INSTRUCTIONS PAGE REGARDING THE PLAN DOCUMENT

This Plan Document bundles all of your health and welfare plans into a single plan. This document is an excellent tool to improve legal compliance and simplify administration of your health and welfare benefit plans.

As a Plan Sponsor, your company is required to have a written Plan Document kept on file for each health & welfare benefit plan. By having this document in place, you have ensured that ERISA compliance regulations are being followed for all of your plans, and have simplified the compliance process by wrapping all your benefits together under one Plan Document which satisfies all of the reporting requirements of the Employee Retirement Income Security Act (ERISA).

There is no mandatory distribution requirement of the ERISA plan document as there is with your Summary Plan Description. Upon a Covered Person's or beneficiary's written request, this written plan document and any attachments are among the documents that must be furnished in response to that request.

The plan administrator may be charged up to $147 per day (indexed for inflation after 2016) if it does not provide the plan document within 30 days after an individual's request. You may impose a reasonable copying charge, not to exceed 25 cents per page, but must charge less if the actual cost to the plan is less in complying with a written request.

[The Adoption Agreement, which immediately follows this instruction page, MUST be reviewed by your legal counsel to ensure that it complies with applicable state-law requirements for action by a corporation or other legal entity, and that it is consistent with your own internal governance procedures and corporate structure. It is provided as a sample and should be modified accordingly if it does not accurately reflect your entity.]

Sample Adoption Agreement for the

[INSERT PLAN NAME]

WHEREAS, [INSERT COMPANY NAME] (the "Corporation") maintains certain employee welfare benefit plans providing the following benefits:

- [INSERT LIST OF BENEFITS]

WHEREAS, the Corporation wishes to treat such benefit programs, in effect as of the date of this resolution and as any one of them may be amended from time to time, and any additional benefit program added by duly authorized action of the Corporation or its representatives, as one Employee Welfare Benefit Plan for various purposes including but not limited to required governmental reports and required disclosure to participants and certain beneficiaries, and for COBRA election purposes;

WHEREAS, the Corporation wishes to amend and restate these benefit programs accordingly;

NOW, THEREFORE, IT IS RESOLVED, that the [INSERT PLAN NAME] (the "Plan") is hereby adopted to read as set forth in the document entitled "[INSERT PLAN NAME]," in substantially the form attached to this resolution; and

RESOLVED, that the Plan may be amended from time to time to update the terms and conditions or change benefits available through the Plan;

RESOLVED, that the officers of the Corporation, or any one of them, is each hereby authorized to execute the Plan and any and all other documents, and to take such other action, which is necessary or convenient to effectuate the foregoing resolutions.

The Corporation hereby adopts the Plan as evidenced on this _____ day of _____, 20_____.

_____	_____
Officer Name, Title	Officer Name, Title
_____	_____
Officer Signature	Officer Signature

Mr. Rooter Plumbing and Mr. Electric Employee Benefits Plan
Plan Document
Amended and Restated Effective
January 1, 2018

This document, together with the attached documents, constitutes the written plan document required by ERISA §402 with respect to benefits subject to ERISA.

ARTICLE 1. Definitions

"AD&D" means accidental death and dismemberment insurance.
"Attachments" means the documentation identified in Exhibit A and attached to this document which together with this document constitute the written plan.
"Cafeteria Plan" means the plan, established by the Company under a separate document through which choices of and pre-tax payment for benefits are made in accordance with Code §125.
"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
"Code" means the Internal Revenue Code of 1986, as amended.
"Company" means Mr. Rooter Plumbing Corp., or any successor thereto.
"Covered Person" means any Eligible Employee covered under the Plan, and any individual who is eligible for and covered under the Plan due to the individual's relationship to an Eligible Employee (such as the Employee's spouse, child, or other eligible family member). If a benefit requires enrollment, only an individual who has enrolled is considered a Covered Person with respect to that benefit.
"Effective Date" means, for this amendment and restatement, January 1, 2018. The Plan has been amended several times since its original effective date.
"Eligible Employee" means an Employee who satisfies the eligibility provisions of Article 3, including the eligibility provisions of the applicable component benefit program, except for any Employee in the following categories:

- employees covered by a collective bargaining agreement to which the Plan Sponsor is a party and which does not provide for participation in the Plan;
- "leased employees" within the meaning of Internal Revenue Code Section 414(n);
- individuals who are classified by the Plan Sponsor as independent contractors, or consultants;
- individuals from whom the Plan Sponsor does not withhold federal income and employment taxes from such person's compensation;
- nonresident aliens who receive no earned income (within the meaning of Code Section 911(d)(2)) from their employer that constitutes income from sources within the United States, as defined in Code section 861(a)(3).

To the extent that the Plan and/or a Plan benefit's provider contracts and/or other plan documents refer to the eligibility of "employees," only individuals classified as "employees" by the Plan Sponsor are eligible to participate in such Plan feature. Independent contractors, consultants and individuals hired through staffing firms shall not be eligible even if they are subsequently determined to be common law employees for any purpose, including without limitation, for wage, labor or tax purposes by the Internal Revenue Service, the Department of Labor or any other Federal or state agency, administrative body or court. Any such determination should have a prospective effect only.
"Employee" shall have the same meaning as ERISA §3(6)
"Employer" means the Plan Sponsor and any participating employers as indicated in Exhibit B.
"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.
"FMLA" means the Family and Medical Leave Act of 1993.
"GINA" means the Genetic Information Nondiscrimination Act of 2008.

"Health FSA" means a health flexible spending arrangement established to comply with Code §§ 105 and 125 in order to allow employees to use pre-tax dollars to pay for certain medical expenses not reimbursed or paid under other programs.
"HRA" means a Health Reimbursement Arrangement funded solely by an employer without any salary reduction in order to provide benefits for substantiated medical expenses.
"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.
"HITECH" means the Health Information Technology for Economic and Clinical Health Act.
"MEWA" means the COSE Health and Wellness Trust and is a multiple employer welfare arrangement as defined at Section 3(40) of ERISA, established to provide benefits to two or more employers (including one or more self-employed individuals) and their beneficiaries.
"MHPA" means the Mental Health Parity Act of 1996.
"MHPAEA" means the Mental Health Parity and Addiction Equity Act of 2008.
"Michelle's Law" means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.
"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.
"Plan" means this Mr. Rooter Plumbing and Mr. Electric Employee Benefits Plan.
"Plan Administrator" means President of Mr. Rooter Plumbing Corp.
"Plan Sponsor" means Mr. Rooter Plumbing Corp.
"Plan Year" means the 12-month period beginning each January 1 and ending each December 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.
"PPACA" means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.
"Sponsoring Entity" means COSE Group Services, Inc. and is the custodian and administrator of a MEWA.
"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.
"WHCRA" means the Women's Health and Cancer Rights Act of 1998.

ARTICLE 2. Introduction

2.1 Introduction

The Company, as Plan Sponsor, established and maintains the Plan for the exclusive benefit of its Employees and certain individuals related to its Employees, such as Employees' spouses and dependents. Certain benefit components of the Plan are offered through a MEWA and the Company, as a participating member, is the Plan Administrator for those benefit components. This document, together with the provider contracts identified in Schedule A, and their respective policies, descriptions and other materials (either written or electronic), constitute the written plan and the summary plan description as required by Section 102 of the Employee Retirement Income Security Act of 1974 ("ERISA") and U.S. Department of Labor Regulation Sections 2520.102-2 and 2520.102-3 for the Mr. Rooter Plumbing and Mr. Electric Employee Benefits Plan (the "Plan").

The policies, contracts or booklets for each underlying Plan feature govern the benefits to be provided and include more details on how the Plan features operate. If there is any conflict between this plan document and such policies, contracts or booklets, then such other documents will control. Participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan will always govern.

When the Plan refers to an insurance contract, it also refers to any attachments to such contract, as well as documents incorporated by reference into such contract (such as the application and the certificate of insurance booklet). A copy of each contract (including the booklet), plan document, or other governing document is attached to this document.

2.2 ERISA Status

The Plan provides benefits that are subject to the requirements of ERISA. With respect to those benefits, this document and its attachments constitute the written plan document required by ERISA §402. Benefit programs included in Exhibit A which contain component features that are not subject to ERISA as part of this Plan are not intended to subject the component feature to ERISA. For example, a dependent care flexible spending account under a cafeteria plan is not an employee benefit plan under ERISA and the benefits thereunder are not covered by ERISA. The Sponsoring Entity is responsible for the form M-1 filing obligations regarding benefit components provided through the MEWA.

The Fiduciary for each ERISA covered benefit is identified in Exhibit A.

ARTICLE 3. Eligibility and Participation Requirements

3.1 Eligibility and Participation

An Eligible Employee with respect to the Plan is any Employee who is eligible to participate in and receive benefits under one or more of the component benefit programs in accordance with the terms and conditions of the Plan (including the terms of the applicable component program). Certain component benefit programs require enrollment (either once or annually) for coverage. Information about enrollment procedures, including when coverage begins and ends for the various component benefit programs, is found in the Attachments. An Eligible Employee begins participating in the Plan upon his or her election to participate in a component benefit program in accordance with the terms and conditions established for that program or, if earlier, upon meeting the eligibility criteria and becoming covered under a component benefit program that does not require enrollment or an election.

Other individuals, such as an Eligible Employee's spouse, children, or other family members, may be eligible to participate in and receive benefits under one or more of the component benefit programs due to their relationship to an Eligible Employee. Information about such eligibility and coverage is found in the respective Attachments.

3.2 Termination of Participation

When an Eligible Employee's participation in the Plan terminates, benefits under the Plan for the Eligible Employee and Covered Persons covered through that Eligible Employee will cease. When an Eligible

Employee's participation in a component benefit program terminates, benefits under that component benefit program for the Eligible Employee and Covered Persons covered through that Eligible Employee will cease. Termination of participation in a component benefit program occurs in accordance with the terms and conditions established for that program.

Benefits under all component programs (for all Covered Persons) will cease upon termination of the Plan.

Other circumstances can result in the termination of benefits. The insurance contracts (including the certificate of insurance booklets), plans, and other governing documents in the applicable Attachments provide additional information.

3.3 Qualified Medical Child Support Orders

The Plan will extend medical benefits to an Eligible Employee's non-custodial child as required by any qualified medical child support order (QMCSO) under ERISA §609(a), including a National Medical Support Notice. The Plan has procedures for determining whether an order qualifies as a QMCSO. Covered Persons and beneficiaries can obtain, without charge, a copy of such procedures from the Company's Human Resources Manager.

3.4 Continuation Coverage Under USERRA

An Employee who is absent from employment for uniformed service has the right to elect to continue his or her group health plan coverage for himself or herself and for any covered dependents for a limited time specified in USERRA. USERRA rights are explained in detail in the summary of continuation coverage rights under USERRA provided in the SPD for the applicable component document.

3.5 Continuation Coverage Under COBRA

If a Covered Person's coverage under a component benefit program that is subject to COBRA (identified in Exhibit A) ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then the Covered Person may have the right to purchase continuation coverage for a temporary period of time. COBRA rights are explained in detail in the applicable certificate of insurance booklet and the summary of continuation coverage rights under COBRA provided in the SPD for the applicable component document.

ARTICLE 4. Plan Benefits

4.1 Benefits and Contributions

Benefits furnished hereunder are provided through the purchase of insurance policies and other provider contracts, unless otherwise indicated in Exhibit A. The Plan Sponsor will collect the applicable employee premiums and will pay when due all premiums required to keep such policies and contracts in force. Funding is derived from the funds of the Plan Sponsor and contributions made by the employees. To the extent participants are required to make contributions toward the cost of a particular benefit feature, their contributions will be used in their entirety prior to using Plan Sponsor contributions to pay for the cost of such benefit. Accordingly, any claims experience dividends, refunds or other adjustments in premiums,

fees or other Plan costs related to benefits provided under the Plan may be used to reduce the amount of contributions made by the Plan Sponsor. The level of any employee contributions is set by the Plan Sponsor, which will be communicated to participants when they first enroll in the Plan, and during each open and special enrollment period. The Plan Sponsor reserves the right to modify employee contribution amounts. Employee contributions will be used to fund, or reimburse the Plan Sponsor for funding, the cost of the Plan benefits as soon as practicable after they have been received from the employee or withheld from the employee's pay through payroll deduction.

4.2 Rebates, Refunds, and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be allocated consistent with applicable fiduciary obligations under ERISA.

4.3 Funding

4.3.1 Benefits not offered through the MEWA

Nothing in the Plan is intended to require the establishment of a trust. The Company pays its portion of the cost of benefits under the Plan from the Company's general assets.

Unless otherwise required by law, contributions to any self-insured component benefits need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Covered Person, and no Covered Person or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

4.3.2 Benefits Offered Through the MEWA

Regarding the benefit components offered through the MEWA, Company pays contributions attributable to those benefit components to the Sponsoring Entity and the Sponsoring Entity remits those contributions to the insurance carriers.

As required under ERISA §403, plan assets paid for benefit components offered through the MEWA, the Medical benefit, are held in a separate trust by the Sponsoring Entity and distributed to the carrier as described in the trust agreement. The Company pays its portion of the cost of group Medical benefits under the Plan into the COSE Health and Wellness Trust (“COSE Trust”).

4.4 Right to Recover Benefit Overpayments and Other Erroneous Payments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Covered Person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator, the Company (or designee), or the applicable insurance company may recover that incorrect payment, whether or not it resulted from the insurance company's or Plan Administrator’s (or its designee’s) own error, from the person to whom it was made or

from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the applicable insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.

With respect to component benefit programs provided through insurance, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable). With respect to self-insured component benefit programs, subrogation or reimbursement rights may be set forth in the plan document or other governing documentation.

4.5 Covered Person's Responsibilities

Each Eligible Employee shall be responsible for providing the Plan Administrator and the Company and, if required by an insurance company with respect to a fully insured benefit, the insurance company with his or her current address and, if required, with the address of any individual covered through the Eligible Employee. Any notices required or permitted to be given to a Covered Person hereunder shall be deemed given if directed to the address most recently provided by the Eligible Employee and mailed by first-class United States mail. The insurance companies, the Plan Administrator, and the Company shall have no obligation or duty to locate a Covered Person.

4.6 Right to Information and Fraudulent Claims

Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully insured benefit, the insurance company with such information and documentation as may be necessary to verify eligibility for or entitlement to benefits under the Plan.

The Plan Administrator (and, with respect to a fully insured benefit, the insurance company) shall have the right and opportunity to have a Covered Person examined when benefits are claimed, and when and as often as it may be required during the pendency of any claim under the Plan. The Plan Administrator and, with respect to a fully insured benefit, the insurance company also shall have the right and opportunity to have an autopsy done in the case of death, where it is not forbidden by law.

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such misinformation to the attention of the Plan Administrator or the insurance company, the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law, terminate the person's Plan coverage, including retroactively. In addition, the insurance company may refuse to honor any claim for benefits under the Plan for the Covered Person related to the person submitting the falsified information. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

ARTICLE 5. Plan Administration

5.1. Plan Administrator

The Plan Administrator has (i) the power and authority in its sole, absolute and uncontrolled discretion to control and manage the operation and administration of the Plan and (ii) all powers necessary to accomplish these purposes.

The Plan Administrator will administer the Plan in accordance with established policies, interpretations, practices, and procedures and in accordance with the requirements of ERISA, the Internal Revenue Code, and all other applicable laws. With respect to the Plan, the Plan Administrator has discretion (i) to interpret the terms of the Plan, (ii) to determine factual questions that arise in the course of administering the Plan, (iii) to adopt rules and regulations regarding the administration of the Plan, (iv) to determine the conditions under which benefits become payable under the Plan and (v) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Subject to any applicable claims procedure, any determination made by the Plan Administrator will be final, conclusive and binding on all parties. The Plan Administrator may delegate all or any portion of its authority to any person or entity. For example, for benefits that are fully insured, the applicable insurance company is delegated certain administrative authority.

DESPITE ANY PLAN PROVISION TO THE CONTRARY, THE POLICIES, CONTRACTS OR BOOKLETS FOR EACH UNDERLYING PLAN FEATURE GOVERN THE BENEFITS TO BE PROVIDED, AND THE PROVIDERS FOR EACH PLAN FEATURE ARE RESPONSIBLE FOR MAKING BENEFIT DETERMINATIONS UNDER EACH SUCH PLAN FEATURE, NOT THE PLAN ADMINISTRATOR. IF THERE IS ANY CONFLICT BETWEEN THIS PLAN DOCUMENT AND SUCH POLICIES, CONTRACTS OR BOOKLETS, THEN SUCH OTHER DOCUMENTS WILL CONTROL.

The Company will bear its incidental costs of administering the Plan.

Forfeiture of the component plans shall, at the discretion of the Plan Administrator be used to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Covered Persons in excess of the contributions paid by such Covered Persons through salary reductions; second, to reduce the cost of administering the component benefit plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Covered Persons in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

5.2 Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the participants and their dependents and defraying reasonable expenses of plan administration. These duties must be carried out with the care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation and in

accordance with Plan documents to the extent that they are consistent with ERISA, the Internal Revenue Code and all other applicable laws.

5.3. The Named Fiduciary

The Plan Administrator is a "named fiduciary" with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing to monitor the fiduciary or (ii) the named fiduciary breached its fiduciary responsibility under ERISA Section 405(a).

5.4 Reliance on Covered Person, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Covered Person as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Covered Person. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

5.5 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Covered Person or class of Covered Persons to amend the amount of their salary reductions for a period of coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or component benefit plans; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Company's qualified plans. In the event that contributions need to be reduced for a class of Covered Persons, the Plan Administrator will reduce the salary reduction amounts for each affected Covered Person in a manner consistent with the Code until the defect is corrected.

5.6 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Company, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Company.

5.7 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

5.8 Compensation of Plan Administrator

Unless otherwise determined by the Company and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Company.

5.9 Bonding

The Plan Administrator shall be bonded to the extent required by ERISA.

5.10 Role of Insurance Company

The Company and/or Sponsoring Entity shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Company, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

Insurance premiums for Covered Persons may be paid in part by the Company out of its general assets and in part by Employees (generally through payroll deductions and, if applicable, pursuant to the terms of the Cafeteria Plan). A schedule of the applicable premiums may be provided during the initial and subsequent open enrollment periods and on request for each of the component benefit programs, as applicable.

With respect to the benefit components offered through the MEWA, insurance premiums for Covered Persons may be paid by the Sponsoring Entity. A schedule of the applicable premiums may be provided during the initial and subsequent open enrollment periods and upon request for each of the component benefit programs, as applicable.

5.11 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Covered Person or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Covered Person or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Covered Person or other person shall be forfeited following a reasonable time after the date any such payment first became due.

5.12 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Covered Person, or the amount of benefits paid or to be paid to a Covered Person or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under ERISA, the Code or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Covered Person or other person the credits to the account or distributions to which he or

she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Company.

ARTICLE 6. Circumstances That May Affect Benefits

6.1 Denial, Loss, and Recovery of Benefits

Various circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. The applicable insurance contracts (including the certificate of insurance booklets), plans, and other governing documents in the Attachments provide additional information about the termination, denial, or loss of benefits.

6.2 Plan Termination

Benefits will cease upon termination of the Plan.

ARTICLE 7. Amendment or Termination of the Plan

7.1 Amendment or Termination

The Company, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Company or any of its delegates. For this purpose, amending the Plan includes making changes to a component benefit program. Terminating a component benefit program (including terminating an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

ARTICLE 8. Claims and Appeals Procedures

8.1 Claims and Appeals for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the respective insurer is the named fiduciary under that component benefit of the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, the Covered Person must follow the claims procedures under the applicable insurance, which may require the Covered Person to complete, sign, and submit a written claim on the insurer's form.

The insurance company will decide a Covered Person's claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance company denies a claim in whole or in part, then the Covered Person will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the Covered Person may appeal to the insurance company for a review of the denied claim. The insurance company will decide the appeal in accordance with its reasonable claims procedures,

as required by ERISA if applicable. If the Covered Person does not appeal on time, then he or she may lose his or her right to file suit in a state or federal court, as he or she will not have exhausted his or her internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). To the extent the component benefit program is subject to provisions of PPACA requiring external review, procedures to that effect will be available.

The insurance contract (including the certificate of insurance) in the applicable Attachment provides information about how to file a claim and appeal a denied claim, and details regarding the insurance company's claims procedures.

8.2 Claims and Appeals for Self-Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Company's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-insured arrangement.

To obtain benefits from a self-insured arrangement, the Covered Person must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim.

The Plan Administrator will decide a Covered Person's claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies a claim in whole or in part, then the Covered Person will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the Covered Person may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide the appeal in accordance with reasonable claims procedures, as required by ERISA. If the Covered Person does not appeal on time, then the Covered Person may lose his or her right to file suit in a state or federal court, because he or she will not have exhausted the internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

See the summary plan description (SPD) or other governing document among the applicable Attachments for more information about how to file a claim and appeal a denied claim, and for details regarding the claims procedures applicable to a claim.

8.3 Claims Deadline

Unless specifically provided otherwise in a component benefit program or pursuant to applicable law, a claim for benefits under this Plan (including the component benefit programs) must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Covered Person or his or her designee to make sure this requirement is met.

8.4 Limitations Period for Filing Suit

Unless specifically provided otherwise in a component benefit program or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures.

ARTICLE 9 - HIPAA Privacy and Security

9.1 Disclosure of Information

The Plan Sponsor may only use and/or disclose Protected Health Information (as such term is defined in 45 C.F.R. §160.103) as permitted by the "Standards for Privacy of Individually Identifiable Health Information" under the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") portion of the American Recovery and Reinvestment Act of 2009, and applicable guidance (the "Privacy Rule").

The Plan will disclose Protected Health Information to the Plan Sponsor only upon its receipt of a certification by the Plan Sponsor that the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides Protected Health Information and electronic Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures permitted by the Privacy Rule of which it becomes aware;
- Make available Protected Health Information based on HIPAA's access requirements in accordance with 45 C.F.R. §164.524;
- Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528, including an accounting of disclosures of any electronic health record (as defined in HIPAA);
- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule;
- If feasible, return or destroy all Protected Health Information 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; and

- Ensure that adequate separation of the Plan and the Plan Sponsor is established as required by 45 C.F.R. 164.504(f)(2)(iii) as described below.

9.2 Certification of the Plan Sponsor

The Plan (or a health insurance issuer or HMO with respect to the Plan, if applicable) will disclose Protected Health Information to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 9.1. The Plan will not disclose and may not permit a health insurance issuer or HMO to disclose Protected Health Information to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 C.F.R. §164.520(b)(1)(iii)(C) is included in the appropriate notice. The Plan Sponsor hereby certifies that this Section 9 constitutes an amendment of the governing Plan documents that complies with HIPAA and that the Plan Sponsor will comply with the conditions of disclosure set forth herein.

9.3 Separation of Plan and the Plan Sponsor

Only designated employees in the human resources department of the Plan Sponsor ("Permitted Employees") will be given access to the Protected Health Information. Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business, will also be included in the definition above of Permitted Employees.

The Permitted Employees may only use the Protected Health Information for Plan administrative functions that the Plan Sponsor performs for the Plan.

9.4 Security of Electronic Protected Health Information

In accordance with 45 C.F.R. §164.314(b)(2), to the extent as may be required by law, the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that the Plan Sponsor may create, receive, maintain, or transmit on behalf of the Plan;

- Ensure that the adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

- Ensure that any agents, including subcontractors, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Plan any security incident of which it becomes aware with respect to electronic Protected Health Information.

ARTICLE 10. General Information About the Plan

10.1 No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between any individual and the Company to the effect that the individual will be employed for any specific period of time.

10.2 Compliance With State and Federal Mandates

This Plan, and component benefit programs, shall be construed, operated, and administered according to all applicable requirements of the Code and ERISA, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and/or ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable state and federal laws, including but not limited to USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, Michelle's Law, GINA, and PPACA.

10.3 Coordination with Insurance Contract or Governing Document

To the extent an insurance contract (including the certificate of insurance), plan document, or other document governing a component benefit program contains terms or conditions that conflict or are inconsistent with this document, the terms of the insurance contract (including the certificate of insurance) plan document, or other governing document shall control, rather than this document, unless such terms are prohibited by or inconsistent with applicable law. For this purpose, silence in an insurance contract (including the certificate of insurance), plan document, or other governing document is not necessarily a conflict or inconsistency.

10.4 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Covered Person under this Plan will be excludable from the Covered Person's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Covered Person to determine whether each payment under this Plan is excludable from the Covered Person's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Covered Person has any reason to believe that such payment is not so excludable.

10.5 Governing Law

The Plan shall be construed and enforced according to the laws of Ohio, except to the extent required by federal law.

10.6 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

10.7 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

10.8 Severability

In the event that any provision of this Plan (including the component benefit programs) is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this Plan. The provision shall be fully severable. The Plan shall be construed and provisions enforced as if such invalid or illegal provision had never been part of the Plan.

*** * * ***

IN WITNESS WHEREOF, Company has caused this Plan to be executed, effective as of the Effective Date.

Mr. Rooter Plumbing Corp.

By: _____

Title: _____

Witness

Signature: _____

EXHIBIT A

Mr. Rooter Plumbing and Mr. Electric Employee Benefits Plan

Benefit Plan List

Benefit Plan	Subject to ERISA?	Subject to COBRA?	Fully-or Self-Insured?	Carrier/Administrator Name Address	Controlling Document (e.g., insurance contract)	Policy #	Named Fiduciary
Group Medical	**Yes**	**Yes**	**Fully-insured**	**Medical Mutual of Ohio 2060 East Ninth Street Cleveland, OH 44115-1355 (800) 382-5729**	**PPO Network Major Medical Health Care Certificates**	**387683**	**President of Mr. Rooter Plumbing Corp.**
Group Dental	**Yes**	**Yes**	**Fully-insured**	**Community Insurance Company 1351 Wm Howard Taft Road Cincinnati, OH 45206 (800) 442-1832**	**Certificate of Coverage**	**644895**	**President of Mr. Rooter Plumbing Corp.**
Group Vision	**Yes**	**Yes**	**Fully-insured**	**Community Insurance Company 1351 Wm Howard Taft Road Cincinnati, OH 45206 (800) 442-1832**	**Blue View Vision Certificate of Coverage**	**Not provided; please see Plan Administrator for number.**	**President of Mr. Rooter Plumbing Corp.**
HRA	**Yes**	**Yes**	**Self-insured**	**PrimeFlex Administrative Services, LLC 1487 Dunwoody Drive West Chester, PA 19380 (877) 769-3539**	**Health Reimbursement Arrangement Mr. Rooter Plumbing Corp. Basic Plan Document**	**Not provided; please see Plan Administrator for number.**	**President of Mr. Rooter Plumbing Corp.**

The documents described above are all defined as Attachments in the foregoing Definitions and are incorporated by reference and attached hereto.

EXHIBIT B

To the

Mr. Rooter Plumbing and Mr. Electric Employee Benefits Plan

January 1, 2018

Participating Employers

Each entity listed below has sufficient common ownership with the Employer so as to constitute a member of a commonly controlled group as described in Code §§414(b), (c), (m), and (o) and has adopted the Plan with the consent of the Plan Sponsor.

Butterfly, Inc. dba Mr. Electric of Cleveland -- EIN: 20-5731645

Columbus Electric -- EIN: 26-2997731

_____

_____

***Common Control Group*: The Internal Revenue Code created rules which treat two or more companies as a single employer if there is enough common ownership or a combination of joint ownership and common activity. It is important for you, along with your legal counsel, to determine whether or not you have a controlled group of companies.**