TEAMSTERS INSURANCE PREMIUM REIMBURSEMENT FUND
PLAN DOCUMENT

INTRODUCTION

On December 11, 2008, the Trustees of the Teamsters Joint Council No. 83 of Virginia Health and Welfare Plan and the Trustees of the Teamsters Joint Council No. 83 of Virginia Pension Plan established this **TEAMSTERS INSURANCE PREMIUM REIMBURSEMENT FUND** to reimburse eligible Participants of participating Employers that agreed to provide coverage for them under the Fund for premiums paid to a Qualifying Health Plan under the rules specified in this Plan Document.

The Plan and Trust Agreement are intended to meet the requirements of Sections 401(a) and 501(c)(9) of the Internal Revenue Code of 1986, as amended, and the Employee Retirement Income Security Act of 1974, as amended. The Plan has been established for the exclusive benefit of Employees and their Beneficiaries.

Pursuant to the authority derived from Article VI, Sections 1 and 6 of the Agreement and Declaration of Trust, the Board of Trustees of the Teamsters Insurance Premium Reimbursement Fund hereby establish, effective September 1, 2011, the following rules and regulations and plan of benefits, which rules and regulations and plan of benefits shall remain in effect until changed by future action of the Board.

ARTICLE 1 - DEFINITIONS

Section 1.1 ADMINISTRATOR shall mean the Trustees or such person or persons as may be designated by the Trustees.

Section 1.2 AGREEMENT AND DECLARATION OF TRUST means the instrument creating the Teamsters Insurance Premium Reimbursement Fund, including any amendments thereto and modifications thereof.

Section 1.3 BENEFICIARY means a person who by means of the Plan of Benefits established pursuant to this Trust Agreement is or may become entitled to benefits thereunder.

Section 1.4 BENEFITS means the insurance reimbursement benefits to be provided pursuant to the Plan.

Section 1.5 CLAIMANT means any person who applies for Benefits under the Plan.

Section 1.6 CODE means the Internal Revenue Code of 1986, as amended.

Section 1.7 COLLECTIVE BARGAINING AGREEMENT means a Collective Bargaining Agreement in force and effect between a Union and an Employer which requires the Employer to

make or to transmit contributions to the Fund, together with any modifications or amendments thereto.

Section 1.8 CONTRIBUTION means the contributions made by the Employers to the Fund pursuant to the terms of a Collective Bargaining Agreement or Participation Agreement. In the event such Collective Bargaining Agreement or the Plan Document provides that the contributions due thereunder shall be made in whole or part by Employees, "Contribution" also shall include such contributions by Employees transmitted by the Employer.

Section 1.9 ELIGIBLE EXPENSE means the cost of premiums required for coverage under a Qualified Health Plan.

Section 1.10 EMPLOYEE means any person for whom a participating Employer is required to remit contributions to the Fund pursuant to a Collective Bargaining or Participation Agreement. The term "Employee" also includes individuals who were employed by National Linen Service immediately prior to the sale of assets on August 31, 2006 and became employed by ALSCO immediately thereafter. The term "Employee" shall not include any owner-operator, partner, independent contractor, or self-employed person who is prohibited by law from being covered under the Fund or whose inclusion would adversely affect the tax-exempt status of the Fund.

Section 1.11 EMPLOYER means any Employer who is now or hereafter becomes and remains approved for participation by the Trustees, and has a Participation Agreement with the Fund or a Collective Bargaining Agreement with a Union requiring periodic contributions to the Fund, and has, in writing, adopted and agreed to be bound by the terms and provisions of the Agreement and Declaration of Trust.

Section 1.12 ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Section 1.13 FUND means the Trust Fund created pursuant to the Agreement and Declaration of Trust and the monies or other things of value which comprise the corpus, income and additions to the Trust Fund.

Section 1.14 HIPAA means the Health Insurance Portability and Accountability Act of 1996, and in the context of the Plan, refers to Section 2741 *et seq.*, regulating the issuance of individual health insurance policies under a state administrative scheme.

Section 1.15 NAMED FIDUCIARY means the Board of Trustees.

Section 1.16 PARTICIPANT means any Employee or former Employee who is or may become eligible to receive a Benefit of any type from this Fund or whose Beneficiary may be eligible to receive any such Benefit.

Section 1.17 PARTICIPATION AGREEMENT means an agreement between the Fund and an Employer which does not have a Collective Bargaining Agreement requiring it to make contributions

to the Fund but which nevertheless wishes to contribute on behalf of its employees. The Participation Agreement must contain contribution rates approved by the Trustees.

Section 1.18 PLAN means the written plan of benefits adopted by the Trustees pursuant to Article VI of the Agreement and Declaration of Trust.

Section 1.19 PLAN YEAR means the fiscal period for which the books and records of the Fund shall be maintained. The fiscal year shall be the twelve months beginning each January 1 and ending each succeeding December 31.

Section 1.20 QUALIFYING HEALTH PLAN means (1) COBRA continuation coverage under the Participant's Employer group health plan; (2) an individual health insurance policy available through the Affordable Care Marketplace; (3) any other individual health insurance policy that the Trustees determine, in their sole discretion, offers comprehensive medical benefits.

Section 1.21 RETIRED EMPLOYEE means an Employee who is eligible for benefits as a retiree under his Employer's Pension or Retirement Plan (whether as an Early, Normal, or Late retirement).

Section 1.22 SCHEDULE OF BENEFITS means the Benefits enumerated in "Schedule A", hereto, and incorporated by reference herein.

Section 1.23 SPOUSE means that person determined by the Trustees to be legally married to a Participant under the laws of the state of the Participant's residence at the time of the Participant's retirement. "Spouse" does not include a person a Participant marries after the effective date of his retirement. "Spouse" also does not include a person who is living outside the United States or Canada or who is on active military duty.

Section 1.24 TRUSTEES.

a. "Employer Trustees" means the Employer Trustees of the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund.
b. "Union Trustees" means the Union Trustees of the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund.
c. "Trustees" means the Employer Trustees and Union Trustees, collectively, and shall include their successors when acting as Trustees.

Section 1.25 UNION means any labor organization which has a Collective Bargaining Agreement requiring periodic contributions to the Fund created by this Trust Agreement, and has, in writing, adopted and agreed to be bound by the terms and provisions of the Agreement and the amendments and modifications thereof and has been approved for participation in the Fund by the Trustees.

ARTICLE 2 - ELIGIBILITY FOR BENEFITS

Section 2.1 Initial Employee Eligibility and Effective Date of Benefits. An Employee will become eligible for benefits on the first day of the month following the effective date of retirement from the Employer if each and all of the following conditions are met as of the effective date of retirement:

a. the Employee is a Retired Employee;

b. the Employee had Contributions paid on his behalf for at least 312 weeks to this Fund or in combination with the NLS-Teamsters Insurance Premium Reimbursement Trust; and

c. the Employee is not eligible for medical benefits under any group health plan (except for COBRA continuation under the Employer's group health plan) or Medicare or Medicaid;

Section 2.2 Initial Spouse Eligibility and Effective Date of Benefits. A Retired Employee's Spouse will become eligible for benefits from the Plan on the same day that the Retired Employee becomes eligible for benefits; provided that a Spouse shall not become eligible for benefits if eligible for benefits under any group health plan (except for COBRA continuation under the Employer's group health plan) or Medicare or Medicaid.

Section 2.3 Termination of Eligibility.

a. A Retired Employee will cease participation in the Plan and will no longer be eligible for benefits from the Fund on the earliest of the following: (i) as of the last day of the month in which the Retired Employee turns age 65, (ii) immediately if the Retired Employee becomes eligible for health benefits from any group health plan (other than COBRA continuation under the Employer's group health plan), (iii) immediately upon eligibility for Medicare or Medicaid benefits, (iv) immediately upon the death of the Retired Employee, or (v) upon reaching the lifetime maximum benefit provided by the Plan.

b. A Spouse will cease participation in the Plan and will no longer be eligible for benefits from the Fund on the earliest of the following: (i) as of the last day of the month in which the Spouse turns age 65, (ii) immediately if the Spouse becomes eligible for health benefits from any group plan (other than COBRA continuation under the Employer's group health plan), (iii) at the end of the month three years after the Retired Employee's termination date, (iv) immediately upon eligibility for Medicare or Medicaid benefits, (v) immediately on the date the Spouse is no longer married to the Retired Employee (vi) immediately upon the death of the Spouse, or (vii) upon reaching the lifetime month or dollar maximums provided by the Plan. If participation and eligibility terminate because the Retired Employee and Spouse are no longer married, participation and eligibility cannot be reinstated by the subsequent remarriage of the Retired Employee and Spouse.

ARTICLE 3 - BENEFITS

An eligible Retired Employee or Spouse who becomes a Participant in the Plan will be entitled to reimbursement of monthly premiums paid for the purchase of coverage under a Qualifying Health Plan at the reimbursement rates set forth on the Schedule of Benefits included in this Plan as Schedule A. Deductibles, co-payments, exclusions, penalties or other medical costs not reimbursed under such Qualifying Health Plan shall not be reimbursed under the Plan. Any costs for coverage under such Qualifying Health Plan in excess of the amounts set forth in the Schedule of Benefits shall be the responsibility of the eligible Retired Employee or Spouse, whichever is applicable.

ARTICLE 4 - PAYMENT OF BENEFITS AND APPEAL PROCEDURE

Section 4.1 Payment of Benefits

a. Time of Payment of Benefits. All Benefits will be paid by the Fund on the first business day of a month for all claims received on or before the 25th calendar day of the prior month. Payment may be delayed if the Fund must make an eligibility determination or must review information deemed necessary to determine the proper benefit amount.

b. Persons to Whom Benefits are Payable. Benefits shall be paid solely to the eligible Retired Employee, and/or Spouse.

c. Facility of Payment. If the Trustees determine that a person entitled to benefits hereunder is unable to care for his affairs because of illness, accident, or incapacity, any payment due may be paid to his legal guardian or other representative. Any such payment shall be made for the account of such incapacitated person and shall, to the extent thereof, be a complete discharge of the obligations under this Plan to such person.

Section 4.2 Claims Procedures

a. Notice of Claim. The Retired Employee and/or Spouse must submit a written application for Benefits under the Plan. If deemed eligible for Benefits, the Retired Employee and/or Spouse must submit to the Fund Office written proof of payment of insurance premiums deemed reimbursable under the Plan of Benefits with sufficient information to identify the eligible person. As used in this Section, "Notice of Claim" means the first time that the Fund is made aware that a claim was incurred on a specific date. No charges can be considered for payment by the Fund until all information required for processing is on file. No claim will be paid or considered for payment if the occurrence of the event on which claim is based took place more than twelve (12) months prior to the date notice of claim is received. However, failure to give written notice within the twelve (12) month period will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give written notice within that time and that written notice was given as soon as reasonably possible.

b. Copy of Premium Check**.** A copy of the premium check issued to the applicable COBRA/HIPAA provider is required for processing all reimbursement claims.

c. Claim Review Procedure.

1. Denial of Eligibility or Claims. The Third Party Administrator shall notify a Claimant in writing if eligibility or a specific claim is denied or partially denied. The written denial shall be provided to the Claimant no later than ninety (90) days after the receipt by the Fund Office of the application for eligibility or Notice of Claim, unless special circumstances require an extension of time for processing the claim. If such special circumstances exist, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial ninety (90) day period, which notice shall indicate the circumstances requiring an extension as well as the date by which the Fund expects to render a decision. In no case shall such an extension of time exceed a period of ninety (90) days from the end of the initial period.

2. The notification shall set forth, in a manner calculated to be understood by the Claimant:

A. The specific reason or reasons for the adverse determination;

B. Reference to the specific Plan provisions on which the determination is based;

C. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

D. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

E. The identity of any medical or vocational experts 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; and

F. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request.

d. Appeals Procedure.

1. Any Claimant who applies for benefits under the Plan and is ruled ineligible or not qualified for such benefits in whole or in part, or who believes he did not receive the full amount of benefits to which he is entitled, or who is otherwise adversely affected by any action of the Trustees acting through the Third Party Administrator, shall have the right to request the Board of

Trustees to review the matter, provided that he makes such a request in writing within one hundred and eighty (180) days after being notified, in writing, of such adverse action. Furthermore, upon written request to the Fund Office during such one hundred and eighty (180) day period, the Participant or Beneficiary shall be extended an opportunity to review pertinent documents at the Fund Office.

2. A Claimant may appoint a representative (who may be an attorney or service provider) to pursue the appeal. If the Claimant appoints a representative to pursue an appeal, a written statement of authorization signed by the Claimant must be supplied to the Fund Office as part of the appeal. An appeal submitted without proof of authorization will be considered filed, subject to submission of proof of authorization. The Fund Office will notify the representative that proof of authorization must be submitted within ten working days or by the expiration of the applicable time requirement set forth in this Section, whichever is the later.

3. The written request for review of an adverse action of the Trustees acting through the Third Party Administrator must be addressed to the Board of Trustees in care of the Third Party Administrator and must state: (a) the name and address of the Claimant who is appealing the adverse decision; (b) the fact that the Claimant is appealing from a decision of the Fund Office (giving the date of the decision appealed from); and (c) the basis of the appeal, i.e., the reason or reasons why the claim should not be denied; and (d) the provisions of the Plan on which the appeal is based.

4. Unless special circumstances require an extension of time, the Board of Trustees shall issue a written decision affirming, modifying, or setting aside the decision appealed from by the date of their next regularly scheduled meeting following the Fund Office's receipt of the written appeal or, in cases where the written appeal. In no case will the period for rendering a decision be extended beyond one hundred and eighty (180) days after the filing of the appeal unless the Board of Trustees request that the Fund Office obtain additional information from the Participant, Beneficiary or service provider. The decision by the Board of Trustees on review shall be in writing and will include specific reasons for the decision, as well as specific references to the pertinent Plan provisions on which the decision is based. Such a decision by the Board of Trustees shall be final and binding. For purposes of this section, the term "Board of Trustees" means the Board of Trustees of the Fund or a duly authorized committee acting on behalf of the Board of Trustees.

5. No person shall file a claim in any court or before any agency for the payment of benefits under this Plan unless he has already filed an application for such benefits with the Trustees as required by this Plan and exhausted the review procedures set forth in this section. No legal or administrative action may be commenced or maintained against the Plan for the payment of benefits under this Plan more than one hundred and eighty (180) days after the Board of

Trustee's decision on the appeal.

e. Manner and content of notification of benefit determination on appeal. The Third Party Administrator shall provide a Claimant with written or electronic notification of a Plan's benefit determination on appeal. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the Claimant.

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A statement that the Claimant is entitled to receive, 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;
4. A statement of the Claimant's right to bring an action under ERISA Section 502(a);
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
6. If the adverse benefit determination is based on a 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; and
7. 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."

Section 4.3 Assignment. The rights or benefits provided to any Participant or Spouse by the Fund or under any Schedule of Benefits established by the Fund, as well as any proceeds, rights, claims, interests or causes of action arising there from, are non-assignable.

Section 4.4 Overpayment Policy.

a. Eligible Participant. If an overpayment is made by the Fund to a Participant or Spouse, the Third Party Administrator will attempt to recover the overpayment from the party to whom the benefit check was made payable. The Fund has the right to withhold benefit payments on any and all future payments and/or claims submitted on behalf of the overpaid Retired Employee or Spouse up to the amount of the overpayment(s). If the Fund is unable to recoup overpayments from future benefit payments and/or claims and the Retired Employee or Spouse declines to return such

amount to the Fund, the Trustees have the right to sue for recovery or to exercise other remedies allowed or provided by law.

b. Ineligible Participant. The following rules shall apply with respect to overpayments made by the Fund on behalf of an ineligible Participant or his family member:
   1. The Fund Office will offset any available or future claims received that would otherwise have been payable in order to recover the amount overpaid in full.
   2. If claims as described in subparagraph 1, above, are not available, or if such claims fail to offset the full amount of the overpayment, then the Fund Office shall make four (4) attempts to recover the overpayment from the party to whom the benefit check was made payable.

c. If the Fund Office is unsuccessful in all attempts to recover the overpayment, the matter will be referred to the Board of Trustees.

ARTICLE 5 - FUNDING

The Benefits described herein shall be funded by Contributions received from an Employer or Employers pursuant to a Collective Bargaining Agreement or Participation Agreement together with any income or earnings derived from the investment of reasonable reserves and any Employee Contributions. Contributions shall be held in a qualifying Trust and benefits shall be payable from such Trust. Benefits shall be paid only to the extent such contributions and income suffice for the purposes set forth in the Trust Agreement. Neither the Trustees nor any Employer nor the Union shall be liable in any manner if the Fund shall be insufficient to provide for the payment of the benefits specified herein.

ARTICLE 6 - AMENDMENTS AND TERMINATION

Notwithstanding any other provision of the Plan, the Trustees shall have the absolute right, in their sole discretion, to amend or terminate Benefits for Participants or Spouses at any time.

ARTICLE 7 - MISCELLANEOUS

Section 7.1 Law Applicable. All questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the Employee Retirement Income Security Act of 1974 ("ERISA") and, as to matters not preempted by ERISA, the laws of the Commonwealth of Virginia.

Section 7.2 Savings Clause. Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained

or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of this Fund.

Section 7.3 Captions. Captions shall be read as integral elements of this Plan to assist in the interpretation of the Plan provisions to which they relate.

Section 7.4 Schedule of Benefits. References in this plan to the "Schedule of Benefits" shall be deemed references to the benefits that cover the Participant or Spouse.

Section 7.5 Construction. The Trustees are empowered to determine all questions pertaining to the interpretation, administration, construction, and application of the Plan, including, but not limited to, the determination of all questions of eligibility and the status and rights of all individuals claiming an interest in benefits provided by the Plan; their decisions are final and binding on all parties.

Section 7.6 Trustees. All questions arising under or with respect to the Plan shall be determined by the Board of Trustees, whose decisions shall be final and binding on all parties.

Section 7.7 Termination of Group Coverage. To the extent permitted by law and unless otherwise specifically set forth herein, no benefits will be provided after the date coverage hereunder for any group ceases due to termination of the group coverage.

Section 7.8 Abandoned Property. Plan benefits that are payable directly to a Participant or Spouse shall be considered abandoned if, after reasonable efforts to contact said Participant, Spouse, family member or estate, such benefits remained unclaimed for more than three years after the date the claim is incurred. "Reasonable efforts" shall include, but not be limited to, mailing or delivering the benefits payments to the last known address of the Participant or Spouse.

Section 7.9 No Vesting in Fund. No Participant shall have any right to, or interest in, any assets of the Fund upon termination of his employment or otherwise, except as provided under this Plan, and then only to the extent of the benefits payable under the Plan to such Participant out of the assets of the Fund. No Participant, Dependent, or Qualified Beneficiary shall at any time have any vested right to any benefits currently provided or hereafter provided by the Plan. Except as otherwise may be provided under Title IV of ERISA, all payments of benefits as provided for in this Plan shall be made solely out of the assets of the Fund and none of the fiduciaries shall be liable therefore in any manner.

Section 7.10 Gender; Number. Wherever any words are used in this Plan Document in the masculine gender they shall be construed as though they were also used in the feminine or neuter gender in all situations where they would so apply, and wherever any words are used in the Plan Document in the singular form, they shall be construed as though they were also used in the plural form in all situations where they would so apply, and wherever any words are used in this Plan Document in the plural form, they shall be construed as though they were also used in the singular form in all situations where they would so apply.

Section 7.11 Compliance with Plan Provisions. Failure of the Trustees to insist upon compliance with any given provision of this Plan at any given time will not affect the Trustees' right to insist upon compliance with such provisions at any other time.

IN WITNESS WHEREOF, the undersigned do hereby cause this instrument to be duly executed for and on their behalf, individually, and by virtue of their offices as thereunto duly authorized.

Union Trustees	Employer Trustees
_____	_____
_____	_____
_____	_____

Schedule A

Effective January 1, 2011

Weekly Contribution	Monthly Benefit	Lifetime Maximum
$3	$350	$6,300
$4	$475	$8,550
$5	$600	$10,800
$6	$725	$13,050
$7	$850	$15,300
$8	$975	$17,550
$9	$1,100	$19,800

Monthly Benefit - the monthly benefit is the maximum amount paid whether the benefit is for the participant, spouse, or a combination of participant and spouse.

Lifetime Maximum – per person