SUMMARY PLAN DESCRIPTION/ PLAN DOCUMENT

for

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL UNION NO. 32 - NECA VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION PLAN (VEBA)

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INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL UNION NO. 32 – NECA VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION PLAN

January 2011

To All Plan Participants:

The Board of Trustees of the International Brotherhood of Electrical Workers Local Union No. 32 - NECA Voluntary Employees' Beneficiary Association Plan (hereinafter "IBEW Local 32 VEBA" or "Plan") is pleased to present you with this Summary Plan Description/Plan Document ("Summary") for the IBEW Local 32 VEBA. This Summary describes the provisions of the IBEW Local 32 VEBA and includes the advisory information required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The IBEW Local 32 VEBA described in this Summary is effective January 1, 2011, and for employees who are eligible to be covered under the Plan on that date, eligibility for benefits begins March 1, 2011.

Only the full Board of Trustees is authorized to interpret the IBEW Local 32 VEBA. No other individual or organization, such as your union or your employer, nor any employee or representative of any individual or organization, is authorized to interpret this Plan or to act as an agent of the Board of Trustees in interpreting the IBEW Local 32 VEBA. Should you have any questions regarding the IBEW Local 32 VEBA, please direct them to the Plan Administrator.

We suggest you share this Summary with the members of your family since they may have an interest in the IBEW Local 32 VEBA. You should keep this Summary with your other important papers and let family members know where it is being kept.

Sincerely,

THE BOARD OF TRUSTEES

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INTRODUCTION

This Summary, distributed during January 2011, is designed to describe the benefits available to you under the IBEW Local 32 VEBA. It is intended that the information provided in this Summary will satisfy the requirements of the Employee Retirement Income Security Act of 1974 for a summary plan description.

This IBEW Local 32 VEBA is the successor of the International Brotherhood of Electrical Workers Local Union No. 32 - NECA Health Care Plan ("IBEW Local 32 Health Care Plan"). Through January 31, 2004, the IBEW Local 32 Health Care Plan provided health care benefits for members of the International Brotherhood of Electrical Workers (hereinafter "IBEW"), Local Union No. 32 (hereinafter "Union"). Effective February 1, 2004, the liability for providing such health care benefits for Union members was transferred from the IBEW Local 32 Health Care Plan to the 4th District International Brotherhood of Electrical Workers Health Fund (hereinafter "4th District Fund"). However, the trust fund for the IBEW Local 32 Health Care Plan continued to hold assets for claims covered by the IBEW Local 32 Health Care Plan that were incurred before February 1, 2004. These assets include Employer Contributions for Union members' overtime hours credited on or after January 1, 2004. On May 10, 2005, the IBEW Local 32 Health Care Plan's Board of Trustees met with Union members and, after discussion, determined that the IBEW Local 32 Health Care Plan should be reconfigured into a voluntary employees' beneficiary association ("VEBA") to provide supplemental health care benefits and certain other types of permissible benefits to Union members. Eligibility for benefits under the VEBA began on December 1, 2005.

The IBEW Local 32 VEBA is maintained pursuant to a collective bargaining agreement (hereinafter "Agreement") between the International Brotherhood of Electrical Workers (hereinafter "IBEW"), Local Union No. 32, and the Lima Division, Western Ohio Chapter, National Electrical Contractors Association (hereinafter "NECA") and other Employers who, by virtue of collective bargaining agreements with the Union, have agreed to participate in and contribute to the IBEW Local 32 VEBA's Trust Fund and who became parties to the Agreement. A copy of the Agreement is available for your examination at the Union Hall, and Participants and their Beneficiaries may also obtain a copy of the Collective Bargaining Agreement for a reasonable charge by writing to: Board of Trustees, IBEW Local 32 VEBA, 1975 N. West Street, Lima, Ohio 45801.

SPECIAL NOTICE!

It is extremely important you keep the Fund Office informed of any changes in address or marital status. This is your obligation, and failure to fulfill this obligation could jeopardize your eligibility for benefits. The importance of a current, correct address on file in the Fund Office cannot be overstated! It is the **ONLY** way the Trustees can keep in touch with you regarding changes under the IBEW Local 32 VEBA and other developments affecting your interests under the IBEW Local 32 VEBA.

I. PLAN IDENTIFICATION AND GENERAL INFORMATION

A. Name of the Plan

The formal name of the Plan is the "International Brotherhood of Electrical Workers Local Union No. 32 - NECA Voluntary Employees' Beneficiary Association Plan."

B. Names and Addresses of the Employers

The Plan is a multiemployer plan as that term is defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), and numerous Employers contribute to it. It would not be practical to list all of the Employers here; however, upon written request to the Administrator of the Plan, you will receive information as to whether a particular Employer or Union is contributing to the Plan, and if so, its address.

C. Name and Address of the Administrator

The Plan Sponsor and/or Administrator of the IBEW Local 32 VEBA is the Board of Trustees of the IBEW Local 32 VEBA; however, the Trustees have the authority to select and retain a professional Third Party Administrator, if and when the need arises. The Board of Trustees, exercising their authority to select and retain a professional Third Party Administrator, has presently engaged Compensation Programs of Ohio, Inc. to administer and process the claims of the Plan. The name and address of the Third Party Administrator is as follows:

Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388
Fax: (330) 270-0912

Questions pertaining to your or your dependent's eligibility and claims processing under the Plan should be directed in writing to the Third Party Administrator.

D. Plan Numbers Assigned to the Plan

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 34-1793456, and the Plan number for purposes of identification is 501.

E. Type of Plan

The Plan is maintained for the purpose of providing reimbursement for medical expenses not covered under other health insurance programs of Participants and other benefits as defined in this Summary.

F. Plan Year

The Plan Year is a twelve (12) month period beginning April 1 and ending March 31. However, effective January 1, 2006, the Plan Year shall be a twelve (12) month period beginning January 1 and ending December 31.

G. Type of Administration Used for the Plan Assets

The Trust Fund shall be administered by a Board of Trustees consisting of six (6) voting Trustees, three (3) of whom shall be designated by the Employers (Employer Trustees), and three (3) of whom shall be designated by the Union (Union Trustees). At the present time, they are:

UNION TRUSTEES	EMPLOYER TRUSTEES
Jerry Dickrede, Sec./Treas.	Danal W. Neal, Chair
Douglas Beining, Trustee	John Frantz, Trustee
Thomas Lendwehr, Trustee	Jerry Hesseling, Trustee

Correspondence can be sent to the Board of Trustees at: Board of Trustees, IBEW Local 32 VEBA, c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515.

H. Attorneys for the Fund and Agent for Service of Process

Allotta, Farley & Widman Co., L.P.A.
2222 Centennial Road
Toledo, Ohio 43617
Phone: (419) 535-0075
Fax: (419) 535-1935
www.afwlaw.com

In addition, service of process may be made upon the Administrator.

I. Funding Medium for the Accumulation of Plan Assets

Assets are accumulated and benefits are provided directly by the Trust Fund. The principal and income of this Plan are to be used for the exclusive benefit of participating Employees, their beneficiaries, and for defraying proper expenses of administering the Plan.

J. Effective Date When Plan Began

September 1, 2005

K. Sources of Contributions to the Plan

Contributions to this Plan are made by Employers in accordance with the Plan's terms and conditions. Contributions to this Plan made by Employers shall be made to the Trust Fund only under the obligations of a Collective Bargaining Agreement and/or other written agreement between the contributing Employer and the Union. The Union shall be the authority for the specific provisions of the Collective Bargaining Agreement establishing the obligation of the Employer to make contributions.

L. Plan Amendment and Termination

The Trustees reserve the right to amend or terminate the Plan at any time and for any reason, within their sole discretion. If the Plan is amended or terminated, you may not receive benefits as described in this Summary. You may be entitled to receive different benefits or benefits under different conditions. However, it is possible that you will lose all benefit coverage. Loss of coverage may happen at any time if the Trustees decide to terminate the Plan or your coverage under the Plan. In no event will you become entitled to any vested rights under this Plan. Further, the provisions of this paragraph may not be modified in any manner except by resolution of the Board of Trustees.

M. Plan Is Not a Contract

The Plan shall not be deemed to be a contract between the Plan Sponsor and any Participant, or to be an inducement to or condition of employment. Nothing in the Plan shall be deemed to give an Employee the right to be retained in the service of any Employer, or to interfere with the right of any Employer to discharge any Employee at any time.

II. ELIGIBILITY

A. Eligibility

You are eligible to participate in the Plan if you:

1. are an Employee; and

2. have a Credit Account with a balance ~~of at least $250~~.

Your Credit Account is funded through Employer Contributions.

B. Continuation of Eligibility

You will continue to remain eligible for participation in the Plan so long as you have a balance in your Credit Account and are an Employee. However, if you cease employment as an Employee and have a balance in your Credit Account, you may continue to use your Credit Account balance to receive the benefits provided under the schedule of benefits set forth in Article IV. Your coverage under the Plan will continue until the amount of money in your Credit Account is exhausted. Once your Credit Account is exhausted, no further benefits are payable.

C. Termination of Coverage

Your coverage under the Plan will end on the earlier of the following:

1. the first day of the month following the twelve (12) consecutive month period during which your Credit Account begins at $0 and remains at $0 for the duration of such period; or

2. the day the Plan is terminated.

Effective January 1, 2010, any child or ward of the Eligible Employee who was covered under the Plan as a result of full-time student status under the definition of the term "Eligible Dependent" shall be granted continuing coverage under the Plan if the Eligible Dependent demonstrates that he or she cannot attend school as a full-time student due to a Medically Necessary Leave of Absence. For this purpose, a Medically Necessary Leave of Absence is a leave of absence from a postsecondary educational institution (including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965) or any other change in enrollment at such an institution that:

1. commences while the child or ward is suffering from a serious Illness or Injury; and

2. is medically necessary (as confirmed in a written communication from the child's or ward's treating Physician); and

3. causes such child or ward to lose student status for purposes of coverage under the Plan's terms.

To be eligible for continuing coverage due to a Medically Necessary Leave of Absence, the Eligible Dependent must have been enrolled in the Plan as a result of full-time student status at a postsecondary educational institution immediately before the first day of the Medically Necessary Leave of Absence. The Plan must also receive written certification from the Eligible Dependent's treating Physician stating that the child is suffering from a serious Illness or Injury and that the leave of absence (or other change in enrollment) is medically necessary.

Continuing coverage due to a Medically Necessary Leave of Absence begins as of the first day of the Eligible Dependent's Medically Necessary Leave of Absence and ends on the date that is the earlier of:

1. the date that is one (1) year after the first day of the Medically Necessary Leave of Absence; or

2. the date on which such coverage would otherwise terminate under the Plan's terms or by termination of the Plan as a whole.

An Eligible Dependent who receives benefits due to a Medically Necessary Leave of Absence shall be entitled to the same benefits (during the Medically Necessary Leave of Absence) as if the child or ward continued to be a covered student at the institution of higher education and was not on a Medically Necessary Leave of Absence.

Any future change in the Plan's coverage terms or conditions that would apply to an Eligible Dependent shall apply equally to an Eligible Dependent who receives continuing coverage under the Plan due to a Medically Necessary Leave of Absence.

D. Reinstatement of Eligibility after Termination

If you terminate your coverage pursuant to C. above, your coverage will be reinstated when you again satisfy the requirements for initial eligibility in the same manner as a new Employee.

E. Military Service

Your eligibility to participate in this Plan will end on the day in which you are inducted, enrolled or enlisted into the military service of this country other than for temporary service. However, any balance in your individual Credit Account will be kept on the Plan's records and will be made available when you return from military service, provided that you notify the Fund Office in writing that you are entering military service. You may, by written notice, request that the Board of Trustees "freeze" your eligibility and any balance in your individual Credit Account at the end of the month you are inducted, enrolled or enlisted into the military service of this country. Upon discharge from military service, and upon written notice to the Administrator within thirty (30) days of the discharge, your "frozen" eligibility will be reinstated and the balance in your individual Credit Account restored effective on the first (1st) day of the month following the month in which you are discharged from military service.

F. Change of Eligibility Rules

The Trustees, in their sole discretion, are empowered to change or amend the foregoing rules of eligibility or the benefits provided by this Plan at any time for any reason.

G. Incorporation of Other Plan Documents

All basic plan documents and all definitions, terms, conditions and provisions therein are adopted and made a part of this Plan. Any questions, interpretations and disputes concerning eligibility for and amount of benefits shall be resolved by the Trustees in their sole discretion and their decision shall be final.

H. Continuation of Group Health Insurance Coverage under 4th District International Brotherhood of Electrical Workers Health Fund through Self-Payments

If you or an Eligible Dependent loses coverage under the 4th District Fund by reason of a "qualifying event" under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), including related regulations and amendments, you may use the funds in your Credit Account to make self-payments to the 4th District Fund in order to continue health coverage under the 4th District Fund on a temporary basis. The rules governing the continuation of your group health insurance coverage under the 4th District Fund are more fully described in the summary plan description for the 4th District Fund and related documents.

III. ELIGIBILITY FOR RETIRED EMPLOYEES

The Trustees reserve the right to change or eliminate retiree coverage, including but not limited to the benefits available, in their sole discretion, at any time and for any reason. Retired Employees do not have any vested rights in their Credit Account.

A. Eligibility Requirements for Retired Employees

If a Participant retires, coverage under this Plan will continue until the amount of money in his or her Credit Account is exhausted. If the Participant exhausts the amount of money in his or her Credit Account before retirement, then he or she will not be eligible to participate unless he or she again satisfies the Plan's eligibility requirements. A Participant will be considered an Eligible Retiree and entitled to coverage under this Plan only if he or she meets all of the following eligibility requirements:

1. he/she is retired from active employment, as evidenced by the receipt of benefits under the IBEW Local No. 32 - N.E.C.A. Pension Plan; and

2. he/she was eligible for active Employee coverage under the Plan on the date he or she retired.

If a Participant retires before he or she is eligible to receive a pension under the IBEW Local No. 32 - N.E.C.A. Pension Plan, coverage under this Plan will continue until his or her Credit Account is exhausted.

B. Retired Employees Who Return to Active Employment

If an Eligible Retiree returns to active employment as an Employee and satisfies the Eligibility Rules for active Employee coverage under this Plan, he or she shall terminate his or her coverage as an Eligible Retiree on the date his or her eligibility under the active program becomes effective and may again become entitled to coverage as an Eligible Retiree if he or she fulfills the eligibility requirements set forth in A. above upon re-retirement.

C. Retiree Benefits

The benefits provided to Eligible Retirees under this Plan shall be the same as the benefits provided to active Employees. The right to change, reduce or eliminate any and all aspects of benefits provided for Eligible Retirees and their Eligible Dependents is a right specifically reserved to the Trustees.

D. Cancellation of Coverage

Coverage for Eligible Retirees shall be canceled as of the earliest of:

1. the date the Eligible Retiree's Credit Account is reduced to zero; or

2. the date the Plan is terminated; or

3. the date coverage for Eligible Retirees under the Plan is canceled.

IV. SCHEDULE OF BENEFITS

Participants are entitled to reimbursement from their Credit Account for any itemized medical bills submitted for payment that:

A. are not covered by any other health insurance plan under which the Participant is covered;

B. relate to medical care expenses incurred by the Participant or an Eligible Dependent on or after January 1, 2005; and

C. satisfy the requirements for amounts paid to an individual as reimbursement for medical care expenses under Section 105(b) of the Internal Revenue Code

("Code").

Examples of eligible medical care expenses are medical bills, pharmaceutical bills, vision and/or dental co-pays, premiums and deductibles. Certain over-the-counter medications that are purchased for the diagnosis, cure, mitigation, treatment, or prevention of disease are also eligible for reimbursement.

Expenses incurred for over-the-counter medicines or drugs that are purchased on or after January 1, 2011 must satisfy the requirements for over-the-counter expense reimbursements under Internal Revenue Service Notice 2010-59. Such expenses may be reimbursed by the Plan only if—

1. you provide the Third Party Administrator with satisfactory evidence of a prescription for such medicine or drug; or
2. the drug is insulin.

For purposes of your eligibility to receive a reimbursement, a "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

The special requirements applicable to over-the-counter drugs or medicines purchased on or after January 1, 2011 do not apply to reimbursements for items that are not medicines or drugs, including equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits.

Expenses for items that are merely beneficial to your general health are not eligible for reimbursement. Examples of ineligible expenses are vitamins, dietary supplements, herbal remedies, toiletries, cosmetics, and sundry items.

You may also use your Credit Account balance for the following purposes:

A. to make self-payments in order to maintain eligibility under the 4th District International Brotherhood of Electrical Workers Health Fund (4th District Fund"); or

B. to pay for funeral expenses that have been incurred in connection with your death or the death of your Eligible Dependent.

V. DEFINITIONS.

A. Agreement and Declaration of Trust or Trust Agreement

"Agreement and Declaration of Trust" or "Trust Agreement" means the Amended Agreement and Declaration of Trust entered into by and between the Union and Employers who, by virtue of Collective Bargaining Agreements with the Union, have agreed to participate in and contribute to this Trust Fund and who became parties thereto and that document, as may from time to time be amended.

B. Collective Bargaining Agreement

"Collective Bargaining Agreement" means any Collective Bargaining Agreement existing between an Employer and the Union which provides for contributions into the Trust Fund as well as any extension or extensions, renewal or renewals of any such Collective Bargaining Agreement or any Collective Bargaining Agreement which provides for contributions into this Trust Fund.

C. Credit Account

"Credit Account" means the method of crediting Employer Contributions received on behalf of each Employee to the Employee's individual Credit Account. The cost of benefits plus Plan expenses is deducted from the Employee's individual Credit Account.

D. Eligible Dependent

"Eligible Dependent" includes only the following, provided they are not eligible to be covered under the Plan as Employees and, if previously covered as Employees, are not eligible to receive any benefits under the Plan as a result of a disability existing when coverage as an Employee was discontinued:

1. An Eligible Employee's legal spouse, while not divorced or legally separated from the Eligible Employee. For this purpose, the term "spouse" means that person, if any, who is recognized under the laws of the State of Ohio, based on a union of two (2) persons, as being the member's lawful husband or wife and who has not been declared divorced or legally separated from the member by any judicial order.

2. An Eligible Employee's natural children, adopted children, children placed for adoption with an Eligible Employee, stepchildren, or legal wards (individually, a "Child," and collectively, "Children") who satisfy the following requirements during (i) or (ii) below, as applicable:

(i) For Plan Years beginning before January 1, 2011, any Child, from birth to age twenty-one (21), who—

(a) is unmarried;
(b) is not working full-time;
(c) lives with the Eligible Employee in a parent-child relationship; and
(d) is primarily dependent upon the Eligible Employee or the Eligible Employee's Spouse for support and maintenance based upon proof which is satisfactory to the Board of Trustees.

For purposes of a Child's status as an Eligible Dependent, the term "primary support and maintenance" means that the Eligible Employee directly provides at least fifty percent (50%) of the Child's financial support or that the Eligible Employee has taken full parental responsibility for and control of the Child, or is raising the Child as his or her own. The Eligible Employee shall provide such periodic proof of dependency as is requested by the Board of Trustees, including, but not limited to, written affidavits.

(ii) For Plan Years beginning before January 1, 2011, a Child of the eligible Employee between ages twenty-one (21) and twenty-three (23) who is a full-time student and who meets one of the following criteria:

(a) An undergraduate student enrolled in an institute of higher learning, taking a minimum of twelve (12) semester hours or the equivalent.

(b) A graduate student enrolled in an institute of higher learning, taking a minimum of 9 (nine) semester hours or the equivalent.

(c) A student who is attending a school with a minimum of fourteen (14) hours of classroom work per week in an accredited school that is licensed in the community as one that gives regular courses or instructions in a trade or profession and where the student is studying to learn a trade or profession or to advance his knowledge in his trade or profession, provided that the individual is dependent on the Eligible Employee for his or her primary support and maintenance and, provided further, that the dependent is not eligible for benefits under the Plan as an Eligible Employee.

Effective January 1, 2010, the term "Eligible Dependent" shall also include a Child of the Eligible Employee between ages twenty-one (21) and twenty-three (23) who is a full-time student and who is eligible for an

extension of coverage as an Eligible Dependent due to a Medically Necessary Leave of Absence, but only as long as the child or ward remains eligible for the extension. Each quarter or semester, the Claims Administrator shall require proof of an Eligible Dependent's eligibility for extended coverage due to a Medically Necessary Leave of Absence.

(iii) For Plan Years beginning on or after January 1, 2011, any Child, from birth to age twenty-six (26), regardless of marital status, work status, living status, or financial dependency; provided, however, that for Plan Years beginning before January 1, 2014, a Child is not entitled to coverage under the Plan if he or she—

(a) is an adult; and
(b) is eligible for employer-based health care coverage under another health care plan.

No Child who is under age nineteen (19) shall be denied coverage under the Plan on account of a preexisting condition.

An Eligible Employee's grandchildren are not covered under the Plan unless the Eligible Employee has assumed legal guardianship for them.

3. A Child who, upon reaching the age of limiting coverage, is incapable of self-sustaining employment due to mental or physical handicap, who is dependent upon the Eligible Employee for primary support and maintenance, and whose mental or physical handicap commenced prior to his attaining the age of limiting coverage. In order for such Child to remain eligible, notification of such handicap must be given to the Fund Office prior to the child's attaining the age of limiting coverage, and the Board of Trustees must make a determination of continuing eligibility. The Eligible Employee may be required to supply proof, upon request by the Board of Trustees or the Claims Administrator, that a Child satisfies these eligibility criteria.

4. A Child who is placed in the Eligible Employee's home pursuant to adoption as of the date the Child is placed in the home and up to—

(i) age twenty-one (21) for Plan Years beginning before January 1, 2011, provided the Child is unmarried; and

(ii) age twenty-six (26) for Plan Years beginning on or after January 1, 2011, regardless of the Child's marital status.

As used herein, "Child placed in the Eligible Employee's home pursuant to adoption" means a Child who has not reached—

(i) age twenty-one (21) for Plan Years beginning before January 1, 2011, provided the Child is unmarried; and

(ii) age twenty-six (26) for Plan Years beginning on or after January 1, 2011, regardless of the Child's marital status,

as of the date of the assumption and retention by an Eligible Employee of a legal obligation for total or partial support of such Child in anticipation of such Child's adoption.

The Child's placement with the Eligible Employee shall terminate upon the termination of the legal obligation for total or partial support of such Child.

5. A Child for whom an Eligible Employee is ordered by a United States court of competent jurisdiction to provide medical coverage in accordance with the provisions of a Qualified Medical Child Support Order.

E. Eligible Employee or Covered Member

"Eligible Employee" or "Covered Member" means any person who meets the Eligibility Rules as adopted by the Trustees and as set forth herein.

F. Eligibility Rules

"Eligibility Rules" means the rules as established by the Trustees pursuant to the provisions of the Trust Agreement and as set forth herein to determine eligibility.

G. Employees

"Employees" means and includes members of a Collective Bargaining Unit represented by the Union who are eligible to participate in and receive the benefits of the IBEW Local 32 VEBA and Trust in accordance with the Agreement and Declaration of Trust. In addition, the term "Employees" shall mean and include regular Employees of the Union, the Trustees, and/or the Fund Office, subject to the review and approval of, and any conditions regarding contributions and participation imposed by, the Trustees.

The term "Employees" shall mean Employees of an Employer who are not members of a Union Collective Bargaining Unit represented by the Union, including, but not limited to, an officer, owner, partner, shareholder, manager, clerical worker, estimator, supervisor and any other Employee (hereinafter collectively referred to as "Nonbargaining Unit Employees"), but only if:

i. equal contributions are made for all Employees;

ii. all Employees receive equal benefits;

iii. all Employees are covered under the Plan established hereunder; and

iv. contributions are subject to the review and approval of the Board of Trustees, and any other conditions regarding contributions and participation imposed by the Board of Trustees.

The Employer shall make Employer Contributions to the Fund for all of its Employees, subject to the nondiscrimination requirements under applicable provisions of the Code and related regulations.

H. Employer

"Employer" means: Any individual, firm, association, partnership, corporation or other business entity who has duly executed and/or is bound by the Collective Bargaining Agreement with said Union or signs a participation agreement with the Trust Fund and in accordance therewith agrees to participate in and contribute to the Trust Fund herein created and provided for.

The Union, to the extent and solely to the extent that it acts in the capacity of an Employer of its Employees on whose behalf it makes contributions to the Trust Fund in accordance with the Collective Bargaining Agreement, the Trust Agreement and the rules and procedures prescribed by the Trustees.

The Trustees, and/or the Fund Office, to the extent that they act in the capacity of an Employer of their Employees on whose behalf they make contributions to the Trust Fund in accordance with the Collective Bargaining Agreement, the Trust Agreement and the rules and procedures prescribed by the Trustees.

Any Employer who contributes to the Trust Fund created hereunder shall, by the act of contributing, become a party to this Plan and the Trust Agreement whether or not any such contributing Employer has signed this Plan, Trust Agreement or a counterpart thereof.

I. Employer Contributions

"Employer Contributions" means payments made to the Trust Fund by an Employer.

J. Illness

"Illness" means any sickness or disease which requires treatment by a doctor. Unless otherwise excluded under the Plan, "Illness" includes pregnancy, childbirth or miscarriage and complications associated therewith. Charges as a result of intentionally self-inflicted illness are excluded under this Plan. Illnesses resulting from or contributed to the same or related cause or causes shall be considered one illness. Determination of whether Illnesses are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

An occupational disease which the person is entitled to benefits under Workers' Compensation law or similar legislation is excluded under this Plan. This Plan excludes any treatment, service, or expense which may be connected with an occupational disease in which the person has received a lump sum settlement for his or her claim for benefits under Workers' Compensation law or similar legislation. This Plan also does not provide benefits for services, supplies or charges which are received in a military facility for a military service related injury, ailment, condition, disease, disorder or illness.

K. Injury

"Injury" means any accidental bodily injury which requires treatment by a physician and is recognized by the terms of this Plan and the Trustees. It must result in loss independently of illness and other causes. All injuries sustained by a person in connection with one accident will be considered one Injury. Determination of whether Injuries are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

An Injury which the person is entitled to benefits under Workers' Compensation law or similar legislation is excluded under this Plan. This Plan excludes any treatment, service, or expense which may be connected with an Injury in which the person has received a lump sum settlement for his or her claim for benefits under Workers' Compensation law or similar legislation. This Plan also does not provide benefits for services, supplies or charges which are received in a military facility for a military service related injury, ailment, condition, disease, disorder or illness. Charges as a result of a self-inflicted Injury or attempt at self destruction while sane or insane are excluded under this Plan. Determination of whether Injuries are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

L. IBEW Local 32 VEBA

"IBEW Local 32 VEBA" means the plan, program, methods and procedures for the payment of benefits from the Trust Fund (directly or indirectly) by the Trustees in accordance with such eligibility requirements as the Trustees may, from time to time, adopt and promulgate, and as set forth herein.

M. Participant

"Participant" means any Employee or former Employee of an Employer or any member or former member of the Union who is or may become eligible to receive a benefit of any type from the Trust Fund, or whose Beneficiaries may be eligible to receive any such benefit.

N. Plan

"Plan" means the IBEW Local 32 Voluntary Employees' Beneficiary Association, as the same may, from time to time, be amended as hereinafter provided.

O. Trust Fund, Trust or Fund

"Trust Fund," "Trust" or "Fund" means the trust fund for the IBEW Local 32 Voluntary Employees' Beneficiary Association and the entire assets of such trust fund, including all funds received by the Trustees in the form of Employer Contributions, together with all contracts (including dividends, interest, refunds and other sums payable the Trust Fund on account of such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits from such investments, and any and all other property of funds received and held by the Trustees under the Trust Agreement.

P. Trustee

"Trustee" means any natural person designated as Trustee under the terms of the original Agreement and Declaration of Trust and his/her successor or successors in office. The Trustees, collectively, shall be the "Administrator," as that term is used in ERISA.

Q. Union

"Union" means the International Brotherhood of Electrical Workers, Local Union No. 32, and its successors.

VI. PROCEDURE FOR FILING A CLAIM

~~To be eligible to file a claim for benefits under the IBEW Local 32 VEBA, you must have a Credit Account balance of at least $250 when the claim is filed.~~ To file a claim, you must first obtain claim forms from the Union Office at: IBEW Local 32, 1975 N. West Street, Lima, Ohio 45801. You may also obtain claim forms from the Third Party Administrator at: Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515 (Phone: (800) 435-2388; Fax: (330) 270-0912). All sections of the claim form must be completed carefully and accurately, signed, dated and filed with the Third Party Administrator, along with an itemized bill for all charges incurred, by the deadline for filing claims for benefits ("Claims Filing

Deadline") under the IBEW Local 32 VEBA. For charges incurred between December 1, 2005 and December 31, 2006, the Claims Filing Deadline is April 15 of the Plan Year following the Plan Year in which the charge is incurred. For charges incurred on or after January 1, 2007, the Claims Filing Deadline is June 30 of the Plan Year following the Plan Year in which the charge is incurred.

Claims filed after the Claims Filing Deadline will be considered only if there was reasonable cause for failure to timely file the claim, as determined by the Trustees in their sole discretion. If proof of a claim cannot be furnished to the Third Party Administrator by the Claims Filing Deadline, the claim will not be denied or reduced if proof is furnished as soon as reasonably possible. Unless you are legally incapacitated, failure to file the claim within two (2) years after the charge is incurred will invalidate the claim or reduce benefits, as determined by the Trustees in their sole discretion.

A decision as to the validity of the claim will be made as promptly as possible after the claim is received, with necessary documentation. If a delay occurs, you will be notified of the reasons for the delay, as well as the anticipated length of the delay, in writing. If further information or other material is required, you will also be informed. You must honor any reasonable request for further information or for a re-payment agreement or you will not be able to receive payment on your claim.

All reimbursements payable under the Plan will be paid as soon as practicable after the necessary claim form is timely received by the Fund Office. If the amount of your claim exceeds your Credit Account balance when you file the claim, you will be reimbursed in an amount not exceeding your Credit Account balance. If you wish to be reimbursed for the remaining portion of your claim, you may file an additional claim when your Credit Account again has a positive balance, as long as your additional claim is filed by the Claims Filing Deadline applicable to the original claim.

VII. PROCEDURE FOR APPEALING A CLAIM

A. Denial of Claim

Questions regarding the interpretation of the Plan's provisions should be presented to the Third Party Administrator, Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515 (Phone: (800) 435-2388); Fax: (330) 270-0912).

If, for any reason, your claim is denied, in whole or in part, you will be provided with a written notice containing the following information:

1. the reason(s) why the claim or a portion of it was denied;

2. reference to Plan provisions on which the denial was based;

3. if the denial was based in whole or in part on any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided free of charge;

4. if the denial was based in whole or in part on medical necessity, experimental/investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided free of charge;

5. any additional information, if any, that is required to perfect the claim and why the information is necessary; and

6. a copy of the Plan's review procedures and time periods that the claimant needs to follow in order to appeal the claim, plus a statement that the claimant may bring a suit under ERISA following the review.

B. Appeal from Denial of Claim

If you dispute a denial of benefits, you may file an appeal within 180 days of receipt of the denial notice with the Third Party Administrator, Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515 (Phone: (800) 435-2388); Fax: (330) 270-0912). This appeal must be in writing. Your appeal will be presented at the next regularly scheduled meeting of the Board of Trustees.

Your request for review must contain the following information:

1. your name and address;

2. your reasons for making the appeal; and

3. the facts supporting your appeal.

In connection with your right to appeal the initial claims determination, you also:

1. may review pertinent documents and submit issues and comments in writing;

2. will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;

3. will, at your 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; and

4. will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The claim review will be subject to the following rules:

1. The claim will be reviewed by an appropriate party, who is neither the individual who made the initial denial nor a subordinate of that individual.

2. The review will be conducted without giving deference to the initial denial.

3. If the initial denial was based in whole or in part on a medical judgment (including any determinations of medical necessity or experimental/investigative treatment), the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This medical expert shall not be an individual who was consulted on the initial claim denial nor the subordinate of such an individual. The name of any medical expert consulted in the review process will be released upon specific request by you or your representative.

You may submit whatever records and evidence you believe are appropriate to support your claim on appeal. However, the Trustees shall rely upon the the Plan's official records in determining your eligibility for benefits and, if you are eligible, the amount of your benefits. In the event of a discrepancy between the the Plan's official records and a claim asserted by you or your beneficiary, the Trustees shall rely upon the the Plan's official records unless shown to their satisfaction that the additional or other records are valid and that they should rely upon those records. The burden of proving a claim for benefits which differs from the the Plan's official records shall be upon you or your beneficiary.

C. Notice of Decision on Appeal

The Trustees will notify you notify you of the resolution of your appeal within 31 days following the meeting of the Board of Trustees at which your appeal was considered. If your appeal has been either partially or completely denied, you will be provided with a written notice containing the following information:

1. the specific reasons for the appeal denial;

2. reference to the specific plan provisions on which the denial is based;

3. a statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;

4. if the appeal denial was based in whole or in part on any internal guidelines or protocols, a statement that you may request a copy of the guideline or protocol, which will be provided to you without charge;

5. if the appeal denial was based in whole or in part on medical necessity, experimental/investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge;

6. a statement apprising claimants that "You or your Plan may have other voluntary 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/or your state insurance regulatory agency."

7. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.

The Trustees have complete authority, within their sole discretion, to construe and interpret the provisions of the plan document and the Trust Agreement. Any interpretation of the plan document or the Trust Agreement made by the Trustees and their resolution of your complaint shall be final.

You may not begin any legal action, including proceedings before administrative agencies, until you have followed these procedures and exhausted the opportunities described in this Article VIII. You may, at your own expense, have legal representation at any stage of these review procedures. These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. If, after following the review process outlined in this Article VIII, you are not satisfied with the result, then you must file any legal action within three (3) years after you have received the final review notice under these procedures.

VIII. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

A. Definition of Protected Health Information

The Board of Trustees of the IBEW Local 32 VEBA (the "Plan Sponsor") sponsors the Plan. The Plan's administrative staff may have access to the individually identifiable health information of Plan participants required for the Plan's administrative functions. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information ("PHI").

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The following HIPAA definition of PHI applies to this Plan:

> *Protected Health Information.* Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Plan Sponsor will have access to PHI from the Plan only as required or permitted by HIPAA.

B. Permitted Disclosure of Enrollment/Disenrollment Information

The Plan (or a health insurance issuer) may disclose to the Plan Sponsor information on whether an individual is participating in the Plan.

C. Permitted Uses and Disclosure of Summary Health Information

The Plan (or a health insurance issuer) may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of:

1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

2. modifying, amending, interpreting or terminating the Plan.

"Summary Health Information" means:

1. information that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan; and

2. information from which certain confidential information described in HIPAA has been deleted, except that certain geographic information need only be aggregated to the level of a five-digit zip code.

D. Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administrative Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in E. below and obtaining written certification pursuant to G. below, the Plan (or a health insurance issuer) may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with HIPAA.

E. Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer), the Plan Sponsor will:

1. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

2. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

5. Make available PHI to comply with HIPAA's right to access in accordance with applicable provisions of HIPAA.

6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with applicable provisions of HIPAA.

7. Make available the information required to provide an accounting of disclosures in accordance with applicable provisions of HIPAA.

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

10. Ensure that the adequate separation between the Plan and the Plan Sponsor (i.e., the "firewall"), required by HIPAA, is satisfied.

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it shall ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. For these purposes, "electronic PHI" means any PHI that is transmitted by, or maintained in, electronic media. The Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

F. Adequate Separation between Plan and Plan Sponsor

The Plan Sponsor will allow third party service providers access to the PHI, subject to business associate agreement restrictions. No other persons will have access to PHI. These specified individuals or entities will only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these service providers do not comply with the provisions of this Section, that service provider will be subject to termination pursuant to the business associate agreement in place. The Plan

Sponsor will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

G. Certification of Plan Sponsor

The Plan (or a health insurance issuer) will disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate applicable provisions of HIPAA, and that the Plan Sponsor agrees to the conditions of disclosure set forth in E. above.

The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to HIPAA, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (a) it receives pursuant to an appropriate authorization (as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)), or (b) that qualifies as Summary Health Information and that it receives for the purpose of either (i) obtaining premium bids for providing health insurance coverage under the Plan, or (ii) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated in this Summary by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

The Plan Sponsor will, in accordance with the Security Regulations, take the following measures:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the "ePHI" that it creates, receives, maintains or transmits on behalf of the Plan.

2. Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means that the Plan Sponsor will use ePHI only for activities related to the Plan's administration and not for employment-related actions or for any purpose unrelated to the Plan's administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or the Plan's provisions regarding such policies and procedures is subject to the Plan's disciplinary procedure.

3. Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

4. Report to the Plan any security incident of which it becomes aware.

Effective February 17, 2010, the Plan and the Plan Sponsor will take the measures necessary to comply with the requirements of the Health Information Technology for Economic and Clinical Heath Act ("HITECH Act") and regulations issued by the United States Department of Health and Human Services implementing the HITECH Act. These measures include the following:

1. Modify and expand existing HIPAA privacy and security rules to protect PHI.

2. Comply with breach notification procedures that require the Plan Sponsor to notify an individual and the United States Department of Health and Human Services (and a prominent media outlet in any breach affecting more than 500 individuals in a state or jurisdiction) when there is a breach of unsecured PHI that affects such individual. For this purpose, "unsecured PHI" is PHI that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technology or methodology specified in guidance issued by the United States Department of Health and Human Services.

3. Disclose expanded information to any individual who requests an accounting of PHI disclosures.

IX. ASSIGNMENT OF BENEFITS

Benefits under this Plan may not be assigned, pledged, alienated, transferred or otherwise encumbered by you or your beneficiaries.

X. MISCELLANEOUS PROVISIONS

A. Payment of Benefits

All benefits under the Plan shall be payable through Employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Fund can operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the Union, any Employer, or the Trustees. The Trustees, the Employers and Union shall not be held liable for any benefits or contracts, except as provided in the Agreement between the Employers and the Union.

B. Substantiation of Claim

In order for the Plan to pay a claim, you must provide proof that you actually have incurred a loss and the exact amount of the claim. You must honor any reasonable request for further information or for a repayment agreement. Otherwise, the Plan will not be able to pay your claim.

C. Right to Rely on Advisors

If the Third Party Administrator questions whether a claim should be paid or whether the services provided to you were unreasonably priced, the Trust Fund has the right to rely on its advisors for the decision.

D. Rights under the Plan are Legally Enforceable

Your rights to participate and obtain benefits in and under this Plan are legally enforceable, which rights can be enforced by filing suit in a state or federal court. However, you do not have the right to bring any legal proceeding or action against the Plan until ninety (90) days after you have properly submitted a complaint under the Complaint Resolution procedures of the Plan. If you are still dissatisfied after exhausting the Complaint Resolution procedures of the Plan, then you may initiate legal action against the Trust Fund and/or this Plan. If you do not bring such legal action against the Trust Fund and/or this Plan within three (3) years of the expiration date, then you will forfeit your rights to bring any action against the Trust Fund and/or this Plan.

E. Claimant Payment

All claim payments will be made to you and/or your beneficiary. However, if you and/or your beneficiary are:

1. deceased; or
2. a minor (under 18 years of age); or
3. in the Board of Trustees' opinion, not legally competent,

then the Board of Trustees may make payment to you and/or your beneficiaries spouse, estate, parent, child, sibling or guardian.

F. Change of Eligibility Rules

The Board of Trustees, in their sole discretion, are empowered to change or amend the Plan's rules governing eligibility to participate at any time by amendment or resolution duly executed.

G. Change in Terms

The terms of this Plan may be changed at any time without advance notice to you, except as prohibited by law. All changes in benefits will be made on a uniform basis, affecting similarly situated Participants and Employees equally, and will not apply to claims incurred before the amendment or termination is effective.

H. Amendments

The Board of Trustees is empowered to amend this Plan from time to time as it deems necessary to carry out the purposes and objectives of the Plan and Trust Agreement in the best interest of the Participants covered by the Plan.

I. Construction by Trustees

The Board of Trustees has complete authority to construe and interpret the provisions of the Plan and Trust Agreement and any ambiguity regarding whether coverage is permitted shall be construed against coverage. No Employer, Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or Trust Agreement. Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the claimant's right to legal action, be final and binding on all parties. No provision of this Plan shall be construed to conflict with any Treasury Department, Department of Labor or Internal Revenue Service regulation, ruling, release or proposed regulation or other which affects or could affect the terms of this Plan, and this Plan shall be deemed to be amended to such extent necessary to resolve any such conflict.

J. Legal Actions

No actions at law or in equity shall be brought to recover any benefits provided under this Plan prior to the expiration of ninety (90) days after written proof of loss has been furnished, nor shall any such action be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

K. Delinquent Contributions

In order to protect the interests of the Participants and beneficiaries of the Plan, the Trustees reserve the right to promulgate rules and regulations denying further participation in the Plan by Employees where Employer contributions on behalf of one or more Employees have been in arrears for a specified number of hours or weeks of service, as determined by the Trustees in their sole discretion, and/or to delay the payment of claims arising from such individuals until contributions are received by the Fund Office on behalf of all Employees.

L. Right to Receive and Release Necessary Information

To determine the applicability of and to implement the terms of this provision or any provision of similar purpose in any other plan, the Trust Fund may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information with respect to any person which the Trust Fund deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Trust Fund such information as may be necessary to implement this provision.

M. Post-Mortem Benefits

Any benefit payable under the Plan after the death of a participant is to be paid to his/her surviving spouse, if any, and otherwise to the Participant's estate. If any doubt exists about the right of any beneficiary to receive any amount, the Plan Administrator may retain the disputed amount until the rights to that amount are determined, without any liability for any interest on the amount, or the Plan Administrator may pay the amount to any court of appropriate jurisdiction. In either event, neither the Plan Administrator nor any Employer is under any further liability to any person.

N. Right of Recovery

Whenever payment of benefits has been made by the Trust Fund in excess of the maximum amount of payment necessary at that time to satisfy the claim, the Trust Fund shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Trust Fund shall determine: any persons to or for or with respect to whom such payments were made, or any other organizations, including but not limited to Participants and their beneficiaries. The Trustees reserve the right to reduce or withhold future benefit payments under the Plan in order to correct a prior overpayment to you.

O. Governing Laws

This Plan shall be construed, enforced and administered and the validity determined in accordance with ERISA, as amended, the Internal Revenue Code of 1986, as amended, and the laws of the State of Ohio.

P. Guaranteed Renewability

This Plan may not deny an Employer continued access to the same or different coverage under the Plan, other than:

1. for nonpayment of contributions; or

2. for fraud or other intentional misrepresentation of material fact by the Employer; or

3. for noncompliance with material plan provisions; or

4. because the Plan ceases to offer coverage in a geographic area; or

5. for failure to meet the terms of an applicable Collective Bargaining Agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the Plan, or to employ Employees covered by such an agreement.

Q. Employment Rights

The establishment of this Plan shall not be construed as conferring any legal rights upon any Employee or any other person for continuation of employment, nor shall it interfere with the rights of any Employer to discharge any Employee and/or treat him or her without regard to the effect which such treatment might have upon him or her as a Participant in this Plan.

R. Medical Examination

No medical examination shall be required of any person in order to obtain coverage for benefits initially.

S. Trustee Rights

The Trustees shall have the exclusive right and discretion to make any finding of fact necessary or appropriate for any purpose under the Plan, including, but not limited to, the determination of eligibility for and the amount of any benefit payable under the Plan. The Trustees shall have the exclusive right and sole discretion to interpret the terms and provisions of the Plan and to determine any and all questions arising under the Plan in connection with the Plan's administration, including, without limitation, the right to remedy or resolve possible ambiguities, inconsistencies or omissions, by general rule or particular decision. The Trustees shall make or cause to be made, by engaging individuals or entities, to make all reports or other filing necessary to meet ERISA's reporting and disclosure requirements. All decisions made by the Trustees, and any action taken by them in respect of the Plan or the Trust Agreement, shall be conclusive and binding on all persons, and shall be given the maximum possible deference allowed by law.

T. Administrative Charges

Individual Credit Accounts of Participants may be assessed a monthly service charge to cover the costs of account administration. The amount charged to each account shall

be determined from time to time by a majority vote of the Trustees. The amount charged shall reasonably reflect the pro-rata cost of administering accounts.

XI. STATEMENT OF ERISA RIGHTS

As a Participant in the IBEW Local 32 VEBA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

A. Receive Information about Your Plan and Benefits

Examine, without charge, at the Third Party Administrator's office and at other locations (certain worksites and the Union Hall), all documents governing the IBEW Local 32 VEBA, including insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Receive a summary of the IBEW Local 32 VEBA's Annual Financial Report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

B. Prudent Actions by Plan Fiduciaries.

In addition to creating rights for plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the IBEW Local 32 VEBA, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

C. Enforce Your Rights.

If your claim for a VEBA benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from the IBEW Local 32 VEBA and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the IBEW Local 32 VEBA's fiduciaries misuse the IBEW Local 32 VEBA's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

D. Assistance with Your Questions.

If you have any questions about your IBEW Local 32 VEBA, you should contact the Third Party Administrator at (330) 666-0337 or toll free at (800) 367-3762. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. The nearest Area Office of the Employee Benefits Security Administration is the Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Fort Wright, Kentucky 41011 at (859) 578-4680.

XII. DISCLOSURE OF GRANDFATHERED STATUS UNDER PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Board of Trustees believes that this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("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 the Plan may not include certain consumer protections of the Affordable Care Act that apply to other health plans—for example, the requirement that preventative health care services be provided 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 Third Party Administrator at:

Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388
Fax: (330) 270-0912

You may also contact the Employee Benefits Security Administration, United States 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.

IN WITNESS WHEREOF, this instrument has been executed by the parties hereto on this 9th day of December, 2010, and effective the 1st day of January, 2011.

UNION TRUSTEES:	**EMPLOYER TRUSTEES:**
Jerold Dickrede, Secretary/Treasurer	Danal W. Neal, Chair
Douglas Beining	John Frantz
Thomas Landwehr	Jerry Hesseling

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