the birthday earliest in the year, shall be considered the primary payor for the Dependent Children. If the birthdays of the two policyholders are on the same date, the policy of plan that has been in effect for the longer time will be primary. This Plan will pay benefits in accordance with its applicable schedule of benefits if it is considered to be primary. Otherwise, the other plan will be required to pay the benefits up to the maximum amount payable in accordance with its schedule of benefits and this Plan will then pay any remaining amounts not covered by such other plan up to, and in accordance with, its Schedule of Benefits so that, in the aggregate, no more than 100% of the "covered charges" will be paid.

(c) **Order of Coverage**. This Plan determines its order of coverage using the following rules:

(1) If a person is covered as an insured or as an employee under one policy and a dependent under another, the policy or plan under which he is the insured or employee is primary.

(2) In case of Dependent Children of divorced parents, the plan of the parent on whom the Judgment of Divorce places the health care responsibility will be the primary insurer. If this is not stated in the judgment, then the following COB rules shall apply:

(i) The plan of the parent with physical custody of the Child/ren shall be primary; then

(ii) The plan of the Spouse of the parent with physical custody of the Child.

(iii) Joint Custody: If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the plans covering the Child(ren) will follow the order of benefit determination rules set forth in this subsection.

(d) **Out-of-State Policy**. If one of the policies or plans is issued in another state that does not use birthdays for coordination of benefits and each policy or plan by its terms is secondary, then the out-of-state policy or plan shall be secondary. Each policy or plan will then be responsible for a maximum of fifty percent (50%) of their allowed expense or allowed benefit.

(e) **Coordination of Benefits - Medicare.** The Plan will provide identical benefits to all Active Participants regardless of Medicare coverage to which an Active Participant may otherwise be eligible; except, in the following circumstances then Medicare shall be primary: (a) a Participant is a Retiree over age 65; (b) a Spouse of a Participant over age 65 for whom Medicare would otherwise be secondary is determined to be a Participant of an Employer with less than twenty (20) employees; (c) a Participant is under age 65 and has received Social Security Disability benefits for 24 months or longer; (d) a Participant is under age 65 and qualifies as an eligible person who requires hemodialysis treatment or a kidney transplant because of chronic kidney disease.

(f) **Coordination of Benefits – Auto Accidents**. If medical, surgical, or prescription drug coverage is available from other provider of insurance, the Plan will provide coverage only a secondary basis and only if the Participant signs a reimbursement agreement in a form acceptable to the Board of Trustees.

(g) **Duty to Comply with Plan Requirements.** If a Participant and/or Beneficiary is eligible for benefits under a health maintenance organization, preferred provider organization, or similar type of plan, which requires that health care services be obtained only from certain designated health care providers and/or organizations, and if such individual fails to comply with the requirements of such policy or plan, then he shall not be eligible for benefits hereunder, pursuant to the coordination of benefits provision. Only if a Participant and/or a Beneficiary is denied benefits under another health care plan, after complying with all its requirements for eligibility and/or coverage, will he become eligible for coverage under the Plan, pursuant to the coordination of benefits provision.

4.5 Reduction of Pre-Existing Condition Exclusion through Creditable Coverage: If the Participant and/or any Dependents had other health care coverage defined as "creditable coverage" under the Health Insurance Portability and Accountability Act (HIPAA), and that other coverage terminated within 63 days of the effective date with this Plan, the prior health coverage will be credited against the any pre-existing condition exclusion under the Plan. In order to reduce the pre-existing condition exclusion period, the Participant must provide proof of prior creditable coverage. Through December 31st 2014, the Plan Administrator will automatically provide Certificates of Creditable Coverage upon termination of coverage or upon written request to the Plan Administrator.

ARTICLE V
ADMINISTRATION

5.1 Trustees Responsible for Administration. The Trustees shall be solely responsible for the administration of the Plan in their sole and absolute discretion except to the extent such authority has been delegated its agents or employees as permitted by law. The decisions of the Trustees or its authorized agents in all matters pertaining to the administration of the Plan shall be final. The Trustees reserve the right to make such rules and prescribe such procedures for the administration of the Plan, as they shall deem necessary and reasonable.

5.2 Records and Reports. The Trustees shall keep such records and other data as may be necessary for the proper administration of the Plan. Upon receipt of a written request, the Trustees shall furnish any Participant or Beneficiary with a copy of the Plan, Trust Agreement, or latest annual report, subject to a reasonable charge where permitted be law not to exceed the lesser of:

(a) The actual cost of reproduction; or

(b) $.25 per page.

5.3 Filing and Determination of Claims

(a) **Definitions**. The following defined terms will be used in this section:

(1) **Adverse Benefit Determination**. A denial, reduction, termination of, or failure by the Plan to provide or make payment for, a benefit available under the Plan. A retroactive cancellation of coverage is also included in this definition. Coverage will not be rescinded unless for fraud or instances of material misrepresentation. 30 days notice will be provided in advance of any retroactive rescission of coverage.

(2) **Urgent Care Claims**. An "Urgent Care" claim is any claim for medical care or treatment which cannot be decided under normal time frames because: (A) it can seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (B) in the opinion of a Medical Provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Any claim that a Medical Provider with knowledge of the claimant's medical condition determines is an "Urgent Care" claim shall be treated as an "Urgent Care" claim by the Plan. Otherwise, the determination regarding whether a claim involves "Urgent Care" shall be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

(3) **Pre-Service Claims**. A "Pre-Service" claim is any claim that, under the terms of the Plan, conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(4) **Concurrent Care Claims**. A "Concurrent Care" claim is any claim regarding an on-going course of treatment to be provided over a period of time or number of treatments, which has previously been approved by the Plan.

(5) **Post-Service Claims**. A "Post-Service" claim is any claim that is not a "Pre-service", "Urgent Care", or "Concurrent Care" claim.

(b) **Claim Filing Deadline and Initial Determination Timeframes**

(1) **General 1-Year Filing Deadline**. All claims for benefits of any kind must be filed with the Plan within one (1) year of their occurrence.

(2) **Urgent Care Claims**. The Plan shall notify the claimant of its decision as soon as possible but no later than 72 hours after receipt of a properly submitted claim. In the event the claimant failed to submit sufficient information to process the claim or failed to follow the Plan's procedures, then the claimant shall be notified of the defect within 24 hours, and shall have 48 hours to provide the information. The Plan shall then notify the claimant of its decision either within 48 hours of its receipt of the requested information or at the end of the initial 48 hours given to the claimant to provide it.

(3) **Pre-Service Care Claims.** The Plan shall notify the claimant within 15 days of receipt of the claim. If the Plan is not able to make a decision due to circumstances beyond the Plan's control, then it may extend the period by an additional 15 days. The Plan may only exercise the 15-day extension if, prior to the end of the initial 15- day period, the claimant is provided with a notice that

provides the reasons for the delay and the date by which the plan expects to render a decision. In the event the extension is due to the failure of the claimant to submit information necessary to reach a decision on the claim, then the claimant shall be given 45 days to provide the necessary information. The claim will then be decided within 15 days of receiving the requested information or within the initial 45 day extension to provide the information, whichever occurs first.

(4) **Post-Service Care Claims.** The Plan shall notify the claimant within 30 days of receipt of the claim. If the Plan is not able to make a decision due to circumstances beyond the Plan's control, then it may extend the period by an additional 15 days. The Plan may only exercise the 15-day extension if, prior to the end of the initial 30- day period, the claimant is provided with a notice that provides the reasons for the delay and the date by which the plan expects to render a decision. In the event the extension is due to the failure of the claimant to submit information necessary to reach a decision on the claim, then the claimant shall be notified within 5 days and given 45 days to provide the necessary information. The claim will then be decided within 15 days of receiving the requested information or within the initial 45 day extension to provide the information, whichever occurs first.

(5) **Disability Claims.** The Plan shall notify the claimant within 45 days of receipt of the claim. If the Plan is not able to make a decision due to circumstances beyond the Plan's control, then it may extend the period for 30 days. The Plan may only exercise the 30-day extension if, prior to the end of the initial 45-day period, claimant is provided with a notice that provides the reasons for the delay, the standards on which entitlement to the benefit is based, and the date by which the Plan expected to render a decision. If additional time is still needed, then the Plan may extend the timeframe an additional 30 days, and shall notify the claimant of the second extension prior to the expiration of the first 30-day extension. The Plan may not exercise the second 30-day extension without again providing notice to the claimant of the reasons for the delay, the standards on which the benefit is based, and the date by which the Plan expects to render a decision. If any extension is based upon the need for the claimant to provide additional information, the claimant shall be given 45 days to provide it.

(6) **Concurrent Care Claims.** An adverse determination regarding a Concurrent Care Claim is any reduction or termination by the Plan of the course of treatment before the end of the period of time or the full number of treatments, unless the reduction or termination occurs as the result of a Plan amendment or termination of the Plan. The Plan will notify the claimant of the adverse benefit determination regarding a Concurrent Care Claim at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Additionally, any request by a claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving Urgent Care shall be decided (A) as soon as possible, taking into account the medical exigencies, and (B) the Plan shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, if the claim was submitted to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(7) **Time**. For purposes of claims reviews and Step 1 and Step 2 appeals, the period for review shall begin when the claim or appeal is filed in accordance with the

Plan's procedures. If an extension of time occurs due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the on which the notification of the extension is sent to the claimant until the claimant responds to the request for additional information.

(c) **Claim Denial Notice**. The notice of claim denial shall contain:

(1) Information sufficient to identify the claim, including date of service, care provider, claim amount (where applicable) and a statement that diagnosis and treatment codes (if any) are available upon request;

(2) The specific reason(s) for denying the claim and specific reference(s) to pertinent Plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such information is necessary;

(4) A description of the Plan's review procedures, internal and external in the case of a final adverse benefit determination, including the time limits under the procedures, and a statement regarding the claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal;

(5) If applicable, a copy of the internal rule, guideline or protocol that was relied upon, and a statement that such rule will be provided free of charge to the claimant upon request;

(6) If the adverse determination is based on the issues of medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge to the claimant upon request;

(7) A description of the expedited review process applicable to "Urgent Care" claims; and

(8) Any other information required by law.

5.4 Appeals Procedures

(a) **Step 1 Appeal.** If the claimant disagrees with the action taken on his/her claim by the Plan, then the claimant may submit a written request for review. The claimant may either submit the claim personally, or may have the claim submitted by the claimant's duly authorized representative. The Plan Administrator will review the claim in accordance with the following rules listed below. The decision of the Plan Administrator in a Step 1 Appeal is not a final adverse benefit determination.

(1) A request for review of the Plan's action must be submitted in writing to the Administrator within 180 days after mailing of the notice of the adverse benefit determination.

(2) Claimant may have an opportunity to review necessary and pertinent documents on which the denial in whole or in part is based and may submit written comments, documents, records, and other information relating to the claim for benefits.

(3) Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. A document is considered relevant to the claim if the

document (1) was relied upon in making the benefit determination, (2) was submitted, considered or generated in the course of making the benefit decision, or (3) demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the Plan and be consistent when applied to similarly situated claimants.

(4) The Plan shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination by the Plan.

(5) The Plan shall not afford deference to the initial adverse benefit determination.

(6) The review will not be conducted by the individual who made the initial adverse determination, nor by the subordinate of such individual.

(7) If the appeal is from an adverse benefit determination that was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, then the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for the purposes of a consultation under this section shall be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the review, nor the subordinate of any such individual. The claimant shall be informed of the identity of each medical or vocational expert whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(8) If the request for review involves an Urgent Care claim, then the claimant shall be offered an expedited review process pursuant to which (A) the request for appeal of an adverse benefit determination may be submitted orally or in writing by the claimant, and (B) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(9) The Plan Administrator shall notify the claimant of its decision of an Urgent Care benefit claim within 72 hours, a Non-Urgent Pre-Service benefit claim within fifteen 15 days, a Non-Urgent Care Post-Service benefit claim within 30 days, and a Disability Claim within 45 days.

(10) If the determination is adverse, the notice shall include the following information:

(i) The specific reason(s) for the adverse determination;

(ii) Reference(s) to the specific Plan provisions on which the determination is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim. A document is considered relevant to the claim if the document (1) was relied upon in making the benefit determination, (2) was submitted, considered or generated in the course of making the benefit decision, or (3) demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the Plan and be consistent when applied to similarly situated claimants;

(iv) If applicable, a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination, or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant upon request;

(v) If the adverse determination is based on medical necessity or experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(vi) A statement regarding the claimant's right to bring a civil action under ERISA section 502(a) following the adverse benefit determination on appeal;

(vii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency" and;

(viii) Any other information required by law.

(b) **Step 2 Appeal**.

(1) The claimant or his or her authorized representative may appeal the final decision by the Plan Administrator, by written notice received by the Board of Trustees within one hundred (180) days of the mailing of the notice of an adverse benefit determination. The written notice only needs to state the claimant's name, address, and the fact that the claimant is appealing from the decision of the Plan Administrator, giving the date of the decision appealed from.

(2) The Board of Trustees shall review the claim and advise the claimant of any adverse benefit determination in accordance with the notice content and timing requirements set forth in Step 1 of the Appeals Procedure, Section 5.4(a) above.

(3) **Decision of the Trustees is Final**. Under the Trust, the Board of Trustees has discretionary authority (a) to make any determination with respect to an individual's eligibility for participation and/or eligibility for benefits under the Plan, and (b) to construe the provisions of the Plan, and its policies, procedures, resolutions, and directives adopted by the Trustees, as amended from time to time. This discretionary authority includes, but is not limited to, the power to construe any disputed or doubtful terms of the Plan and its policies, procedures, resolutions or directives. Any decision rendered by the Trustees after compliance with the foregoing procedures shall be final and binding upon the claimant, his/her beneficiaries, heirs, legatees, and personal representatives. No further appeals shall be available under the Plan.

5.4. Misstatement in Application for Benefits. If any person in his application for benefits, or in response to any request of the Trustees for information, makes any statement which is erroneous or omits any material fact or fails before receiving his first payment to correct any information he previously incorrectly furnished to the Trustees for their records, the amount of the benefit shall be adjusted on the basis of the true facts, and the amount of any overpayment theretofore made to such person shall be deducted from the next payments as the Trustees shall direct. Retroactive rescission of coverage shall only occur in the event of fraud or material misrepresentation to the Plan. The Plan Administrator shall provide at least 30 days written notice in advance of any retroactive rescission of coverage.

5.5. Interpretation. The Trustee shall have discretionary authority to make any determination with respect to an individual's eligibility for participation or eligibility for benefits under the Plan, and to construe

the provisions of the Plan, policies and procedures, and resolutions and directives adopted by the Trustees, as amended from time to time. This discretionary authority shall include, but not be limited to the power to construe any disputed or doubtful terms of the Plan, policies or procedures, resolutions or directives, as amended from time to time.

5.6. Contributions to the Plan. Pursuant to certain Collective Bargaining Agreements, the Trustees, the Union and the Associations have executed a Trust Agreement. The terms of the Trust Agreement provide for receipt and holding of contributions payable by the Employers along with interest and other income. The contributions and income from interest and investments are to pay benefits and provide funds for its operation. The Employers shall have no rights, title or interest in the contributions made to the Plan and no part of the Plan shall revert to the Employers.

5.7. Funding and Payment of Benefits. The amount of Employer Contributions shall be determined by the terms of the Collective Bargaining Agreement between each such Employer and the Union. All benefit payments will be paid by the Trustees and all contributions available for investment will be invested by the Trustees in such manner as serves the best interests of the Plan and its Participants. Prior to the termination of the Plan, no part of the Plan assets may be applied other than for the exclusive benefit of Participants and their Beneficiaries.

5.8. Duty to Notify the Plan of Changes. The Benefits Office must be notified of any changes regarding the following:

(a) **Marriage** - To add a Spouse or stepchildren to coverage, the marriage must be reported within thirty (30) days. A copy of the certificate of marriage must be filed in the Benefits Office. The Spouse and stepchildren will be covered from the moment of marriage, as provided herein.

(b) **Foster children** – To add a foster child to coverage, the Participant must provide the Fund Office with a true copy of the Court order placing the foster child with the Participant within 30 days of the entry of the order. Upon the child leaving the care of the Participant either by attaining the age of majority or by other court order, the Participant shall notify the Fund Office within 30 days of the triggering event and coverage shall end on the last day of the month in which the triggering event occurs.

(c) **New Children** - To add a Participant's Child to coverage, the birth must be reported within thirty (30) days. A copy of the birth certificate must be filed in the Benefits Office. The Child will be covered from the moment of birth, as provided herein.

(d) **Adoptions** - Adoption or placement of a Child must be reported within thirty (30) days to add the Child as an eligible Dependent and a copy of the legal adoption papers or court order for placement must be filed in the Benefits Office.

(e) **Change of Address** - Any change of address shall be reported immediately.

(f) **Name Change** - Any name change shall be reported immediately.

(g) **Deaths** - Deaths should be reported immediately. A certified copy of the death certificate is required.

(h) **Divorce** - Divorce must be reported immediately and a full copy of the judgment of divorce must be filed in the Benefits Office. A former spouse is not eligible for benefits commencing on the date of the divorce, except as provided under the Continuation of Coverage (COBRA) Provisions outlined herein. Eligible Dependent Children will continue to be covered if they continue to be legal Dependents.

(i) **26th Birthday** - Dependent children attaining the age of twenty-six (26) or foster children who no longer meet the definition of a "foster child" under applicable law are no longer eligible for coverage. Once no longer eligible for coverage, such dependent may elect continuation of coverage under the COBRA provision of the Plan.

5.9 HIPAA and HITECH Privacy Requirements.

(a) **Use and Disclosure of Protected Health Information (PHI)**. The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations, as those terms are defined in 45 C.F.R. § 164.501.

(b) **The Plan will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary.** With an authorization, the Plan will disclose PHI to constituent plans affiliated with the Union for purposes related to administration of these plans.

(c) **Trustee Certification**. The Plan will disclose PHI to the Trustees, subject to the conditions set forth in subsection D.

(d) With Respect to PHI, the Trustees agree to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(2) Ensure that any agents, including a subcontractor, to whom the Trustees provide PHI received from the Plan agree to the same restrictions and conditions that apply to the Trustees with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions unless authorized herein or by an individual;

(4) Not use or disclose PHI in connection with any other benefit or plan of the Trustees unless authorized by an individual;

(5) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(6) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA and HITECH;

(7) Make available the information required to provide an accounting of disclosures;

(8) Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA and HITECH; and

(9) If feasible, return or destroy all PHI received from the Plan that the Trustees still maintain in any form, and retain no copies of such PHI when no longer needed

for the purpose of 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).

(e) In order to maintain adequate separation between the Plan and the Plan Sponsor, only the following employees or classes of employees may be given access to PHI:

(1) Any Plan employees;

(2) The Plan administrator;

(3) Staff designated by the Plan administrator; and

(4) Third-party providers who have executed a business associate agreement.

(f) **Limitations of PHI Access and Disclosure**. The persons described in subsection 5.9(e) may only have access to and use and disclose PHI for plan administration functions that the Trustees perform for the Plan.

(e) **Noncompliance**. If the persons described in subsection 5.9(e) do not comply with this Plan document, the Trustees shall resolve any issues of non-compliance in accordance with the provisions of HIPAA, HITECH and regulations thereunder.

(f) **Notification Upon Breach**. Following the discovery of a breach of unsecured PHI, the Plan will notify each individual whose unsecured PHI has been, or is reasonably believed to have been, inappropriately accessed, acquired or disclosed in the breach. Notice will be provided in plain language and include:

(1) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

(2) A description of the types of unsecured PHI that were involved in the breach (e.g., full name, Social Security number, date of birth, home address, account number, disability code);

(3) The steps individuals should take to protect themselves from potential harm resulting from the breach;

(4) A brief description of the steps the Plan is taking to investigate the breach, mitigate losses, and to protect against further breaches; and

(5) Contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, an e-mail address, website, or postal address.

ARTICLE VI
MISCELLANEOUS

6.1. Right to Receive and Release Necessary Information. For the purposes of determining the applicability of and implementing the terms of this Plan or any provision of similar purpose of any other plan, the Plan may, without the consent of or notice to any person release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the

Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

6.2. Facility of Payment. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of its provisions, and amounts so paid shall be deemed to be benefits paid under this Plan. To the extent of such payments, the Plan shall be fully discharged from further liability under this Plan.

6.3. Right of Recovery. Whenever payments have been made by the Plan with respect to Covered Charges in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments to the extent of such excess, from any person to, or for whom such payments were made, any other insurance companies, or any other service providers.

6.4. Automatic Subrogation. In the event of any payments of services under this Plan, the Plan shall, to the extent of such payments, be automatically subrogated to all rights of recovery of the Participant or Dependant arising out of any claim or cause of action which may accrue against a third party. Any such Participant or Dependant hereby agrees, by virtue of accepting coverage hereunder, (regardless of whether a specific reimbursement agreement is executed), to reimburse the Plan for any benefits so paid hereunder, out of monies recovered from such third party as the result of judgment, settlement or otherwise, regardless of whether such Participant or Dependant has been made whole by such recovery from a third party. Such Participant or Dependant hereby agrees to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments, or other documents as the Trustees may require in order to facilitate the security and enforcement of their rights. Participant or Dependant hereby agree to cooperate with the Plan and its representatives in completing all appropriate forms in order to provide such information surrounding any accident as the Plan or its representatives deem essential to fully investigate the incident.

The Plan, by payment of any proceeds, shall automatically be granted a lien on any settlement, judgment or other payment or recovery received by the Participant or Dependant. In addition to consenting to said liens, the Participant or Dependant pledges to take any necessary steps to assist the Plan in securing any such lien. The Plan's right of recovery shall be a first priority lien against any proceeds recovered by the Participant or Dependant, which right shall not be reduced or compromised by the application of any so-called "Make-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the Plan's priority recovery rights by allocating the proceeds exclusively to non-medical expense damages.

A Participant or Dependant may not incur any expenses or costs on behalf of the Plan, attributable to any rights of the Plan under this Section; specifically, neither court costs nor attorney's fees shall be deducted from the Plan's recovery without the prior written consent of the Plan, such costs and expenses being the sole responsibility of the Participant or Dependant. Any so-called "Plan Doctrine," "Common Plan Doctrine," "Attorney's Plan Doctrine" or other equitable remedy shall not defeat the Plan's right to unconditional full reimbursement granted hereunder.

6.5. Workers' Compensation (Work Related Illness or Injury). Benefits will not be paid under this Plan for any illness or injury if the Participant is entitled to Workers' Compensation benefits for that illness or injury. If the Trustees are unable to determine whether the illness or injury is work related and covered by Workers' Compensation, the Trustees may, but shall not be required to, provide benefits until such a determination is made. If the Trustees determine that the Plan will provide benefits, those benefits will only be provided if the Participant agrees in writing to indemnify and reimburse the Plan for all such benefits paid hereunder out of any money recovered by the Participant in the form of Workers' Compensation benefits, damages, compensation or settlement of any claims against his Employer or any

third party arising out of that illness or injury. The Participant hereby agrees to take all actions to furnish all such information and assistance and to execute and deliver all necessary instruments as the Plan may require to facilitate the enforcement of the provision of this paragraph. The term "Participant" referred to in this Section shall also mean all Spouses and Dependents of any Participant.

"Work-Related" and/or "Occupational Claim" - shall mean a claim arising out of work-related illnesses and injuries which are generally paid by Workers' Compensation Insurance and not by the Plan. In case it is difficult to determine whether it is work related, the Trustees may, but shall not be required, to make voluntary payments from the Plan for Medical, Hospital and related expenses resulting from such illness or injury, but no such payments will be made in any case unless such work-related claim or occupational-related claim has first been filed with the Workers' Compensation Bureau and in the event the claim is denied/disputed. Benefits for such claims will be paid pursuant to an assignment, in accordance with the provisions of the Plan, subject to reimbursement in the event benefits are, at a later date, received from Workers' Compensation or any third party, regardless of whether the Participant is made whole by such recovery.

6.6. Assignments. The agreement for assignment of medical claims for work related injuries, asbestosis or asbestosis related claims, or similar claims may be required prior to payment of benefits hereunder.

6.7. Release of Participant Records. Information regarding a Participant or Dependent or the records of a Participant or Dependent may be furnished or released upon receipt of an authorization properly executed by the Participant or Dependent upon receipt of a Court Order or Subpoena served upon the Trustees or the Administrative Manager.

6.8. Right to Amend and Terminate. The Trustees may amend, by majority vote, any or all provisions of this Plan at any time, without obtaining the approval or consent of any Union, Association, Employer, Employee, Participant or Beneficiary, provided that no amendment shall divert Plan assets to an Employer. This Plan may be terminated by an instrument, in writing, executed by the Trustees, as provided in the Trust Agreement.

6.9. Headings. The headings and subheadings in the Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

6.10. Construction. In the construction of the Plan, the feminine shall include the masculine, and the singular, the plural, in all cases where such meanings would be appropriate.

6.11. Effect of Invalidity of Provision. If any provision of this Plan is held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and this Plan shall be construed and enforced as if such provision had not been included.

6.12. Approval of Internal Revenue Service. This Plan is adopted, subject to the approval by the Internal Revenue Service as meeting the requirements of the Code and Regulations thereunder with respect to the deductibility of contributions to the Plan and expenses thereof and with respect to the tax exemption of such Plan. In the event that such approval is not secured for the Plan, as adopted, it may be amended for purposes of securing qualification under the Code, as may be necessary to secure such approval.

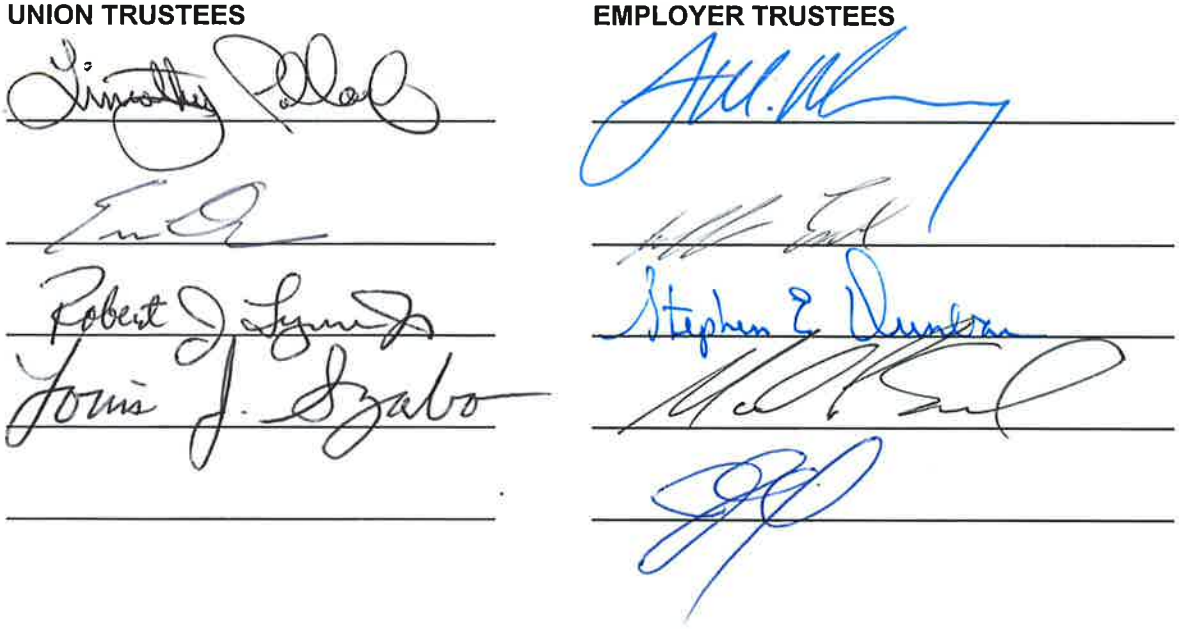
6.13 Choice of Law & Venue. To the extent not preempted by federal law, this Plan shall be governed and controlled by the laws of the State of Michigan as to interpretation, enforcement, validity, construction, and effect and in all other respects. Any and all disputes regarding the terms and conditions of this Plan will be heard in the United States District Court for the Eastern District of Michigan.

6.14 **Employer Contributions, Title**. Employer Contributions become Plan assets at the time they are due and owing to the Plan. Title to all Employer Contributions paid into and/or due and owing to this Plan shall be vested in and remain exclusively in the Board of Trustees of the Plan. An Employer shall have no right, title or interest in the Employer Contributions owing to the Plan. The Board of Trustees may exercise all available remedies provided by law to collect delinquent Employer Contributions.

IN WITNESS WHEREOF, the Trustees of the Northwestern Ohio Plumbers & Pipefitters Local 50 Active Health and Welfare Plan, hereby execute this Plan on OCTOBER 9, 2014.

UNION TRUSTEES

EMPLOYER TRUSTEES



APPENDIX A

SCHEDULE OF BENEFITS FOR CLASS I & CLASS II PARTICIPANTS

PARTICIPANTS IN THE

NORTHWESTERN OHIO PLUMBERS & PIPEFITTERS EMPLOYEE BENEFITS PLAN

Effective _____

NOVARA TESIJA, PLLC
ATTORNEYS AND COUNSELORS AT LAW

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Edward J. Pasternak
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**Also admitted in Nevada and Washington, DC

Of Counsel
Gary W. Novara, PLLC
David A. Priehs, PC

October 16, 2014

Deb O'Callaghan, Plan Associate
NWOPP Fringe Benefit Funds
BeneSys, Inc.
700 Tower Dr., Ste. 300
Troy, MI 48098

Re: ***Northwestern Ohio Plumbers & Pipefitters Local 50 Fringe Benefit Funds - Fund Documents***

Dear Ms. O'Callaghan:

Enclosed for your records, please find original fully executed copies of the following documents for the Northwestern Ohio Plumbers and Pipefitters Local 50 Fringe Benefit Funds:

1. Restated Plan Document - Active Health and Welfare Fund;
2. Statement of Policies and Procedures regarding document retention - Retiree and Retiree Health and Welfare Funds; and
3. First Plan Amendment – Pension Fund;

which were adopted at the Trustees' October 9, 2014, meeting.

As always, should you have any questions regarding the enclosed, please advise.

Very truly yours,

NOVARA TESIJA, P.L.L.C.

John I. Tesija

JIT/ldm
Enclosure(s)
Cc (w/o/encls.): UA Local 50

W:\FUNDS\NWOPP\Joint Funds\corresp\benesys enc signed plan documents 10.09.14 mtg for records.doc

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