

**AIRCONDITIONING
AND REFRIGERATION
INDUSTRY
HEALTH AND WELFARE
TRUST FUND**

ESTABLISHED BY

**AIRCONDITIONING AND REFRIGERATION FITTERS DIVISION
LOCAL 250 UNITED ASSOCIATION**

and

**AIRCONDITIONING AND REFRIGERATION CONTRACTORS
ASSOCIATION OF SOUTHERN CALIFORNIA, INC.**

and

SIGNATORY EMPLOYERS

SUMMARY PLAN DESCRIPTION

FOR

ACTIVE AND RETIRED EMPLOYEES

REVISED NOVEMBER 2003

AIRCONDITIONING AND REFRIGERATION INDUSTRY HEALTH AND WELFARE TRUST FUND

1380 S. Sanderson Avenue
Anaheim, California 92806
Telephone: (714) 917-6100

To All Active and Retired Participants and Dependents:

This new Booklet has been printed to provide you with a complete description of the benefits available to you and your family.

Many changes have been made since the printing of the last Booklet. We therefore urge you to read this Booklet carefully so that you will understand the benefits provided and your rights to those benefits. Please pay particular attention to the following benefit changes:

- **Non-Preferred Provider Organization (PPO) Copayment for Fee-For-Service Participants.** All non-PPO provider claims are paid up to 60% of Allowable Charges.
- **Non-PPO Out-of-Pocket for Fee-For-Service Participants.** Any non-PPO charges you pay out-of-pocket will not count toward the \$2,000 out-of-pocket maximum.
- **Prescription Drug Benefit for Fee-For-Service Participants.** The Plan has implemented a 3-tier copayment structure, for both retail and mail prescription drug purchases. For retail purchases (30-day supply), the copayments are: Generic = 10% of Rx cost; Formulary (Preferred) Brand = 20%; and Non-Formulary Brand = 40%. For mail order (90-day supply), the copayments are: Generic = \$10 per Rx; Formulary (Preferred) Brand = \$30 per Rx; and Non-Formulary Brand = \$60 per Rx.
- **Office Visit Copayment for Health Maintenance Organizations (HMOs).** The office visit copayment for Kaiser and PacifiCare Participants is \$20 per visit.
- **Prescription Drug Benefit (Kaiser).** The prescription drug copayment for Kaiser is \$10 per generic prescription, and \$25 per brand name prescription, for a 100-day supply.
- **Prescription Drug Benefit (PacifiCare).** For retail purchases, the prescription drug copayment for PacifiCare is \$10 per generic prescription, and \$25 per brand name prescription, for a 30-day supply. For mail order purchases, the prescription drug copayment is \$20 per generic prescription, and \$50 per brand name prescription, for a 90-day supply.
- **Routine Physical Exam Benefit.** The maximum benefit for all members and their eligible spouses has increased to \$300 per individual per calendar year.
- **Outpatient Mental Health Benefit.** The maximum benefit of \$50 per visit has been eliminated; however, the number of visits per calendar year has been reduced from 50 visits to 26 visits. The maximum number of visits is no longer combined with the Alcohol and Drug Abuse Benefit.
- **Alcohol and Drug Abuse Benefit.** The number of visits per calendar year has been reduced from 50 visits to 26 visits. The maximum number of visits is no longer combined with the Outpatient Mental Health Benefit. There is still a \$50 per visit maximum.
- **Acupuncture, Chiropractic and Physical Therapy Benefits.** The number of visits per calendar year is now 26 visits each for the Acupuncture, Chiropractic and Physical Therapy Benefits. The applicable dollar limits per visit still apply.

- **Contraceptives.** In addition to oral contraceptives, the Plan now covers other contraceptive devices which must be administered in the physician's office, such as an I.U.D.
- **Default Medical Plan.** New participants are no longer required to enroll in an HMO for the first 12 months of eligibility. In addition, new participants who do not make a medical plan selection will automatically be enrolled in the Fee-For-Service Plan. The default dental plan is still the United Concordia Dental Plan.
- **Accident and Sickness Weekly Benefit.** The Accident and Sickness Weekly Benefit, available to members who become totally disabled as a result of an injury or an illness, has increased to \$150 per week, for a maximum of 26 weeks.
- **Emergency Care.** If certain conditions are met, the Plan will pay non-PPO providers at 90% of Allowable Charges for Emergency Care.
- **Lifetime Maximum.** The lifetime maximum has been increased to \$500,000 per individual.

Should you have any questions, please contact the Trust Fund Office.

Sincerely,

BOARD OF TRUSTEES

PROVIDER DIRECTORY

Provider	Website	Telephone No.
Affiliated Health Funds (PPO Provider)	www.oefunds.org/healthwelfare/ahf/ahf.htm	(626) 356-1090
Continuum (Mobile Unit-Physical Exam)	www.continuumhc.com	(800) 542-6233
Express Scripts (Rx Provider)	www.express-scripts.com	(800) 347-8777
Interplan Corporation (PPO Provider)	www.interplancorp.com	(800) 444-4036
Kaiser Permanente (HMO) (Membership Services)	www.kaiserpermanente/california.org	(800) 464-4000
MDIA (MRI and CAT Scan PPO)	www.mdia.com	(800) 400-4674
MEDFOCUS Radiology Network (MRI and CAT Scan PPO)	www.medfocus.net	(800) 398-8999
PacifiCare (HMO) PacifiCare (Behavioral Health)	www.pacificare.com	(800) 624-8822 (800) 999-9585
ppoNEXT (PPO Provider)	www.pponext.com	(800) 334-5646
PHM Diagnostics (MRI and CAT Scan PPO)	www.onecallmedical.com	(800) 659-0200
United Concordia (Prepaid Dental Plan)	www.ucci.com	(800) 937-6432
Vision Service Plan	www.vsp.com	(800) 877-7195
Trust Fund Office		(714) 917-6100

GLOSSARY OF ABBREVIATED TERMS

COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
ERISA	Employee Retirement Income Security Act of 1974
HMO	Health Maintenance Organization
PPO	Preferred Provider Organization
QMCSO	Qualified Medical Child Support Order
RVU	Relative Value Unit
UCR	Usual, Customary and Reasonable
UR	Utilization Review

**AIRCONDITIONING AND REFRIGERATION INDUSTRY
HEALTH AND WELFARE TRUST FUND**

1380 S. Sanderson Avenue
Anaheim, CA 92806
Telephone: (714) 917-6100

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I. ACTIVE PARTICIPANT ELIGIBILITY RULES

If you are an active employee working for a participating employer(s) covered under the terms of a Collective Bargaining Agreement with the Union or a Participation Agreement, and contributions are made on your behalf for Health and Welfare benefits, you will be eligible as an active Participant on the first day of the month following the month in which contributions are first received, regardless of the number of hours worked in the first month in which you perform covered work. Thereafter, beginning with the second month, 100 hours per month must be worked on which contributions are paid to this Plan to maintain eligibility.

No Hour Bank will be established for the first six months of eligibility covered under this Plan. After six months of eligibility, an Hour Bank will begin to accumulate for all hours worked for participating employers (after the 100 hours is deducted each month), subject to a maximum Hour Bank limitation of 600 hours.

Hour Bank Exception. If you were an active Participant *prior to July 1, 2002*, you may accumulate a maximum Hour Bank of 800 hours (or 8 months). If you qualify for the exception and your coverage terminates, you may restore your Hour Bank for up to 8 months if you accrue 100 hours or more within the 24-month period commencing with the month benefits were terminated. As soon as you have completed this 100-hour requirement, you will be eligible for the 800 hour maximum.

ELIGIBLE DEPENDENTS

Your lawful spouse, and your unmarried natural or legally adopted children who are (a) less than 19 years of age and (b) dependent upon you for support and maintenance, are eligible Dependents. Children born out of wedlock will be considered eligible Dependents if the eligible Participant can show satisfactory proof of parentage; i.e., a birth certificate.

Children will be covered up to their 25th birthday, provided they are full-time students in an accredited institution of learning and dependent upon you for support and maintenance. You are responsible for providing the Trust Fund Office with proof of full-time student status.

If your lawful spouse is also an active Participant under this Trust, your spouse will be eligible both as an active Participant and as a Dependent. Your lawful spouse's benefits will be payable subject to the Coordination of Benefits provision.

If your Dependent child is also eligible as an active Participant under this Trust, benefits will be payable in accordance with the highest plan of benefits for which he or she is eligible.

Benefits for your Dependents begin on the later of: (1) the date you become eligible; or (2) the date you acquire your dependents (for adopted children, the date of placement for adoption); or (3) if the child is born out of wedlock, the 90th day after the date of birth. **IN ORDER FOR YOUR DEPENDENTS TO BE ELIGIBLE, PROOF OF THEIR DEPENDENCY, SUCH AS A CERTIFIED MARRIAGE CERTIFICATE OR BIRTH CERTIFICATE, MUST BE ON FILE WITH THE TRUST FUND OFFICE.**

NOTE: Coverage for stepchildren and Dependents under a formal guardianship arrangement is available under the Plan's selected HMO plans (for medical), but *only* if the active Participant elects coverage under an HMO plan. Dental coverage is available through either the prepaid dental plan or the Fee-For-Service Dental Plan. The eligibility requirements for stepchildren and children under legal guardianship are the same as for natural children. Benefits are strictly limited to those provided under the HMO plans. Any other benefits paid by this Plan but which are not provided by the HMO plans (such as death or vision benefits) are not provided for stepchildren or children under legal guardianship.

Coverage for eligible Dependents pursuant to a Qualified Medical Child Support Order (QMCSO) is governed by Federal law. A copy of the Plan's procedures governing QMCSO determinations may be obtained, without charge, upon request from the Trust Fund Office.

CONDITIONS UNDER WHICH PARTICIPANT ELIGIBILITY ENDS

1. During the second through sixth month of eligibility, before an Hour Bank is established, your eligibility will terminate if 100 hours are not worked for which contributions are paid to this Plan to maintain eligibility.
2. Your eligibility will terminate on the first day of the month in which the hours in your Hour Bank total less than 100 hours. Any hours remaining in your Hour Bank will be forfeited at the end of 24 consecutive months if the balance in your Hour Bank does not total at least 100 hours during such period. The 24-month period begins on the date your eligibility from your Hour Bank terminates.
3. Eligibility for you and your Dependents will cease on the day you start performing work in Non-Covered Air Conditioning and Refrigeration Service. Your Hour Bank will be suspended and subject to reinstatement only if you work 1,000 hours or more for which contributions are made to this Trust within twelve consecutive calendar months following the date on which the prohibited work in Non-Covered Air Conditioning and Refrigeration Service ceases. In such instances, you will be treated in all respects as having no hours accumulated in an Hour Bank. Neither you nor your Dependents will have any right to COBRA continuation coverage. You must notify the Trust Fund Office promptly whenever you engage in such prohibited work. In the event the Trust receives information that you are not entitled to an Hour Bank because of such work, consideration of any hours in your Hour Bank and all eligibility under the Trust Fund will be suspended immediately and you will be given written notice of the grounds for the action taken.

You will have sixty (60) days within which to file a written request for reconsideration of the suspension, and loss of Hour Bank. In the absence of such a timely request, suspension of the Hours account shall become final. Determination by the Trustees of the request for reconsideration will be final and binding on all persons affected by the decision, subject to the provisions for appeal set forth in this Plan.

4. If you have an ownership interest of five percent (5%) or more in the employer contributing on your behalf, your eligibility and your Dependents' eligibility for benefits may be terminated or suspended if the employer is delinquent in payment of any contributions due to any employee benefit plan under the Collective Bargaining Agreement, until such time as the delinquency is paid, at the full and absolute discretion of the Trustees. The Trustees also reserve the right to terminate or suspend eligibility of other employees if their employer remains delinquent.

CONDITIONS UNDER WHICH DEPENDENT ELIGIBILITY ENDS

Eligibility for your Dependents will terminate on the first of the month following any of these occurrences: (1) the date of entrance into full-time active duty with the Armed Forces of the United States; (2) the date your eligibility terminates, or (3) the date they no longer meet the definition of a Dependent. Your Dependents may then elect to continue coverage for up to 36 months under the COBRA option (see page 18.)

IMPORTANT: CHANGES IN DEPENDENT STATUS

It is the Participant's and/or Dependent's responsibility to notify the Trust Fund Office immediately when Dependent status changes. This includes divorce/final dissolution of marriage, legal separation, death, a dependent child over 19 who is no longer enrolled as a full-time student, a child over 19 being employed with health coverage, and any other events which would make your Dependent not eligible for further coverage. The changing of a beneficiary for death benefits is *not* acceptable notification of divorce or other change in Dependent status. *Even if a divorce decree requires that you maintain your former spouse as a Dependent under your health plan, your former spouse is not eligible as a Dependent under this Plan unless your former spouse is eligible for, elects and purchases COBRA continuation coverage.* If claims are paid for, or premiums are paid on behalf of, any dependent spouse or child and it is later found that the dependent was not eligible, you and/or the dependent will be responsible for reimbursing the Plan for the actual amount paid out in benefits by the Trust plus interest and any costs and attorney's fees if a lawsuit is filed to recover the money.

A spouse who is legally separated from a Participant is no longer an eligible Dependent and will have no further coverage under the Plan. A legal separation means that you have court documents which stipulate that you are legally separated.

If your Dependent child is incapable of self-support because of being physically or mentally handicapped on the date the child's coverage would otherwise terminate because of age, coverage for the child will be continued if within 31 days of that date you submit to the Trust Fund Office satisfactory proof of the child's incapacity. Health and Welfare benefits will be continued during the period of his or her incapacity while you remain eligible, and the Plan may subsequently require proof of his or her continued incapacity. This extension will continue until (1) the day he or she ceases to be eligible for reasons other than age, (2) the day he or she ceases to be incapacitated, or (3) the 31st day after the Plan requests additional proof of his or her incapacity if you fail to furnish such proof.

In the event of your death, if you are an active Participant, coverage for your eligible Dependents will be continued for the number of months of credit remaining in your Hour Bank, unless they no longer qualify as a Dependent due to age or military service. In the case of your spouse, coverage will terminate upon remarriage, if earlier than the termination of the Hour Bank.

RESTORATION OF COVERAGE

If your coverage has been previously terminated because of lack of sufficient hours in your Hour Bank, your coverage will be restored on the first day of the first month following the calendar month in which your Hour Bank totals 100 hours or more, provided those hours are accumulated within 24 consecutive months after your benefits have terminated.

HOW TO CONTINUE YOUR COVERAGE IF YOU LOSE ELIGIBILITY

When loss of eligibility occurs because you have failed to work sufficient hours or because you are disabled and are no longer eligible under the extension of coverage for disabled active Participants (see "Credit for Disability Hours" below), you may be eligible to pay to continue coverage for yourself and your Dependents through COBRA Continuation Coverage. Please see the COBRA section on page 18 for more information.

PARTICIPANTS IN THE ARMED FORCES

On the date you enter full-time active duty with the armed forces of the United States, your eligibility for benefits will terminate. If you have an Hour Bank, eligibility for your family will continue for one month after the date you enter full-time active duty. (Your coverage will be provided by the armed forces.) If you return to work with a Participating Employer within 90 days after your date of discharge, you will be reinstated for benefits on the first day of your re-employment and will be credited with any hours held in your Hour Bank at the time of entrance into active duty.

Active Participants who enter into full-time active duty with the armed forces of the United States, and their eligible Dependents, may also elect to continue coverage by submitting to the Trust Fund Office, within 60 days after the Participant entered the armed services, a written election to continue coverage. The maximum period of coverage for the Participant and his or her eligible Dependents is the lesser of (1) an 18 month period beginning on the date the Participant's absence from employment with a Participating Employer begins, or (2) if the Participant does not return to work within 90 days after discharge, the day after the expiration of the 90-day period. Participants (and their Dependents) who elect to continue coverage must pay for such coverage in the same amount and in the same manner as provided for under COBRA continuation coverage. For more information, see the COBRA Continuation Coverage section of this booklet, or call the Trust Fund Office.

CREDIT FOR DISABILITY HOURS FOR ACTIVE PARTICIPANTS

After you initially become eligible, if you become Totally Disabled while eligible due to an illness or injury, benefits for you and your family will be continued without monthly deduction from your Hour Bank for the period of "Total Disability" but not for more than one year.

At the end of the 12-month period, if you are still Totally Disabled, you may continue your eligibility on the basis of hours remaining in your Hour Bank. If less than 100 hours remain in your Hour Bank, those residual hours may be used to re-establish eligibility.

EFFECT OF HOUR BANK DEPLETION ON RETIREE BENEFITS

If you leave covered employment for which contributions were being made on your behalf and deplete your Hour Bank, then you must work in covered employment and have contributions made on your behalf for the same number of years, or more, as you were in Non-Covered employment in order to be eligible to receive benefits from the Health and Welfare Fund as a retiree. However, if you (a) leave covered employment after accruing 25 years or more of Pension Credit under the Airconditioning and Refrigeration Industry Retirement Trust Fund and (b) thereafter work continuously until retirement in a position not covered by the Collective Bargaining Agreement for an employer contributing to this Trust Fund, you will be eligible to receive such retiree benefits after retirement commencing with the first month following the month in which you reach age 62.

If you are nearing retirement, see page 6 for a complete description of retiree eligibility and certain conditions regarding returning to work which affect retiree benefits.

ELIGIBILITY AND COVERAGE RULES FOR ORGANIZATIONAL, RE-ORGANIZATIONAL AND TRANSITIONAL EMPLOYEES, INCLUDING EMPLOYEES WORKING UNDER THE NATIONAL MECHANICAL SERVICE AGREEMENT

The standard eligibility and coverage rules apply to employees classified as “organizational,” “re-organizational” or “transitional” employees, as determined by the Union (the Airconditioning and Refrigeration Fitters Division of Local 250 of the United Association), except as otherwise indicated below. Such employees currently include employees working under the National Mechanical Service Agreement.

In general, “organizational” employees are employees who formerly worked in Non-Covered Air Conditioning and Refrigeration Service (see Definitions section, page 23) and who are now working or going to work as journeymen, apprentices or apprentice trainees.

In general, “re-organizational” employees are employees who worked in covered service under this Plan before working in Non-Covered Air Conditioning and Refrigeration Service, and who have now returned or are returning to covered service as journeymen, apprentices or apprentice trainees for an employer who is obligated to contribute to this Plan on their behalf pursuant to an applicable Collective Bargaining Agreement.

In general, “transitional” employees are employees (not apprentices or apprentice trainees) who formerly worked in Non-Covered Air Conditioning and Refrigeration Service, who have a minimum of five years of air conditioning and refrigeration experience, who pass the requisite journeyman’s test, and who were being paid \$16 to \$18 per hour. Union wages would be paid over this amount pursuant to the applicable Collective Bargaining Agreement, but less than a journeyman’s wages, with the fringe package paid at 5th-year apprentice rates. “Transitional” employees will subsequently be reviewed every six months for wages, but fringes will remain at the 5th-year apprentice rate until the employee reaches or attains the full journeyman wage rate (unless the fringe package is increased due to a new contract period).

For re-organizational employees only, any suspension of benefits previously imposed will be lifted and whatever hours were in that person’s Hour Bank at the time of his suspension will be unfrozen after the initial six months of eligibility, provided the employee is “re-organized” within 24 months of his suspension of benefits. A re-organizational employee who never had a suspension of benefits imposed will also have his hour bank restored after the initial six months of eligibility, provided he is “re-organized” within 24 months of his suspension of benefits.

II. RETIRED PARTICIPANT ELIGIBILITY RULES

Who is Eligible?

You are eligible to continue to receive benefits from the Health and Welfare Trust Fund if you are receiving a pension benefit from the Air Conditioning and Refrigeration Industry Retirement Trust Fund (including Disability, Service, or Early Retirement pension), and you make the required monthly copayments, subject to the following:

1. You have at least fifteen (15) years accredited service with Participating Employers; and
2. Contributions have been made on your behalf for 500 or more hours since May 1, 1959 through July 1, 1973, or 5,000 hours for employees entering the Retirement Plan after July 1, 1973;
3. Prior to your retirement, if you left covered employment for which contributions were made on your behalf and depleted your Hour Bank, you will not be eligible for health and welfare benefits as a retiree unless you have returned to covered employment and earned vesting credits for a period of time equal to or greater than the number of years you were not in covered employment;
4. If you are on a Disability Retirement, health and welfare coverage will end two years after your Hour Bank runs out, unless you have received a Social Security Disability Award. If you are disabled and eligible for Medicare, you must enroll in Part A and Part B.

Despite the foregoing, if you:

1. Leave covered employment after accruing 25 years or more of Pension Credit under the Airconditioning and Refrigeration Industry Retirement Trust Fund; and
2. Thereafter work continuously until retirement in non-covered employment for an employer contributing to this Trust Fund,

you will be eligible to receive such retiree benefits after retirement commencing with the first day of the first month following the month in which you reach age 62.

How Much Are The Monthly Retiree Copayments?

The retiree copays are determined by multiplying the current cost of retiree coverage by a "Copay Percentage". The cost of coverage depends on whether the retiree is enrolled in the Fee-For-Service Plan or in an HMO (PacifiCare or Kaiser), and on whether the retiree is eligible for Medicare. The Trust Fund Office will notify you of the current costs of coverage.

To determine the Copay Percentage applicable to a retiree, and if married, to the retiree's spouse, first start with the "Basic Percentage" of 50%. For a retiree who retired in 2003, or later, and is age 55 at the age of retirement with 25 years of service, the copay is determined by multiplying the cost of coverage by 50%. If you are not 55 at the time of retirement or do not have 25 years of service credit or if you retired before 2003, the Basic Percentage will be adjusted to a higher or lower percentage according to the following rules:

Adjustments to Basic Percentage

1. If you retired before 2003, subtract 1% from the Basic Percentage for each year of retirement before 2003 (up to a maximum of 10 years or 10%).
2. If you have more than 25 years of service credit, subtract 2% from the Basic Percentage for each additional year of service credit over 25.
3. If you have less than 25 years of service credit, add 2% to the Basic Percentage for each year below 25. (This adjustment will not apply if you are receiving a Disability Pension.)
4. If you were under age 55 at the time you retired, add 1% to the Basic Percentage for each year of age under 55. (This adjustment will not apply if you are receiving a Disability Pension.)

If the retiree is married, the Copay Percentage would also be applied to the cost of coverage that applies to his or her spouse.

Special Note for Retirees Receiving a Disability Pension: Retirees who are receiving a Disability Pension should note that adjustments 3 and 4 above do not apply to you. If you are receiving a Disability Pension and have dependent children who are covered under the Plan, a Copay Percentage of 15% will apply to your children.

The appropriate amount will be deducted from your pension check each month. The Trustees reserve the right to change the amount of the required copay. The monthly copays will be updated each year to reflect the change in the cost to provide coverage.

Are My Dependents Eligible?

Your lawful spouse is eligible as a Dependent provided you have been married for at least one year at the time of your retirement and are not legally separated. Your dependent children are NOT eligible unless you are receiving a disability pension.

If you are a disabled retiree, your unmarried natural children, legally adopted children and step-children less than 19 years of age are eligible Dependents. A child is considered legally adopted the date the child is placed in the prospective adoptive parents' home, pursuant to adoption proceedings. Step-children of disabled retirees may be covered only by an HMO plan. Therefore, if you want to cover your step-children, the entire family must be in the HMO. Dependent children may also be covered up to their 25th birthday, provided they are full-time students in an accredited institution of learning and dependent upon you for support and maintenance. You are responsible for providing the Trust Fund Office with proof of full-time student status.

If your lawful spouse is also eligible as an active or retired employee under this Trust, your spouse will be eligible as both a Participant and a Dependent, and benefits will be payable subject to the Coordination of Benefits provision.

Benefits for your Dependent spouse begin on the date you become eligible.

In the case of Dependent children of disabled retirees, benefits will begin on the later of:

1. The date you become eligible; or
2. The date you acquire your Dependents (the date the child is placed in the prospective adopted parents' home pursuant to adoption proceedings).

When Does My Eligibility End?

Your eligibility for Health and Welfare benefits as a retired participant will terminate on the earliest of the following dates:

1. The last day of the month preceding the month in which no pension benefit under the Airconditioning and Refrigeration Industry Retirement Trust Fund is payable, whether the payment is halted or suspended;
2. The date on which this Plan is terminated by the Trustees;
3. The first day of the month for which a required self-payment has not been received by the Trust Fund Office; and
4. The first day of the month in which you work in Non-Covered Air Conditioning and Refrigeration Service.

What Happens If I Return to Covered Employment or other Approved Employment within the Air Conditioning and Refrigeration Industry?

When you retire, the Hour Bank you earned as an active employee is "frozen." However, if you return to work as an active employee with a participating employer, your Hour Bank will be "unfrozen" and will contain the same number of hours you were credited with at the time of your retirement. If the number of hours in your Hour Bank amounts to 100 or more, you will be eligible as an active employee immediately. However, if the number of hours in your Hour Bank amounts to less than 100, you must work the additional number of hours necessary to bring your Hour Bank balance to 100 in order to be eligible that month. **If you do not have the required number of hours, you will not be eligible under the Active Plan or the Retiree Plan. Contact the Trust Fund Office if you have any questions concerning your continuing eligibility.**

Retirees who are approved for certain kinds of work while drawing a monthly pension benefit may qualify for health and welfare coverage. The rule is that if you have no health coverage from the employer you are working for, then you may participate in the Plan's health and welfare coverage, but only under one of the HMOs for medical coverage and under United Concordia for dental coverage. When you discontinue the approved work, you may go back to the Fee-For-Service Medical and Dental plans, but not until the next regular open enrollment period after you stop working.

All work must have the approval of the Board of Trustees prior to the starting of work.

A retiree who has reached age 55 and has earned a minimum of 25 years of future service credits may do the following work and still receive pension benefits:

1. Refrigeration and air conditioning wholesale parts house worker;
2. Teaching air conditioning and refrigeration in a junior college, public or private occupational school and full-time at United Association Training Centers;
3. City and/or civil service work performing air conditioning or refrigeration work. Physical plant and/or stationary engineer or hospital engineer; or
4. Sales, dispatcher, estimator, or a similar job only if working for a Local 250 signatory employer which contributes to this Plan. **THIS DOES NOT ALLOW THE RETIREE TO WORK WITH THE TOOLS, OR TO HAVE AN OWNERSHIP INTEREST, INCLUDING A COMMUNITY PROPERTY INTEREST, IN THE COMPANY FOR WHICH HE OR SHE IS WORKING.**

These rules are subject to additional review and change by the Trustees from time to time as deemed necessary in the Trustees' sole discretion.

When Does My Dependent's Eligibility End?

Eligibility for your Dependents will terminate on the first of the month following any of these occurrences: (1) the date of entrance into full-time active duty with the Armed Forces of the United States; (2) the date your eligibility terminates, or (3) the date they no longer meet the definition of a Dependent. Your Dependents may then elect to continue coverage for up to 36 months under the COBRA option (see page 18.)

IMPORTANT: CHANGES IN DEPENDENT STATUS

It is the Participant's and/or Dependent's responsibility to notify the Trust Fund Office immediately when Dependent status changes. This includes divorce/final dissolution of marriage, legal separation, death, a dependent child over 19 who is no longer enrolled as a full-time student, a child over 19 being employed with health coverage, and any other events which would make your Dependent not eligible for further coverage. The changing of a beneficiary for death benefits is *not* acceptable notification of divorce or other change in Dependent status. *Even if a divorce decree requires that you maintain your former spouse as a Dependent under your health plan, your former spouse is not eligible as a Dependent under this Plan unless your former spouse is eligible for, elects and purchases COBRA continuation coverage.* If claims are paid for, or premiums are paid on behalf of, any dependent spouse or child and it is later found that the dependent was not eligible, you and/or the dependent will be responsible for reimbursing the Plan for the actual amount paid out in benefits by the Trust plus interest and any costs and attorney's fees if a lawsuit is filed to recover the money.

A spouse who is legally separated from a Participant is no longer an eligible Dependent and will have no further coverage under the Plan. A legal separation means that you have court documents which stipulate that you are legally separated.

If your Dependent child is incapable of self-support because of being physically or mentally handicapped on the date the child's coverage would otherwise terminate because of age, coverage for the child will be continued if within 31 days of that date you submit to the Trust Fund Office satisfactory proof of the child's incapacity. Health and Welfare benefits will be continued during the period of his or her incapacity while you remain eligible, and the Plan may subsequently require proof of his or her continued incapacity. This extension will continue until (1) the day he or she ceases to be eligible for reasons other than age, (2) the day he or she ceases to be incapacitated, or (3) the 31st day after the Plan requests additional proof of his or her incapacity if you fail to furnish such proof.

What Happens To My Spouse If I Pass Away?

If you and your spouse are eligible for health and welfare benefits under the Plan and you pass away, your spouse will continue to receive health and welfare benefits as follows:

If you have selected Joint and Survivor benefits under the Retirement Plan, your spouse will receive health and welfare benefits after your death on the basis of the Joint and Survivor benefit percentage you elected to receive when the application for the Joint and Survivor Pension benefit was originally made (i.e., 50%, 75%, 100%). However, if you are enrolled in a pre-paid plan, benefits will not be reduced.

If you have not selected Joint and Survivor benefits, and if you die within five years of retirement, your spouse will receive full health and welfare benefits for the balance of the five years. Your spouse will not be eligible for benefits after this five-year period or if you die five years or more after you retire.

How Much Will My Spouse Have To Pay To Continue Benefits?

The amount of the monthly copayment required by your spouse will be determined according to the same schedule as for retirees (see page 6), or the copayment schedule as it may be modified in the future.

III. MEDICAL AND DENTAL PLAN OPTIONS FOR YOU AND YOUR DEPENDENTS

MEDICAL BENEFITS

Three medical benefit plan options are currently available to you and your eligible Dependents:

- **Two prepaid health plans are currently provided through either PacifiCare or Kaiser.** You must live within the service area of the HMO's service providers in order to enroll in one of the HMOs. If you enroll in one of these options, you and your eligible Dependents will be covered under that HMO for all hospital and medical services and supplies. However, the Fee-For-Service Plan will continue to provide you with Vision, Hearing Aid, and Chiropractic benefits.
- **A Fee-For-Service Plan provided directly by the Trust Fund.** If you are enrolled in this option, you and your eligible Dependents will be covered under the Fee-For-Service Plan for hospital and medical services and supplies. It is recommended that you go to a Preferred Provider Organization (PPO) facility which will reduce your out-of-pocket expenses, as explained in this Booklet on page 35.

DENTAL BENEFITS

Two dental plan options are currently available to you and your eligible Dependents:

- **A prepaid dental plan is currently provided through United Concordia.** If you are enrolled in this option, you and your eligible Dependents will be covered under the United Concordia Dental Plan for dental services and supplies.
- **A Fee-For-Service Plan provided directly by the Trust Fund.** If you are enrolled in this option, you and your eligible Dependents will be covered under the Fee-For-Service Plan for dental services. You may use any licensed dentist in the United States.

When to Make Your Health Plan Selection

You are given the opportunity to make your plan selections when you first become eligible for benefits. Eligible retirees are given the opportunity to make plan selections when they first become eligible for pension benefits from the Retirement Trust Fund. Once enrolled in the plans you have selected, you may change your selections during the Plan's annual Open Enrollment Period, which will be held during the month of March each year. The changes you make will be effective May 1st. You may also change your selection if you are enrolled in one of the HMOs and/or a prepaid dental plan and you move away from their service areas.

If you fail to select a health or dental plan when you first become eligible for benefits, you and your family will be placed in the Fee-For-Service Medical Plan, and the United Concordia Dental Plan. During subsequent Open Enrollment Periods, if you do not select a different health or dental plan, you will remain in the plans you were covered under at the time of the last open enrollment.

Summary of Options

If you select medical coverage under one of the HMOs, you do not have to select dental coverage under the prepaid dental plan, and vice versa. Your medical and dental choices are completely independent of each other. For example, you may select one of the following combinations of coverages with the current providers:

PacifiCare and United Concordia Dental Plan	PacifiCare and Fee-For-Service Dental Plan
Kaiser and United Concordia Dental Plan	Kaiser and Fee-For-Service Dental Plan
Fee-For-Service Medical Plan and United Concordia Dental Plan	Fee-For-Service Medical Plan and Fee-For-Service Dental Plan

A complete description of the medical and dental benefits provided directly by the Plan is contained in this Booklet. Brochures are available from the Trust Fund Office that will provide you with a description of the benefits offered by PacifiCare, Kaiser and United Concordia. Complete listings of the HMOs’ and United Concordia’s providers are also available.

Once you have become eligible under the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund in accordance with the rules outlined in the eligibility section of this Booklet, you and your eligible Dependents will be eligible for benefits under this Plan.

IV. SUMMARY OF BENEFITS

Below is a brief summary of the benefits available to active and retired eligible Participants and their eligible Dependents. For a complete description of the eligibility requirements and benefits, please refer to the following pages of this Booklet. If you are enrolled in PacifiCare, Kaiser and/or the United Concordia Dental Plan, please refer to the booklets issued by those providers.

MEDICAL BENEFITS

For those enrolled in the Fee-For-Service Medical Plan

Lifetime maximum	\$500,000
Deductible	\$150 per person; maximum of three deductibles per family. <i>All benefits are subject to the deductible, except routine physical exams.</i>
Yearly out-of-pocket maximum of Allowable Charges per person	\$2,000 (including yearly maximum of allowable deductibles). <i>Only PPO provider charges apply. Non-PPO provider charges do not count toward the out-of-pocket maximum.</i>

Inpatient Hospital

PPO contracting hospital	90% of Allowable Charges;
Non-PPO hospital	60% of Allowable Charges.

Outpatient Hospital

For treatment received within 24 hours of an accident (at either a PPO or a non-PPO facility)	100% of Allowable Charges;
For all other medical services received as an outpatient at a PPO contracting hospital	90% of Allowable Charges;
For all other medical services received as an outpatient at a non-PPO hospital	60% of Allowable Charges.

Convalescent Hospital (Skilled Nursing Facility)

Maximum payment of \$65 per day for room and board; other services are paid at 60% of Allowable Charges; limited to a maximum of 365 days per lifetime.

Physician Services

PPO Provider	90% of Allowable Charges;
Non-PPO Provider	60% of Allowable Charges.

All Other Medical Services

(unless otherwise stated)

PPO Provider	90% of Allowable Charges;
Non-PPO Provider	60% of Allowable Charges.

Mental Health Services

Inpatient	30 days lifetime maximum confinement;
PPO Provider	90% of Allowable Charges;
Non-PPO Provider	60% of Allowable Charges;
Outpatient	26 visit maximum every calendar year.

Alcohol and Drug Abuse Benefits

Inpatient	20 day maximum per calendar year; lifetime maximum payment of \$10,000 per person;
PPO Provider	90% of Allowable Charges;
Non-PPO Provider	60% of Allowable Charges;
Outpatient	Lifetime maximum payment of \$2,000 per person;
Physician	\$50 maximum per visit; 26 visit maximum every calendar year.
Acupuncture	\$20 maximum payment per visit; 26 visit maximum every cal. year.
Chiropractic	\$30 maximum payment per visit; 26 visit maximum every cal. year.

Conversion Factors

The conversion factors for calculating the Maximum Covered Charge, as defined in the Definitions Section of this Booklet (page 23), are as follows:

Anesthesia	\$51.00
Surgery	\$44.00
Laboratory	\$33.00
X-Ray	\$33.00
Office Visits	\$26.00
All other Medical Services	\$38.00

Physical Therapy	26 visit maximum every calendar year;
PPO Provider	90% of Allowable Charges;
Non-PPO Provider	\$75 maximum payment per visit.

MRI and CAT Scans

PPO Providers—	
Facility referred by PHM Diagnostics, MEDFOCUS, or MDIA	90% of Allowable Charges;
Facility not referred by PHM Diagnostics, MEDFOCUS, or MDIA	90% of Allowable Charges, up to a maximum payment of \$800 for MRIs, and \$450 for CAT Scans.
Non-PPO Providers	60% of Allowable Charges, up to a maximum payment of \$800 for MRIs and \$450 for CAT Scans.

PRESCRIPTION DRUG BENEFIT

(For those enrolled in the Fee-For-Service Medical Plan)

Mail Order Prescription Drugs—Provided by Express Scripts (90-day supply)

Copayment	<ul style="list-style-type: none">• \$10 for generic drugs• \$30 for formulary (preferred) brand name drugs *• \$60 for non-formulary brand name drugs *
Plan pays	100% after Participant pays copayment.

Walk-in Prescription Drugs—Provided by Express Scripts through PERxCare Pharmacies (30-day supply)

Copayment	<ul style="list-style-type: none">• 10% of cost for generic drugs (\$5 minimum)• 20% of cost for formulary brand name drugs (\$10 min; \$50 max) *• 40% of cost for non-formulary brand name drugs (\$25 minimum) *
Plan pays	100% after Participant pays copayment.

Walk-in Prescription Drugs—Provided by Non-Contracting Pharmacies

(Also applies to contracting pharmacies when you do not have your prescription drug card.)

Copayment	<ul style="list-style-type: none">• \$10 for generic drugs• \$30 for formulary (preferred) brand name drugs *• \$60 for non-formulary brand name drugs *
Plan pays	Member pays in full, then submits claim form to Express Scripts for reimbursement. Plan pays up to the amount of PERxCare Pharmacy's normal cost after Participant pays copayment.

* *If you purchase a brand name drug, and there is a generic equivalent available, even if your physician prescribes "Dispense as Written", you will have to pay the brand name copayment, plus the difference in cost between the brand name and generic drug.*

VISION THERAPY BENEFIT

(For those enrolled in the Fee-For-Service Medical Plan)

Benefit	90% of Allowable Charges if a PPO provider; 60% of Allowable Charges if a non-PPO provider; lifetime maximum payment of \$500 per person.
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HEARING AID BENEFIT

(For all Eligible Participants and Dependents)

Benefit	A maximum payment of \$500 per hearing aid, per ear, during any three-year period.
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ROUTINE PHYSICAL EXAMINATION BENEFIT

(For those enrolled in the Fee-For-Service Medical Plan)

Benefit	\$300 per individual, per calendar year maximum payment for all Participants and their eligible spouses. (No deductible applies.)
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WELLNESS PROGRAM BENEFIT

(For those enrolled in the Fee-For-Service Medical Plan)

Immunizations and flu shots	100% of Allowable Charges up to \$25 per immunization or flu shot; office visit not covered.
Screening mammograms	100% of Allowable Charges up to a maximum payment of \$110 per visit, including the examination and test; limited to once for women age 35-39, and once a year for women age 40 and over.
Prostate screening	100% of Allowable Charges up to a maximum payment of \$110 per visit, including the examination and test; limited to one rectal exam and PSA blood screening per calendar year for men age 50 and over.

DENTAL BENEFIT

(For those enrolled in the Fee-For-Service Dental Plan)

Benefit	100% of schedule; \$1,750 calendar year maximum per person.
Orthodontia	100% of Allowable Charges; \$2,400 lifetime maximum payment per person (subject to the \$1,750 yearly maximum stated above).

VISION BENEFIT

(For all Eligible Participants and Dependents)

Benefits provided by Vision Service Plan (VSP)

Active Participants	\$20 deductible per person; one exam, one set of lenses and frames per 12-month period.
Dependents of Active Participants	\$20 deductible per person; one exam and one set of lenses per 12-month period, and frames every 24-month period.
Retired Participants and Dependents	\$30 deductible per person; one exam and one set of lenses per 12-month period, and frames every 24-month period.

DEATH BENEFIT

(For all Eligible Participants and Dependents)

Death Benefits for an Active Participant (excluding COBRA Participants)

Resulting from natural causes	\$35,000
Resulting from accidental causes	\$45,000

Death Benefits for a Dependent of an Active Participant (excluding COBRA Participants)

Spouse	\$ 1,000
Child—birth to age 19 years	\$ 1,000

Dismemberment Benefits for Active Participants (excluding COBRA Participants)

Loss of 1 hand, foot or eye	\$ 5,000
Loss of 2 hands, feet or eyes, or combination thereof	\$10,000

Death Benefits for a Retired Participant

Resulting from natural or accidental causes \$10,000

Dismemberment Benefits for Retired Participants

Loss of 1 hand, foot or eye \$ 5,000

Loss of 2 hands, feet or eyes,
or combination thereof \$10,000

ACCIDENT AND SICKNESS WEEKLY BENEFIT

(For Active Participants only, excluding COBRA Participants)

The maximum period of payment during any disability is 26 weeks.

Non-Occupational \$150 per week; accident benefits commence the 1st day and sickness benefits commence the 8th day of disability.

Occupational \$150 per week; benefits begin the 1st day of disability.

HOSPICE BENEFIT

(For those enrolled in the Fee-For-Service Medical Plan)

PPO contracting provider 90% of Allowable Charges;

Non-PPO provider 60% of Allowable Charges;

Lifetime Maximum \$10,000

HMO PARTICIPANTS

(For those enrolled in an HMO Medical Plan)

If you are enrolled in either the Kaiser or PacifiCare HMO Medical Plan, please refer to the Summary of Benefits provided by the HMO for the benefits that apply to you.

V. COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health coverage (called “COBRA continuation coverage”) at group rates in certain instances (called “qualifying events”) where coverage under the Plan would otherwise end.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage.

You and/or your eligible Dependents will be required to pay for COBRA continuation coverage on at least a monthly basis. However, you may pay for more than one month at a time. The monthly premiums must be paid directly to the Trust Fund Office. The Trust Fund Office will send additional information concerning premium amounts and payment deadlines.

Rights of Active Participants

If you are an active Participant covered by the Plan, you may have the right to choose continuation coverage if you lose (or lost) coverage because of a reduction in hours or termination of employment (for reasons other than your gross misconduct). However, if you are working or have worked in Non-Covered Air Conditioning and Refrigeration Service in violation of the rules of the Plan (see page 24), you and your Dependents will not be eligible for COBRA coverage. If your employment terminates due to your retirement, please see page 6 to find out if you qualify for retiree coverage.

Rights of a Dependent Spouse

If you are the spouse of an active or retired Participant covered by the Plan, you may have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following reasons:

1. The death of your spouse;
2. The voluntary resignation or the termination of your spouse’s employment (other than for gross misconduct), or a reduction in hours resulting in loss of eligibility in accordance with the eligibility rules of the Plan;;
3. Divorce or legal separation from your spouse;
4. Your spouse’s retirement; or
5. Your spouse qualifies for Medicare.

Rights of Dependent Children

In the case of a Dependent child of an active or retired Participant covered by the Plan, he or she may have the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

1. The death of the Participant or retiree parent;
2. The voluntary resignation or the termination of the Participant parent’s employment (other than for gross misconduct), or a reduction in hours resulting in loss of eligibility in accordance with the eligibility rules of the Plan;
3. The child ceases to qualify as an eligible Dependent as defined by the Plan;
4. The retirement of the Participant parent; or
5. The parent covered by the Plan qualifies for Medicare.

For purposes of this rule, a "Dependent" means any person who was an eligible Dependent immediately before the Participant had a COBRA qualifying event, or a child who would have qualified as an eligible Dependent but was born or adopted while the Participant was covered through COBRA (provided proper documentation is submitted and the applicable self-payment is made within 31 days from the date dependent status was met).

Notice Obligations

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

For the other qualifying events (divorce, legal separation of the participant and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Trust Fund Office in writing. The Plan requires you to notify the Trust Fund Office within 60 days after the qualifying event occurs.

When the Trust Fund Office is notified that a qualifying event has occurred, the Trust Fund Office will notify you that you have the right to choose continuation coverage, and send a COBRA Continuation Coverage Election Form. Under the law, you have at least 60 days from the date you would lose coverage because of a qualifying event to inform the Trust Fund Office by completing and submitting the Election Form that you want continuation coverage. If you do not choose continuation coverage, your group health coverage may end.

Please write to:

Trust Fund Office
Attn: Eligibility Department
Airconditioning and Refrigeration Industry Health and Welfare Trust Fund
1380 S. Sanderson Avenue, Anaheim, CA 92806
(714) 917-6100

Payment Obligations

Payment for the required premium must be made on the following basis:

1. All payments must be made by check, cashier's check, or money order.
2. The initial COBRA payment should be received by the Trust Fund Office no later than the 20th day of the month prior to the month for which you desire coverage in order to avoid possible delays in claim payments and eligibility problems. However, this initial payment will be accepted up to 45 days from the Participant's election date. The initial payment must cover the number of months from the date coverage would otherwise have terminated, including the month in which the initial payment is made.
3. After the initial COBRA payment is made, payments must be made each month to continue coverage. Monthly payments should be mailed by the 20th day of the month preceding each coverage month to avoid possible delays in claim payments and eligibility problems. Failure to make a monthly payment within 30 days of the beginning of the coverage month will result in automatic termination of coverage as of the end of the period for which payment has been made with no further notice from the Trust Fund Office.

The Trust Fund Office will not send monthly bills or warning notices. It is the responsibility of the qualified Participant to submit payments when due. Once terminated, COBRA coverage cannot be reinstated.

Limitations and Termination of COBRA Continuation Coverage

If you choose continuation coverage, the Plan is required to offer you group health coverage which, at the time coverage is being provided, is identical to the group health coverage provided under the Plan to similarly situated employees or family members, except you will not be provided continuation coverage for life insurance, accidental death and dismemberment (AD&D), or disability benefits. You may select either medical coverage only, or medical, dental, and vision coverage. You cannot select dental and vision coverage only. If you select medical coverage only, you cannot later add dental and vision coverage.

The law requires that you be afforded the opportunity to maintain continuation coverage for thirty-six (36) months unless you lost coverage due to a termination of employment or a reduction in work hours resulting in a loss of eligibility in accordance with the eligibility rules of this Plan. If you lose coverage due to termination of employment or reduction in work hours, the required continuation coverage period for you and your eligible Dependents is eighteen (18) months unless:

1. You (or one of your Dependents) are totally disabled at the time you lose coverage or within 60 days of losing coverage, and at the end of the first eighteen (18) months you (or your disabled Dependent) qualify for Social Security disability benefits. In this instance the required continuation coverage period is twenty-nine (29) months if you report your Social Security disability determination to the Trust Fund Office before the initial eighteen (18) months of continuation coverage expires and within sixty (60) days after the date of the Social Security determination; or
2. The Participant was entitled to Medicare at the time of loss of coverage. In this instance, the required continuation coverage period for the Participant's Dependents is the longer of eighteen (18) months from the date coverage was lost or thirty-six (36) months from the date the Participant became entitled to Medicare. For the Participant, the required continuation coverage period remains eighteen (18) months in this instance.

If a second qualifying event occurs during the COBRA continuation coverage period, the coverage may be extended for up to thirty-six (36) months from the first qualifying event. This extension is available to the spouse and dependent children if the participant dies, enrolls in Medicare, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan is notified of the second qualifying event within sixty (60) days of the second qualifying event.

Your continuation coverage will terminate earlier than described above in the event any of the following events occur prior to the expiration of the COBRA continuation coverage period:

1. The Plan no longer provides group health coverage;
2. The premium for your continuation coverage is not paid on time;
3. After your COBRA election, you become covered under another group health plan (unless you have a pre-existing health condition for which the new plan excludes or limits coverage);
4. After your COBRA election, you become entitled to Medicare;
5. With respect to a disabled person under the 11-month extension (total of 29 months), Social Security determines that you are no longer disabled. If this occurs, COBRA coverage will terminate for the individual and any eligible Dependents the first day of the month following the month in which the determination was made; or
6. The COBRA Participant (former Participant or Dependent) performs work in Non-Covered Air Conditioning and Refrigeration Service.

If you have any questions regarding COBRA continuation coverage, please contact the Trust Fund Office.

For More Information

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Under the Plan, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes or Changes in Family or Individual Status

In order to protect your family's rights, you should keep the Trust Fund Office informed of any changes in the addresses of family members.

In addition, if there are any changes to your marital status, or the dependent status of any of your children under the Plan, please notify the Trust Fund Office immediately.

You should keep a copy, for your records, of any notices you send to the Trust Fund Office.

California COBRA

If you are an HMO participant under the Plan living in California, you may be eligible for additional COBRA-like coverage under California state law. Check your HMO plan's benefits booklet or contact your HMO for more information on your rights and how you may be eligible to elect post-COBRA extended coverage under California law. This coverage is not provided by the Trust Fund.

CERTIFICATE OF FORMER GROUP HEALTH PLAN COVERAGE

The certificate of former group health plan coverage provides evidence of your health coverage under the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund. If you become covered under a new group health plan that excludes coverage for certain pre-existing medical conditions, you may need to furnish the certificate to the new plan administrator. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

If you or your Dependent(s) lose coverage under the Plan, you will be furnished with a certificate of former plan coverage. You may need the certificate if your new plan excludes coverage for pre-existing conditions. If you are eligible for COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage stops. You may also request a certificate within 24 months after losing coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Reconstructive breast surgery expenses incurred by a covered person as the result of a mastectomy on one or both breasts, and in a manner determined in consultation between the attending physician and the patient, are covered as shown below. Any exclusion of benefits for cosmetic surgery does not apply to this benefit. This coverage is subject to the Plan's annual deductibles and co-insurance provisions.

1. Reconstruction of the breast on which the mastectomy has been performed.
2. Surgery on and reconstruction of the non-diseased breast to produce symmetry between the breasts.
3. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

VI. DEFINITIONS

The definitions listed below define some of the terms used in this Booklet and are given to help you better understand the benefit program:

ALLOWABLE CHARGES: For PPO providers, Allowable Charges means the service provider's contract rate. For non-PPO Providers, Allowable Charges means the Maximum Covered Charge as established and amended in the sole and absolute discretion of the Board of Trustees.

CLAIM: Claim means a request for a Plan benefit made by a claimant (or the claimant's authorized representative) in accordance with the Plan's claims provisions described on page 58 and claims and appeals procedures described on page 70. To be considered a Claim, the following elements must exist:

1. Written or electronically submitted communication to the Trust Fund Office (oral communication is acceptable for urgent care claims);
2. The communication must name a specific claimant;
3. The communication must name a specific medical condition or symptom; and
4. The communication must name a specific treatment, service or product for which approval or payment is requested.

CONVALESCENT HOSPITAL: Any institution that meets all of these requirements:

1. Provides skilled nursing care under 24-hour supervision of a Physician or graduate Registered Nurse;
2. Has available at all times the services of a Physician who is a staff member of a general hospital;
3. Provides 24-hour-a-day nursing service by a graduate Registered Nurse, Licensed Vocational Nurse or Skilled Practical Nurse and has a graduate Registered Nurse on duty at least 8 hours per day; and
4. Is not a place for rest, for custodial care, for the aged, for alcohol or drug rehabilitation; nor is it a hotel or any institution similar to those listed.

DENTIST: A Dentist licensed to practice dentistry in the State in which the treatment is rendered, as long as the treatment is within the scope of his or her license. Dentist will not include the active Participant or his Dependents, or any person who is the spouse, parent, child, brother or sister of such active Participant or his Dependents.

DEPENDENT: See page 1.

EMERGENCY: A "Qualified Emergency" is defined by the Plan as a sudden occurrence of a medical condition which, if not treated immediately, may result in permanent health problems, serious medical complications, serious impairment of bodily functions or serious or permanent dysfunction of a bodily organ or part. Examples of medical conditions that would constitute a "Qualified Emergency" are:

- Severe chest pain
- Uncontrolled bleeding
- Loss of consciousness
- Severe shortness of breath
- Sudden onset of paralysis and/or slurred speech
- Severe burns
- Broken bones
- Poisoning

A “Non-Qualified Emergency” is defined as any medical condition that does not, in the Trustees’ sole and absolute discretion determined in accordance with procedures specified in the Trust Agreement, constitute a “Qualified Emergency” as defined above.

HOSPICE: Hospice Care is a program designed to provide palliative care for terminally ill patients who have a prognosis of less than six months to live.

HOSPITAL: Any institution which meets all of these requirements:

- Maintains permanent and full time facilities for bed care of five or more resident patients;
- Has a Physician in regular attendance;
- Continuously provides 24-hour-a-day nursing service by Registered Nurses;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, place for the aged, or a place for alcohol or drug rehabilitation;
- Is operating lawfully in the jurisdiction where it is located.

MAXIMUM COVERED CHARGE: The Maximum Covered Charge is computed by multiplying the Relative Value Unit (RVU) by the conversion factors given in the Summary of Benefits on page 14. The RVU is derived by utilizing a method that ranks a medical and/or surgical procedure as a function of difficulty.

MEDICARE PLAN: The basic hospital portion and voluntary supplemental medical portion of U.S. Public Law 89-97, including any future amendments.

NON-COVERED AIR CONDITIONING AND REFRIGERATION SERVICE: Non-Covered Air Conditioning and Refrigeration Service means air conditioning and refrigeration work in the geographical jurisdiction of this Plan for an employer which does not have, or self-employment which is not covered by, a Collective Bargaining Agreement with a plumbing and pipefitting industry union requiring contributions to this Plan or a related Plan. It includes all work or services of the kind performed by any contributing employer to the Plan which relates in any way to any work of the kind performed by Participants in the Plan. It includes such jobs as management, ownership, sales, estimating or consulting positions for air conditioning and refrigeration employers or in the air conditioning and refrigeration industry, as well as work of the type done by bargaining unit members and related work.

OPEN ENROLLMENT PERIOD: Every year, you are given the opportunity to change your Health Plan selections during the Open Enrollment Period, which will be held during the month of March. The changes you make will be effective May 1st. See page 11 for more information.

PARTICIPANT: See page 1.

PARTICIPATING EMPLOYER: An employer required by a Collective Bargaining Agreement or Participation Agreement with the Airconditioning and Refrigeration Fitters Division, Local 250, United Association, or applicable law to make contributions to the Plan. “Participating Employer” also means an employer that has agreed to contribute to the Plan on the same basis as any Participating Employer and that has been approved by the Board of Trustees to participate in the Plan.

PHYSICIAN: A licensed doctor of medicine or doctor of osteopathy. To the extent that benefits are provided, physician will include a person licensed to practice as an acupuncturist, chiropractor, dentist, optometrist, podiatrist, psychiatrist or psychologist certified to practice in the State of California or in any state or other jurisdiction which has a board of examiners for the certification of psychologists. This term will also include other professionals acceptable to the Trustees. Physician will not include the active Participant or his Dependents, or any person who is the spouse, parent, child, brother or sister of such active Participant or his Dependents.

PLAN: This benefit program as adopted and thereafter amended by the Board of Trustees.

PREFERRED PROVIDER ORGANIZATION (PPO): See page 35.

PROVIDER: Provider includes the following professionals acting within the scope of their license and who do not ordinarily reside in the active Participant's home and are not the active Participant or his Dependents, or the spouse, parent, child, brother or sister of such active Participant or his Dependents:

1. A Medical Doctor (M.D.)
2. A Doctor of Osteopathy (D.O.)
3. A Chiropractic Doctor (under limited conditions.)
4. A Doctor of Medical Dentistry (D.M.D.)
5. A Doctor of Dental Surgery (D.D.S.)
6. A Doctor of Podiatry (D.P.M.)
7. A Physical Therapist.
8. A Psychologist (Ph.D.)
9. A Master of Social Work (L.C.S.W., M.S.W., and M.F.C.C.)
10. An Ophthalmologist (M.D.) or an Optometrist (O.D.)
11. An Acupuncturist.
12. A certified Nurse-Midwife.
13. An Occupational Therapist (O.T.)
14. A Registered Nurse as First Assistant (R.N.F.A.)
15. A Physician Assistant (P.A.) (under limited conditions.)
16. A Nurse Practitioner.
17. A certified Nurse Anesthetist.
18. A Home Health Agency.

TOTAL DISABILITY OR TOTALLY DISABLED: A condition in which you, or your Dependent, are wholly and continuously prevented by bodily injuries or sickness from performing every duty pertaining to your, or your Dependent's, regular and customary occupation.

VII. FEE-FOR-SERVICE MEDICAL BENEFITS

For All Eligible Active and Retired Participants and Dependents Enrolled in the Fee-For-Service Medical Plan

The medical benefits provided for you and your family are explained in further detail on the following pages. The cost for all of the following services and supplies will be reimbursed based on the Allowable Charges. Please refer to the definition of "Allowable Charges" in the Definitions Section. Additionally, all services and supplies must be medically necessary for the care and treatment of injury or illness (unless otherwise stated) in order for benefits to be payable.

Once the deductible is satisfied in a calendar year, your Fee-For-Service Medical Benefit Plan pays the percentage specified in the Summary of Benefits until an individual has paid \$2,000 of out-of-pocket Allowable Charges for Preferred Provider Organization (PPO) charges only, including their deductible. Thereafter, the Plan pays 100% of Allowable Charges incurred by the individual during the remainder of the calendar year, up to the lifetime maximum benefit. Please be aware that non-PPO charges do not apply towards the out-of-pocket maximum.

Lifetime Maximum Benefit

The lifetime maximum benefit is \$500,000 per person. This means that no more than \$500,000 will be paid in Comprehensive Medical Benefits for a covered Participant or eligible Dependent.

However, if benefits have been paid during a calendar year, up to \$20,000 of the amount paid will be automatically reinstated each January 1.

Deductible

A \$150 deductible applies separately to all family members until at least three members of the family incur \$150 in covered expenses during each calendar year. Therefore, at least three people in the family must meet the deductible prior to the waiver of any remaining individual deductibles. Covered expenses incurred in the last three months of a calendar year, which are applied towards the deductible, may also be credited toward the deductible for the next calendar year. This deductible applies to HMO Participants for the chiropractic and hearing aid benefits.

Covered Services and Supplies

Hospital Services

The hospital benefits described below do not apply to psychiatric care or treatment of alcoholism, drug addiction or drug abuse. Separate benefits are provided for these conditions.

You will pay a lower percentage of the bill if you are admitted to a PPO hospital than if you are admitted to a non-PPO hospital. Refer to page 35 for more information on PPOs.

Room and Board

When you or any of your eligible Dependents are admitted to a hospital, you will be reimbursed for the hospital's charges for care in a room of two or more beds (or an allowance of the most prevalent semi-private room rate toward other accommodations) at 90% of Allowable Charges if you use a PPO hospital, and 60% of Allowable Charges if you use a non-PPO hospital.

If you or any of your eligible Dependents are admitted to an intensive care or coronary care unit of a hospital, the Plan will pay the Allowable Charges in accordance with the previous paragraph. Please remember that if you use a PPO hospital, your out-of-pocket expenses will be less than if you do not use a PPO hospital.

Convalescent hospital room and board charges are paid up to \$65 per day for room and board. Other services are paid at 60% of Allowable Charges. Coverage is limited to a maximum of 365 days per lifetime.

Miscellaneous Inpatient Hospital Services and Supplies

Inpatient hospital charges for medically necessary services and supplies (other than room and board) will be payable at 90% of Allowable Charges if you use a PPO hospital, and 60% of Allowable Charges if you use a non-PPO hospital.

REMEMBER: Not all providers treating patients in a PPO hospital are PPO providers. Some services and supplies may be provided by non-hospital employees or organizations which are not signed up with the PPO. Benefits will be paid at the non-PPO level for services and supplies provided by non-PPO providers, even if the services are rendered in a PPO hospital, unless specifically authorized by the Board of Trustees. It is your responsibility to ask for PPO providers, or you (and the Plan) may end up paying more.

Emergency Care

If a "Qualified Emergency" (as defined on page 23) is in effect, the Plan will pay benefits for covered charges in excess of any applicable deductible at 90% of Allowable Charges for PPO providers, and 90% of Allowable Charges for non-PPO providers. If it is a "Qualified Emergency," your share of the charges will count toward the out-of-pocket maximum, except that any amounts billed by a non-PPO provider in excess of the Allowable Charge will not count. After the out-of-pocket maximum has been reached, the Plan will pay 100% of the applicable Allowable Charge for covered charges by PPO providers or 100% of the Allowable Charges for covered charges by non-PPO providers.

If a "Non-Qualified Emergency" (as defined on page 24) is in effect (a covered person seeks treatment on an emergency basis for a "Non-Qualified Emergency"), the Plan will pay benefits for covered charges in excess of any applicable deductible at 90% of Allowable Charges for PPO providers, and 60% of Allowable Charges for non-PPO providers, and your share of the non-PPO charges will *not* count toward the out-of-pocket maximum.

Outpatient Hospital Care

Charges for medically necessary services and supplies will be payable at 90% of Allowable Charges if you use a PPO provider, and 60% of Allowable Charges if you use a non-PPO provider.

If you or your eligible Dependent are not admitted to the hospital, but incur hospital charges in the outpatient department of a hospital or surgical center, the Plan will cover Allowable Charges for the following covered medical services and supplies:

1. Treatment of bodily injuries sustained in an accident within 24 hours of the accident will be payable at 100% of Allowable Charges *subject to the deductible*;
2. Emergency medical care that normally cannot be performed in a doctor's office or laboratory (a medical emergency is the sudden onset of a condition requiring immediate treatment such as a heart attack, poisoning, loss of consciousness or convulsions); and
3. Services and supplies in connection with a surgical operation.

Except as otherwise stated, charges for medically necessary services and supplies will be payable at 90% of Allowable Charges if you use a PPO provider, and 60% of Allowable Charges if you use a non-PPO provider.

Surgical Services

Charges for medically necessary services and supplies will be payable at 90% of Allowable Charges if you use a PPO provider, and 60% of Allowable Charges if you use a non-PPO provider.

If you or your eligible Dependent incur expenses for a surgical procedure performed by a physician, you will be reimbursed up to the maximum Allowable Charge for that particular procedure.

Anesthesia Benefits

The fees of an anesthesiologist are covered at 90% of Allowable Charges if the surgeon and hospital are both PPO providers, or 60% of Allowable Charges if either the surgeon or the hospital is not a PPO provider.

Ancillary Providers

The Plan will also reimburse you for the Allowable Charges of an Assistant Surgeon, a Registered Nurse as First Assistant, and a Physician Assistant, *if medically necessary*. The maximum Allowable Charge for an Assistant Surgeon is 20% of the Allowable Charge for the primary Surgeon. The maximum Allowable Charge for a Registered Nurse as First Assistant is 10% of the Allowable Charge for the primary Surgeon. The services of a Physician Assistant (P.A.) will be covered, as determined by the Plan to be medically necessary, up to 65% of what would normally be paid to an Assistant Surgeon.

Hospice Benefits

Hospice Care is a program designed to provide palliative care for terminally ill patients who have a prognosis of less than six months to live. Services may be received in a Hospice Care Facility, in the home, or in a designated part of a Hospital, but will be limited to the average Hospital daily charges in the area where treatment is received and will not be payable for more than six consecutive months.

Charges for medically necessary services and supplies will be payable at 90% of Allowable Charges if you use a PPO provider, and 60% of Allowable Charges if you use a non-PPO provider, up to a lifetime maximum of \$10,000.

Mental Health Benefits

Charges for medically necessary services and supplies will be payable at 90% of Allowable Charges if you use a PPO provider, and 60% of Allowable Charges if you use a non-PPO provider.

If you or your eligible Dependent incur hospital expense resulting from the care and treatment of mental and nervous conditions while confined as a patient, Allowable Charges will be payable and limited to a 30 day lifetime maximum.

Physician charges for psychometric testing, psychotherapy or psychiatric sessions, performed on an inpatient basis, will be payable in accordance with the previous paragraph.

Outpatient benefits will be limited to a maximum of 26 sessions per calendar year.

Alcohol and Drug Abuse Benefits

Charges for medically necessary services and supplies will be payable at 90% of Allowable Charges if you use a PPO provider, and 60% of Allowable Charges if you use a non-PPO provider.

If you or your eligible Dependent incur hospital expenses resulting from the care and treatment of alcoholism or drug abuse while admitted to an acute care facility or Chemical Dependency Recovery Hospital (CDRH), benefits will be payable and limited to a 20 day maximum per calendar year and a lifetime maximum payment of \$10,000.

Covered medical expenses will not include charges for outpatient care received in a social rehabilitation unit.

Physician charges for treatment of drug and alcohol abuse on an inpatient or outpatient basis will be limited to a maximum payment of \$50 per visit, and 26 visits per calendar year.

Outpatient hospital charges and physician charges for the treatment of alcohol and drug abuse are subject to a combined \$2,000 lifetime maximum payment per person, including your deductible.

Acupuncture Benefit

If you or your eligible Dependent receive acupuncture treatment performed in or outside a hospital, the Plan will pay the Allowable Charges for such treatment up to a maximum payment of \$20 per visit and 26 visits per calendar year.

Chiropractic Benefit (for Fee-For-Service and HMO Enrollees)

If you or any of your eligible Dependents receive chiropractic treatment performed in or outside a hospital by a Chiropractor, the Plan will pay the Allowable Charges for such treatment up to a maximum payment of \$30 per visit and 26 visits per calendar year. The Plan deductibles apply to the chiropractic benefit for both Fee-For-Service and HMO Participants.

Hearing Aid Benefit (for Fee-For-Service and HMO Enrollees)

If you or any of your eligible Dependents incur expenses for a hearing aid upon authorization by a physician, benefits will be payable at 100% for such expense up to a maximum payment of \$500 per hearing aid, per ear, during any three-year period. The Plan deductibles (see page 26) apply to the hearing aid benefit for both Fee-For-Service and HMO Participants.

Excluded Expenses

The Hearing Aid benefit does not include expenses incurred for:

1. Cleaning, repair, or maintenance of a hearing aid.
2. Batteries.
3. Replacement of lost, stolen or broken hearing aids for which payment is made under this benefit.
4. More than one hearing aid per ear during any three-year period. Such period shall be determined from the date on which the covered person last incurred expense for which a claim was made under this benefit.

Physical Therapy

If you or your eligible Dependent receive physical therapy treatment in a PPO outpatient facility, the Plan will pay 90% of Allowable Charges up to a maximum of 26 visits per calendar year.

If you or your eligible Dependent receive physical therapy treatment outside of a hospital by a non-PPO provider, the Plan will pay the Allowable Charges for such treatment up to a maximum amount of \$75 per visit and a maximum of 26 visits per calendar year.

Physical therapy is only covered with a physician referral.

Speech Therapy

If you or your eligible Dependent receive speech therapy treatment in a PPO outpatient facility, the Plan will pay 90% of Allowable Charges up to a maximum of 26 visits per calendar year. For a non-PPO facility, the Plan will pay 60% of Allowable Charges up to a maximum of 26 visits per calendar year.

Pain Management

For pain management services, the Plan will pay 90% of Allowable Charges for PPO facilities, and 60% of Allowable Charges for non-PPO facilities, up to the following maximums:

Hospital maximum benefit:	\$900
Surgery center maximum benefit:	\$800
Physician's office maximum benefit:	\$700
Lifetime maximum:	\$10,000

Sleep Apnea

For the diagnosis of sleep apnea, the Plan will pay 90% of Allowable Charges for PPO facilities, and 60% of Allowable Charges for non-PPO facilities, up to the following maximums:

Facility maximum benefit:	\$1,000
Physician maximum benefit:	\$1,000
Lifetime maximum:	\$2,000

MRI and CAT Scans

If you or your eligible Dependent use a facility referred to you by PHM Diagnostics, MEDFOCUS or MDIA, the Plan will pay 90% of Allowable Charges.

If you or your eligible Dependent use a facility that is *not* referred to you by PHM Diagnostics, MEDFOCUS or MDIA, *but it is a PPO provider*, the Plan will pay 90% of Allowable Charges, up to a maximum payment of \$800 for MRIs and \$450 for CAT Scans.

If you or your eligible Dependent use a facility that is *not* referred to you by PHM Diagnostics, MEDFOCUS or MDIA, *and it is not a PPO provider*, the Plan will pay 60% of Allowable Charges, up to a maximum payment of \$800 for MRIs and \$450 for CAT Scans.

Certified Nurse-Midwives

Allowable charges for the services of a certified Nurse-Midwife will be payable at 60%, up to a maximum payment of \$600 per delivery.

Birthing Centers

Allowable charges made by a birthing center are payable at 60%, up to a maximum of \$1,200 per delivery. A birthing center is a facility established to manage low risk, normal, uncomplicated pregnancy, with delivery within 24 hours of admission to the center. Birthing centers may be free-standing, hospital-based or hospital-associated. In all cases, the birthing center must be licensed and operated under the direction of an M.D. or D.O. specializing in obstetrics and gynecology. It must provide skilled nursing services under the direction of an R.N. or certified Nurse-Midwife in the delivery and recovery rooms and have a written agreement with an area hospital for immediate transfer in case of an emergency.

Maternity Benefits

Benefits are provided for pregnancy on the same basis as any other illness. Care for pregnancy of a Dependent child is not covered.

Under the Fee-For-Service Plan, the length of allowed hospital stay in connection with childbirth for newborn children and their mothers is at least 48 hours following a vaginal delivery, and at least 96 hours following a Cesarean section. However, federal law and this Plan generally do not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96) hours. In any case the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 (or 96) hours.

Organ Transplant Provision

Allowable Expenses incurred for a Covered Transplant Procedure during an eligible Participant's or Dependent's Transplant Benefit Period will be payable provided that:

- A. The expenses are incurred at a PPO facility. The physician may be a non-PPO provider;
- B. The recipient must obtain prior approval from the Trust Fund Office for certification of medical necessity and that the procedure is not considered experimental under the terms of the Plan; and
- C. The recipient does not suffer from a terminal illness and is reasonably expected to live at least one or more years beyond the transplant date; and
- D. Coverage for the organ transplant and related expenses is limited to claims incurred up to 12 months after the date of transplant, for procedures approved and certified by the Trust Fund Office as medically necessary.

I. DEFINITIONS:

Covered Transplant Procedure — shall mean any one of the following human to human organ or tissue transplants performed during a Transplant Benefit Period: (a) bone marrow; (b) heart; (c) heart/lung; (d) liver; (e) lung; (f) kidney-pancreas; (g) kidney; (h) certain organ parts including only cornea, skin, bone, and tendons. Also covered are transplants of certain artificial organ parts, including only: joint replacement for functional reasons, skin, heart valves, grafts and patches (vascular), pacemaker, metal plates and eye lens. No other transplants are covered.

Transplant Benefit Period — shall mean the period that begins on the later of (a) the date of the Participant's or Dependent's effective date of coverage under this Plan or (b) the date of the onset of the covered illness or injury requiring the transplant and ends 12 months after the date the Covered Transplant Procedure is performed.

Recipient — shall mean a Participant or Dependent covered by this Plan who meets the eligibility requirements.

Allowable Expenses — shall mean those expenses that are directly related to the Covered Transplant Procedure and the benefit amounts provided therefore, except the amounts payable by the Plan shall not, in any event, exceed the Usual, Customary and Reasonable charge determined by the Board of Trustees in its sole discretion.

II. ALLOWABLE EXPENSES UNDER THE ORGAN TRANSPLANT BENEFIT:

The Fund will reimburse the following Allowable Expenses incurred as the result of a covered Transplant Procedure during a Participant’s or Dependent’s Transplant Benefit Period:

- (a) Transportation of recipient and a companion to and from the site of the transplant. If recipient is a minor, transportation for two persons who travel with the minor will be covered. Reasonable and necessary lodging and meal costs incurred in the interim by such companions are included, except there is a daily limit of \$200 for all lodging and meal costs. Total payment for all transportation, lodging and meal costs for all persons for the Covered Transplant Procedure shall not exceed \$5,000.
- (b) Hospital room and board, and medical supplies.
- (c) Diagnosis, treatment and surgery by a Doctor.
- (d) Nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- (e) Rental of wheelchairs, hospital-type beds and other mechanical equipment required to treat respiratory impairment.
- (f) Local ambulance service, medication, x-rays and other diagnostic services, laboratory tests, oxygen.
- (g) Rehabilitation therapy, including speech therapy (not for voice training or a lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy.
- (h) Surgical dressings and supplies.
- (i) Plan benefits will be provided to an organ donor for Allowable Expenses incurred by that person, whether or not such person is an eligible Participant in the Plan, provided the expenses incurred are directly related to the transplant surgery and are not payable by any other medical plan in the absence of this Plan’s coverage. However, in all such cases, the organ recipient must be an eligible Participant or Dependent of this Plan.
- (j) The maximum benefit payable by the Plan for all costs related to a Covered Transplant Procedure, which are incurred during a Transplant Benefit Period, will not exceed the charges stated below:

(1) Bone Marrow	\$ 150,000	(5) Lung	\$ 150,000
(2) Heart	135,000	(6) Kidney-Pancreas	150,000
(3) Heart/Lung	225,000	(7) Kidney	75,000
(4) Liver	185,000	(8) Cornea	5,000

The preceding limits do NOT include prescription drug charges. See Prescription Drug Benefits for coverage. After the Transplant Benefit Period, any further transplant claims will be treated as any other claims by the Plan.

III. EXCLUSIONS UNDER THE ORGAN TRANSPLANT BENEFIT:

No benefits will be payable by the Plan for the following:

- (a) Animal and/or mechanical organs except as provided for above.

- (b) Any expense incurred for which the Participant would not legally have to pay if there was no coverage for benefits.
- (c) Custodial care.
- (d) If a Participant or Dependent establishes a Transplant Benefit Period and subsequently loses coverage under the Plan, all benefit payments cease for services incurred after the time coverage terminates.
- (e) Any organ or tissue transplant required as the result of an accidental injury or illness that is not covered by the Plan.
- (f) Any transplants which are considered to be experimental.

All Other Covered Expenses

Charges for any of the services or supplies listed below, when certified as necessary by the attending physician, will be payable at 90% of Allowable Charges if you use a PPO provider, and 60% of Allowable Charges if you use a non-PPO provider:

1. Services of an organization or agency which meets the requirements for participation as a Home Health Agency under Medicare for treatment which is certified as necessary by a doctor and administered within 90 days from the date of disability.
2. Initial artificial limbs or eyes (required to replace natural limbs or eyes lost while covered under this Plan), casts, splints, trusses, braces or crutches.
3. Rental of a wheel chair, hospital-type bed, or other durable medical equipment used exclusively for treatment of injury or sickness, not to exceed the reasonable purchase price.
4. Blood, blood plasma and blood processing fees.
5. Physician's fees for medical services (including home, office and hospital visits).
6. Diagnostic x-ray and laboratory services, including Pap smears.
7. Services of a Registered Nurse, as well as a certified Nurse-Midwife, provided the services rendered require the skill or training of a Registered Nurse.
8. Services of a registered Physiotherapist for short-term therapy. Services must be ordered by a physician under an individual treatment plan and must be certified by the physician as medically necessary for the improvement of the patient's condition through short-term care.
9. Use of x-ray, radium and other radioactive substances.
10. Oxygen and rental of equipment for administration of oxygen.
11. Professional ambulance service to the nearest hospital where treatment of the ailment can be given.
12. Services of a Podiatrist.
13. Injectable drugs, including insulin, when prescribed by physician. This treatment must be certified by the physician as medically necessary for the improvement or stabilization of the patient's condition. The allowance for injectable drugs is limited to the average wholesale price.
14. The Plan will pay 90% of the cost of a One-Touch Diabetic Tester, up to a maximum benefit of \$100. The patient must have a receipt with a description of the supply.
15. Contraceptives that must be administered in the physician's office, such as an I.U.D., will be covered as any other medical service.

PLAN EXCLUSIONS

Maternity Benefits are not a covered expense for Retired Participants.

Medical Expense Benefits will not be payable for:

1. Medical examinations, services or supplies, including the duplication of diagnostic testing, which are not necessary for the treatment of an injury or sickness, except as specifically provided.
2. Inpatient diagnostic testing, unless medically necessary.
3. Any operation or treatment in connection with the fitting or wearing of dentures or treatment of the teeth or gums except (a) where such operation or treatment is necessary as a result of tumors and (b) expenses for treatment of accidental injury to natural teeth (including their replacement), if the treatment is incurred within two years after an accident which occurred while covered under the Plan.
4. Charges in connection with the pregnancy of a Dependent child.
5. Routine nursery care provided to a newborn child during the mother's confinement in the hospital.
6. Temporomandibular joint syndrome and myofunctional therapy and procedures associated therewith.
7. Stand-by personnel in connection with Cesarean sections.
8. Expenses incurred in connection with prognathism, retrognathism or micrognathism.
9. Cosmetic surgery, except operations necessary to repair disfigurement due to an accident or medical condition which occurred while covered under this Plan. Only cosmetic surgery performed within two years of an accident which occurred while covered under the Plan will be considered a covered expense unless the surgery cannot be performed within two years due to medical complications.
10. Expenses in connection with the reversal of sterilizations.
11. Rest cures and custodial care.
12. Expenses incurred in connection with radial keratotomy, radial keratoplasty, or any other procedure performed only to improve visual acuity.
13. Eye refractions, eye glasses, the fitting of eye glasses or hearing aids.
14. Charges for any hospital care, medical, vision or dental services or supplies paid for under any other benefits provided under this Plan.
15. Premarital examinations.
16. Drugs dispensed by a physician in his office.
17. Expenses incurred in connection with weight reduction.
18. Charges related to treatment of infertility.
19. Charges for treatment of impotency or erectile dysfunction.

EXTENDED BENEFITS

Medical benefits will be extended if you or your eligible Dependent are totally disabled as of the date of the loss of eligibility and are incurring covered medical expenses. Benefits will be available only for covered medical expenses incurred for the continued treatment of the injury or illness causing Total Disability. This extension will cease on the earlier of the following dates:

1. The date of recovery from Total Disability;
2. Twelve months following the date eligibility terminated;
3. Upon termination of the Plan;
4. The date the Totally Disabled person becomes covered under any other group plan which does not limit coverage for the disability.

VIII. PREFERRED PROVIDER ORGANIZATION (PPO)

For all Eligible Active and Retired Participants and Dependents Enrolled in the Fee-For-Service Medical Plan

If you or any of your eligible Dependents obtain services from a hospital, physician, or other provider contracted with Affiliated Health Funds (AHF), ppoNEXT or Interplan Corporation, the percentage of covered expenses payable by the Plan will be higher, and your out-of-pocket expenses will be lower.

What are Affiliated Health Funds, ppoNEXT and Interplan?

Affiliated Health Funds (AHF), ppoNEXT and Interplan Corporation are Preferred Provider Organizations (PPOs) that contract with hospitals, physicians, and other providers in order to reduce the cost of medical care for this and other large trust funds. These organizations help save you and the Plan money.

How Does the Program Work?

The Trust Fund Office supplies you with an AHF directory of providers. For a physician or other providers in the ppoNEXT network, call 1-800-334-5646, or for Interplan, call 1-800-444-4036, and you will be referred to a physician in your area. You may also obtain a directory of ppoNEXT or Interplan providers by calling the Trust Fund Office.

Select one of the providers from either AHF, ppoNEXT or Interplan, and call for an appointment. Inform the provider that you are covered by the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund *and* either AHF, ppoNEXT or Interplan.

If you are referred to a specialist or hospital, be sure to remind your primary doctor that you want to use an AHF, ppoNEXT or Interplan physician or hospital.

You do not have to sign up with a particular physician or medical group and use them exclusively for your medical needs. You may use the services of a PPO physician and/or hospital whenever you choose to.

Why Use PPO Physicians and Hospitals?

1. The Plan will pay 90% of Allowable Charges if you use a PPO provider, but only 60% of Allowable Charges if you use a non-PPO provider. In addition, charges for non-PPO providers do not count toward the out-of-pocket maximum.
2. Hospital charges for maternity and routine nursery care will be covered at 90%. Routine nursery care is not covered without the use of a PPO provider.

3. In addition, PPO providers' Allowable Charges are generally less than non-PPO providers' charges. This means both you and the Plan will save money if you use a PPO provider. PPO providers cannot charge you more for a covered service than what is allowed under the PPO contracts. This means less out-of-pocket expense for you. If you use a hospital, physician, or other health care provider who is not under contract with AHF, ppoNEXT or Interplan, there is no guarantee that the provider's entire charge will be allowed by the Plan. For example, hospital daily room and services charges often exceed \$2,000 per day. Even if the entire charge is "allowable," the Plan only pays 60%, and you pay 40%, or over \$800 for the daily charge. AHF, ppoNEXT and Interplan, however, have contracts with hospitals at rates that are much less than non-PPO hospitals. Those charges are paid at 90%, and you pay only 10% of the lesser charge. This saves you much more money out-of-pocket than if you use a non-PPO facility.

REMEMBER: Not all providers treating patients in a PPO hospital are PPO providers. Some services and supplies may be provided by non-hospital employees or organizations that are not signed up with the PPO. Benefits will be paid at the non-PPO level for services and supplies provided by non-PPO providers (for example, services provided by a non-PPO specialist, or non-PPO laboratory services), even if the services are rendered in a PPO hospital, unless specifically authorized by the Board of Trustees. It is your responsibility to ask for PPO providers, or you (and the Plan) may end up paying more.

IX. RECOVERY INCENTIVE PROGRAM
For All Eligible Active and Retired Participants and Dependents
Enrolled in the Fee-For-Service Medical or Dental Plan

This program applies to bills received from hospitals, as well as other medical and dental providers.

This is a program to encourage you to carefully review and audit your medical and dental bills. The program is designed to provide a cash incentive to you when you discover and arrange for recovery of overcharges made on your medical or dental bills, which in turn result in benefit dollars saved for the Plan. The program rules are as follows:

1. As described below, a cash incentive will be paid to you when you help the Plan recover an amount that was initially overcharged on a provider bill for you or your Dependent. The cash incentive you will receive will be based on the actual amount of the overcharge that the provider agrees is invalid as a result of direct negotiations between you and the provider.
2. When an overcharge of \$25 or more is discovered and reversed, the Plan will pay 25% of the overcharge but not more than \$500 (25% of \$2,000). Any overcharges in excess of \$2,000 will be reviewed by the Board of Trustees who may authorize additional compensation. All overcharge reimbursements will be on a per family per calendar year basis (maximum reimbursement per family is \$500 per calendar year except by Board approval).
3. For purposes of the cash incentive, only hospital expenses which the Plan covers (not telephone bills, television rental, newspapers, etc.) shall be considered in determining the amount of a hospital overcharge.
4. Proof of eligibility for a cash incentive must be submitted to the Trust Fund Office in the form of a copy of the initial itemized bill with the overcharges circled, and a copy of the adjusted bill showing that the provider corrected the discrepancy. Such proof should be submitted to the Trust Fund Office within 45 days following the date of the service. Within 30 days after receipt of proof and verification that the overcharge has been recovered or reversed, the Trust Fund Office will mail you a check in the amount of the cash incentive. It should be noted that such reimbursements are considered income and you should consult with the I.R.S. or a tax accountant about the method to use to report this.
5. The Trustees and the Trust Fund Office will not get involved in resolving any differences between you and the provider with respect to disputed charges. You are solely responsible for handling such disputes.
6. The following sets forth specific suggestions for a careful and complete review of a hospital bill:
 - a. Before leaving the hospital, make sure the hospital either provides or arranges to send an itemized bill;
 - b. List everything that happens while in the hospital by reconstructing events, either daily or immediately upon discharge;
 - c. Match your list from (b) above against bills to detect any discrepancies;
 - d. Check the bill carefully for charges that represent any treatments, services, or supplies that were not received;
 - e. Circle any overcharges. Report the overcharges to the hospital billing department and request a corrected bill. If the patient properly identifies the specific discrepancies in the hospital bill, hospitals must eliminate unsubstantiated charges unless there is evidence in the medical file to the contrary. A copy of the adjusted bill will be used as proof that the hospital corrected the discrepancies; and
 - f. Earn a recovery reward by sending the Trust Fund Office a copy of the initial bill with the overcharges circled and a copy of the corrected bill.

X. ANNUAL ROUTINE PHYSICAL EXAMINATION AND WELLNESS BENEFITS
For All Eligible Active and Retired Participants and Dependents
Enrolled in the Fee-For-Service Medical Plan

ANNUAL ROUTINE PHYSICAL EXAMINATION BENEFIT

For You and Your Spouse

While you are eligible, the Plan will reimburse you 100% for physician charges and x-ray and laboratory tests that you or your Dependent spouse incur in connection with an annual routine physical examination. However, benefits will be limited to a maximum payment of \$300 per calendar year for you and \$300 per calendar year for your Dependent spouse. *This benefit is not subject to a deductible.*

The physical examination can be performed by the physician of your choice. However, the physical exam must include the following items:

1. Urinalysis;
2. Complete blood work;
3. Electrocardiogram; and
4. A pap smear (for females).

Continuum

You may instead choose to have your annual routine physical examination performed by an organization called "Continuum." This organization provides physical examinations in mobile units which are set up from time to time in areas close to your home or office. You will be advised by Continuum when the mobile unit will be in your area. If you choose to use them for a physical examination, you then make arrangements directly with them for an appointment at your convenience. After the examination is completed, Continuum will send you a complete report with the results of your examination and all accompanying tests which they perform. The Trust Fund Office will be billed for your examination. *This benefit is not subject to a deductible.*

WELLNESS BENEFIT

For You and Your Spouse

While you are eligible, the Trust will reimburse you 100% for the following:

1. \$25 per immunization and/or flu shot. The office visit is not covered.
2. For women, screening mammograms up to a maximum payment of \$110 per visit, including the examination, test and interpretation. The following age limitations and intervals apply:

<u>Age</u>	<u>Mammogram</u>
35 - 39	one time
40 and over	once a year

3. For men over 50 years of age, prostate screening up to a maximum payment of \$110 per visit, including the examination, test and interpretation. Rectal examinations and PSA blood screening tests are limited to one per calendar year.

XI. DENTAL BENEFITS

For All Eligible Active and Retired Participants and Dependents Enrolled in the Fee-For-Service Dental Plan

DENTAL BENEFITS FOR YOU AND YOUR FAMILY

While you and your family members are eligible for the medical and hospital benefits provided by the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund, you are also eligible for the benefits of the Dental Plan.

Two dental plan options are available to you and your eligible Dependents:

1. **United Concordia Dental Plan.** United Concordia is a pre-paid dental plan similar to an HMO. If you elect this Plan, you and your eligible Dependents will be covered under the United Concordia Dental Plan for all covered dental services and supplies. Benefits of the Plan are only available from the dentists listed in the provider directory. Specialist services are covered when you are referred by your chosen provider. There is no deductible or yearly maximum, and no charge for basic and preventive care, root canals, crowns and bridges. Call United Concordia at 1-800-937-6432 for more information.

Orthodontic services are provided as part of the dental benefits provided by United Concordia, subject to the following provisions:

- There is a fee of \$1,500 for adolescents, and a fee of \$2,000 for adults. In addition, there is a “records” fee of \$265, which includes x-rays, models, treatment plan, etc.
- You must remain on the United Concordia Plan during the period of time you or your eligible Dependent is undergoing orthodontic treatment. Any early termination will result in pro-rata charges for all unfinished work.

2. **Fee-For-Service Dental Plan.** Under the Fee-For-Service Dental Plan, benefits are paid directly by the Trust Fund. If you elect this Plan, you and your eligible Dependents will be covered under the Fee-For-Service Dental Plan for all covered dental services and supplies. You may use any licensed dentist in the United States for necessary dental care. The Fee-For-Service Dental Plan is described below.

Fee-For-Service Dental Plan

The Plan will reimburse you for Covered Dental Expenses as listed below, at 100% of the Schedule of Dental Procedures, but not more than 100% of your dentist’s usual, customary and reasonable fees. The maximum aggregate amount payable for Covered Dental Expense for you or your eligible Dependent in any calendar year or portion thereof is \$1,750 per person.

The Dental Plan also provides benefits for orthodontic procedures payable at 100% of Allowable Charges, up to a lifetime maximum payment of \$2,400. Orthodontia benefits are also subject to the \$1,750 calendar year maximum.

COVERED DENTAL SERVICES

Diagnostic

Provides all the necessary procedures to assist the dentist in evaluating the existing condition to determine the required dental treatment, including office visits and consultations, clinical examinations, biopsies, study models, vitality tests and x-rays.

Preventive

Prophylaxis, topical application of fluoride solutions, and space maintainers.

Oral Surgery

Provides operative procedures in and about the oral cavity and jaws including pre- and post-operative care, e.g., extractions.

General Anesthesia

When administered for a covered oral surgery procedure performed by a dentist.

Restorative Dentistry

Provides for the restoration of decayed, diseased or damaged natural teeth to a satisfactory state of health, function and aesthetics. This includes the use of amalgam, synthetic porcelain and plastic. The use of gold restorations, crowns and jackets are provided when teeth cannot be restored with the above materials.

Endodontics

Provides necessary procedures for the treatment of diseases of the pulp chamber and pulp canals.

Periodontics

Provides necessary procedures for the treatment of diseases of the tissues supporting the teeth.

Prosthodontics

Provides for artificial replacement of missing natural teeth with bridges, or partial complete dentures.

Orthodontics

Procedures associated with straightening and realignment of the teeth and orthodontics.

EXCLUSIONS AND LIMITATIONS

Covered Dental Expenses do not include expenses incurred for:

1. Any dental procedure performed for cosmetic reasons.
2. Charges for replacement of a prosthesis (dentures, crowns, bridges, partials, etc.), if such replacement occurs within five years from the date expense was incurred, unless;
 - a. Such replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth;
 - b. The prosthesis is temporary and is being replaced by a permanent prosthesis; or
 - c. The prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury while covered.

3. Any procedure which began before the date you or your Dependent became covered under this Dental Plan, or any supplies furnished in connection with such procedure. For purposes of this provision, x-rays and prophylaxis (cleaning) treatment will not be deemed to begin a dental procedure.
4. Any treatment that is payable under any other benefit of the Plan.
5. Orthognathic procedures and myofunctional therapy and procedures associated therewith.
6. Combined charges for orthodontia and treatment of temporomandibular joint syndrome that exceed \$2,400 per lifetime.
7. Placement of dental implants and all associated procedures.

ALSO SEE GENERAL EXCLUSIONS SECTION ON PAGE 56.

EXTENSION OF BENEFITS

1. Dental benefits will be extended for 30 days after loss of eligibility to cover any services rendered or supplies furnished in connection with a dental procedure that commenced prior to the date of loss of eligibility. Benefit payments will be made to the same extent as if eligibility had not been lost, provided this Dental Expense Benefit is still in force on the date the expense was incurred. For purposes of this provision, examinations, x-rays, prophylaxis (cleaning) treatment and orthodontics will not be deemed to commence a dental procedure.
2. If you or your eligible Dependents are Totally Disabled as a result of an accident on the date of loss of eligibility, benefits will be provided to the same extent as if your eligibility had not terminated. Only expenses incurred within three (3) months of the date of the accident for repair of, or alleviation of damage to natural teeth, will be payable. You or your Dependent must remain continuously disabled during the three-month period and the accident must have occurred while the Dental Expense Benefits were in effect.

SCHEDULE OF DENTAL PROCEDURES

The following list is a summary of the dental procedures allowed under the Fee-For-Service Dental Plan. A complete listing is available from the Trust Fund Office.

PROCEDURE #	PROCEDURE	MAXIMUM PAYABLE
DIAGNOSTIC (00100-00999)		
00110	Initial Oral Examination	\$ 55.00
00120	Oral Exam	40.00
00210	X-rays, complete	100.00
00220	Intraoral—Single, First Film	28.00
00230	Intraoral—Each Additional Film	15.00
00272	Bitewing—two films	40.00
00274	Bitewing—four films	53.00
00330	Panoramic—maxilla and mandible, film	79.00
PREVENTIVE (01000-01999)		
01110	Prophylaxis—Adult	\$ 69.00
01120	Prophylaxis—Children under age 14	55.00
01201	Topical application of fluoride including prophylaxis—Children	68.00
RESTORATIVE (02000-03999)		
02140	Amalgam—one surface, permanent	\$ 76.00
02150	Amalgam—two surfaces, permanent	91.20
02160	Amalgam—three surfaces, permanent	100.00
02330	Composite resin—one surface	100.00
02331	Composite resin—two surfaces	115.20
02750	Porcelain crown with gold	600.00
02790	Gold crown (full cast)	577.60
02950	Crown build-up—including pins	144.00
02954	Prefabricated post and core—in addition to crown	172.00
03120	Pulp-cap—indirect	68.00
03310	Root canal—one	460.00
03320	Root canal—two	520.00
03330	Root canal—three	640.00
PERIODONTAL (04000-04999)		
04210	Gingivectomy or gingivoplasty, per quadrant	\$ 320.00
04220	Gingival curettage, per quadrant	121.60
04260	Osseous surgery, per quadrant	680.00
04341	Periodontal scaling and root planning, per quadrant	140.00
04910	Preventive periodontal procedures	81.60
PROSTHODONTICS (REMOVABLE) (05000-05999)		
05110	Complete upper dentures	\$ 839.20
05120	Complete lower dentures	760.00
05610	Repair broken complete or partial denture	100.00
PROSTHODONTICS (FIXED) (06000-06999)		
06240	Porcelain fused to gold—bridge	\$ 560.00

PROCEDURE #	PROCEDURE	MAXIMUM PAYABLE
SURGERY (07000-07999)		
07110	Single tooth extraction	\$ 80.00
07120	Each additional tooth	76.00
ADJUNCTIVE GENERAL SERVICES (09000-09999)		
09110	Palliative (emergency) treatment of dental pain, minor procedure	\$ 77.60
09220	General anesthesia	200.00
09310	Consultation—per session	96.00
09430	Office visit (during regular office hours)	44.00

XII. PRESCRIPTION DRUG BENEFITS

For All Eligible Active and Retired Participants and Dependents Enrolled in the Fee-For-Service Medical Plan

Prescription Drug Plan for You and Your Eligible Dependents

While you and your Dependents are eligible under the Fee-For-Service Medical Plan provided by the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund, you are also eligible for the benefits of the Prescription Drug Plan. Your walk-in benefits and your mail order benefits are currently provided by Express Scripts.

The Plan allows several means for obtaining your medications. The mandatory mail-service program offers the convenience of home delivery for all your “maintenance” long-term prescription drug needs, while the national network of retail pharmacies, which contract with Express Scripts, provide “walk-in” services to meet your immediate needs for acute drug therapy. In addition, you can also obtain your medication from a non-participating pharmacy; however, you will be required to pay for the medication in full at the pharmacy and submit an authorized receipt for reimbursement. Both walk-in and mail order prescription drugs are subject to a copayment, as described below.

What are the Copayments?

Mail Order Prescription Drugs—Provided by Express Scripts (90-day supply)

Copayment	<ul style="list-style-type: none">• \$10 for generic drugs;• \$30 for formulary (preferred) brand name drugs; *• \$60 for non-formulary brand name drugs *
Plan pays	100% after Participant pays copayment.

Walk-in Prescription Drugs—Provided by Express Scripts through PERxCare Pharmacies (30-day supply)

Copayment	<ul style="list-style-type: none">• 10% of cost for generic drugs (\$5 minimum copay);• 20% of cost for formulary brand name drugs (\$10 min; \$50 max) * (\$10 minimum, \$50 maximum copay);• 40% of cost for non-formulary brand name drugs (\$25 minimum) *
Plan pays	100% after Participant pays copayment.

Walk-in Prescription Drugs—Provided by Non-Contracting Pharmacies

(Also applies to contracting pharmacies when you do not have your prescription drug card.)

Copayment	<ul style="list-style-type: none">• \$10 for generic drugs• \$30 for formulary (preferred) brand name drugs *• \$60 for non-formulary brand name drugs *
Plan pays	Member pays in full, then submits claim form to Express Scripts for reimbursement. Plan pays up to the amount of PERxCare Pharmacy’s normal cost after Participant pays copayment.

* *If you purchase a brand name drug, and there is a generic equivalent available, even if your physician prescribes “Dispense as Written”, you will have to pay the brand name copayment, plus the difference in cost between the brand name and generic drug.*

Please contact Express Scripts or the Trust Fund Office for a list of formulary medications.

PLEASE NOTE: When you use the mail order program, both you and the Plan save money. A drug which is obtained through the mail order program generally costs less than the same drug obtained through a walk-in pharmacy.

May I Use Generic Prescription Drugs?

When your physician writes a prescription for you or your eligible Dependent, he or she can prescribe the brand name drug or the “generic” substitute. The generic substitute generally costs less to manufacture and sell, and reduces costs to the Plan.

“Generic drugs” are drugs that are identified by their chemical name, not a brand name. For example, St. Joseph’s and Bayer are brand names for aspirin, and “Aspirin” is the generic name. Generic drugs must meet the same federal standards as their brand name equivalents. Generic medications are widely accepted by physicians, pharmacists and health plan providers. The availability of generic drugs is constantly expanding. Brand name drugs are significantly more expensive than generic drugs, due to the drug manufacturers spending large sums of money on research, development, marketing and advertising of brand name drugs. It is important to remember that generic medications are just as safe and effective as the more expensive brand name drugs.

If you currently have a prescription and need a refill, and decide you would like to have a generic substitute, please ask your pharmacist to give you the generic substitute.

WALK-IN PHARMACY PROGRAM

You can have your prescription filled at either a contracting or a non-contracting pharmacy.

EXPRESS SCRIPTS CONTRACTING PHARMACIES

You can purchase your prescription at any Express Scripts participating pharmacy.

How Do I Order Prescriptions from a Contracting Pharmacy?

If you need a supply of 30 days or less for a non-maintenance or “acute” therapy drug, take your prescription along with your Express Scripts I.D. card to one of the many conveniently located participating pharmacies. You must pay your copayment to the dispensing pharmacy. Maintenance medication obtained from a retail walk-in pharmacy is limited to a **maximum of one refill**.

A list of major participating pharmacies is on page 49. For more information, you may call Express Scripts at (800) 347-8777.

NON-CONTRACTING PHARMACIES

In the case of an emergency, or if you do not use an Express Scripts participating pharmacy, obtain your medication from the non-participating pharmacy, pay for the medication in full at the pharmacy, and submit your receipt and claim form to Express Scripts for reimbursement (you must also do this if you do not have your Express Scripts I.D. card at the pharmacy). **Please note that reimbursement is subject to a reduced benefit.** Express Scripts only pays up to what it would have paid for the same drug at a pharmacy in their network. You pay the difference between the retail price and the amount Express Scripts pays, as well as the copayment.

How Do I File a Claim for Prescriptions?

1. You should obtain a claim form from the Trust Fund Office. A separate form must be filed for each prescription for which benefits are payable.
2. Complete the employee's section of the claim form.
3. Take the claim form to your pharmacist so that he can complete the pharmacy section of the form.
4. Mail the completed claim form within 90 days from the date your prescription was filled for reimbursement to:

Express Scripts
4500 Alexander Boulevard, N.E.
P.O. Box 27226
Albuquerque, NM 87125-7226

You should expect reimbursement from Express Scripts within 15 – 20 days after they receive the claim form.

EXPRESS SCRIPTS MANDATORY MAIL ORDER PHARMACY PROGRAM

The Express Scripts mail order program is mandatory if you or your eligible Dependent take prescription drugs on an ongoing basis; that is, you regularly require a supply of prescription drugs for more than 30 days. These drugs are typically called maintenance drugs. For example, if you take Inderal daily for high blood pressure, it is a maintenance medication. On the other hand, Penicillin for an infection would not be a maintenance medication.

You may obtain your initial maintenance drug prescription up to a 30-day supply at a retail pharmacy, plus one refill up to a 30-day supply for the same prescription drug. In order to receive the same medication beyond the one original and one refill, the prescription must be filled through the mail-service program.

Through the mail-service program, the Plan will cover up to a 90-day supply of needed maintenance prescription drugs. With this program, the doctor also has the option of prescribing up to three (3) refills which will entitle you to a maximum of a 12-month supply, resulting in considerable savings in both time and money.

Once your prescription is received by Express Scripts, a pharmacist will fill it, another pharmacist will make sure it was filled correctly, then a shipper will check it and ship it to you. Express Scripts generally ships your prescription within 24 hours of receiving it, but you should allow at least 10 days from receipt of the prescription by Express Scripts until delivery of your medication. Express Scripts provides a toll-free phone number to answer any of your questions or concerns regarding your prescription. The toll-free phone number is (800) 347-8777.

Remember: If you need more than a 30-day supply of prescription drugs on an ongoing basis, you must use the mail order program.

How Do I Order My Prescription Using the Mail Service?

To obtain prescription forms and self-addressed postage envelopes for the mail-service program, please call the Trust Fund Office or Express Scripts at (800) 347-8777.

1. Complete the Mail Order Patient Profile. It is only necessary to include the form with your first order. If more space is needed for Dependents, please list on a separate sheet. NOTE: Your member ID# is generally your Social Security Number. If you are unsure, please contact the Trust Fund Office.
2. Ask your doctor to prescribe your medication, plus refills. Your doctor should prescribe *the number of pills required for a 90-day period*, plus three refills. For example, if you are required to take 3 pills a day of a certain medicine, then a 90-day supply would be 270 pills.
3. Send the completed profile, your prescription(s), and your copayment(s) in the pre-addressed, postage-paid envelope to:

Express Scripts
4500 Alexander Boulevard, N.E.
P.O. Box 27226
Albuquerque, NM 87125-7226

Refills

At the appropriate time noted on your refill notice, send the refill notice, your copayment, and your prescription request to Express Scripts in the postage-paid envelope provided. Before mailing, please make certain you have refills remaining, and check the expiration date on your refill notice. You should receive your refill within 14 days of this mailing.

You may also call the toll-free number for Express Scripts, 1-800-347-8777, to order refills over the telephone.

What Drugs are Covered?

1. Drugs that, under Federal or State of California Law, require the written or oral prescription of a licensed physician or dentist.
2. In addition, the following items when they are prescribed in writing by a doctor:
Insulin and Diabetic Supplies, including: Insulin Syringe, Needles, Disposable Needles, Sugar Test Tape, Acetone Test Tablets, Benedict's Solution or Equivalent.
3. Colostomy supplies.
4. Vitamins that require a prescription.
5. Birth control pills and other physician-prescribed contraceptive devices.
6. Retin-A, for medical, not cosmetic reasons. Prescriptions for Retin-A must be submitted with a letter from your physician describing the diagnosis for which it is being used, and requires pre-authorization from the Trust Fund Office.
7. Smoking deterrents, but only through the mail order program on a one-time basis.

What Drugs Are Not Covered?

1. Drugs or medications not requiring a physician's or dentist's prescription.
2. Injectable drugs (except insulin), blood and blood plasma, immunization agents.
3. Multiple and non-therapeutic vitamins, cosmetics, dietary supplements, health and beauty aids.

4. Non-drug items such as appliances, prosthetics, bandages, heat lamps, etc.
5. Any drugs or medicine taken in accordance with the physician's directions that exceed a 90-day period without the necessity of a refill unless prior written agreement has been reached with the Trust.
6. Rogaine (minoxidil) solution.
7. Progesterone suppositories.
8. Drugs or medications taken by or prescribed for a patient in a hospital, sanitarium or rest home.
9. Drugs for which reimbursement is provided under Workers' Compensation or occupational disease laws.
10. Any drugs or medications not reasonably necessary for the care or treatment of bodily injuries or sicknesses.
11. Drugs dispensed in the physician's office.
12. Drugs prescribed in connection with weight reduction.
13. Drugs prescribed in connection with the treatment of infertility or to enhance fertility.
14. Drugs prescribed in connection with the treatment of impotency or erectile dysfunction, except for limited coverage for Viagra.

ALSO SEE GENERAL EXCLUSIONS SECTION ON PAGE 56.

PERxCARE (Express Scripts) WALK-IN PHARMACIES

The following is a partial list of participating pharmacies:

A

A&P Pharmacy
ABCO Pharmacy
Albertsons
Arbor Drugs

B

Big B
Bills Drugs
Brooks

C

City Market
CVS/Peoples

D

Discount Drug Mart
Drug Emporium

E

Eckerd

F

Farmer Jack
Fay's Drug Stores
Fry's Food Pharmacy

G

Giant Eagle
Gooding Pharmacy

H

HiSchool Pharmacy
Hook
Horton & Converse

K

Kash & Karry
Kerr
K-Mart
Kroger

L

Longs

M

Medicap
Medico Healthmart

O

Osco Drug

P

Pathmark
Perry Drug Store
Par Mor
Publix Pharmacy

R

Reliable Drug
Revco
Rite Aid
Rockbottom

S

Safeway
Sav-On
Shopko Pharmacy
ShopRite
Smitty's Super Value
Stop & Shop
SuperRx Drug

T

Target Pharmacy
The Medicine Shoppe
Thrift Drug Store
Thrifty Drug
Thrifty Jr. Drug

V

Vons

W

Weis Pharmacy
Winn Dixie Pharmacy
Woolworth's

XIII. VISION CARE BENEFITS

For All Eligible Active and Retired Participants and Dependents

Vision Care Benefits for You and Your Family

When you and your Dependents are eligible for the Fee-For-Service or HMO medical and hospital benefits provided by this Plan, you are also eligible for vision care benefits through Vision Service Plan (VSP).

Vision Service Plan

The vision care plan provided by Vision Service Plan (VSP) is composed of a panel of over 22,000 doctors to provide professional vision care for you and your eligible Dependents.

What are the Benefits?

1. **Vision Examination** —A complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.
2. **Lenses**—The VSP Panel Doctor will order the proper lenses (only if needed). The program provides the finest quality lenses fabricated to exacting standards. The doctor also verifies the accuracy of the finished lenses.
3. **Frames**—The Plan offers a wide selection of frames. However, if you select a frame which costs more than the amount allowed by the Trust, (or a large frame that requires oversized lenses) there will be an additional charge.
4. **Contact Lenses**—Your allowance applies to the cost of your contact lens exam and your contact lenses. You will receive a 15% savings off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.

How Much Do I Pay?

Vision Service Plan provides two separate plans: (1) Plan C for Active Participants and their eligible Dependents; and (2) Plan B for Retired Participants and their eligible Dependents.

Plan C – For Active Participants and their Eligible Dependents:

<u>Benefit</u>	<u>Frequency</u>	<u>Copay</u>	<u>In-Network</u>	<u>Out-of-Network Reimbursement</u>
Exam	12 months	\$ 20	Covered in full	Up to \$ 45
<i>Prescription Eyewear—You may choose between glasses or contacts. Remember if you choose contacts, you will not be eligible to receive glasses (lenses and frames) in the same service period.</i>				
Lenses	12 months		Single Vision Lined Bifocal Lined Trifocal Lenses and tints are covered in full	Single Vision \$45 Lined Bifocal \$45 Lined Trifocal \$65 Tints \$ 5
Frames	12 months		Up to \$120	Up to \$ 47
Contact Lenses	12 months		Up to \$105	Up to \$105

Plan B – For Retired Participants and their eligible Dependents:

The benefits are the same as Plan C, with the following exceptions:

Copay: \$ 30;

Frames: Frequency is every 24 months;

Tints are not covered.

How Do I Use This Plan?

1. Contact a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member; provide your identification number (Social Security Number) and group name (Airconditioning and Refrigeration Industry Health and Welfare Trust Fund). The doctor will verify eligibility and benefits. If you need to locate a VSP participating doctor, call VSP at (800) 877-7195, or visit their website at www.vsp.com.
2. VSP will pay the doctor directly. You are responsible for any applicable copayment and any additional costs for items not covered.
3. If you use a doctor from the VSP list, this assures direct payment to the doctor and guarantees quality and cost control. However, if you decide to use the services of a doctor who is not a VSP Panel Member, you will be required to pay the doctor's fee in full. You will be reimbursed by VSP in accordance with the reimbursement schedule on the previous page. However, there is no assurance that the schedule will be sufficient to pay for the examination or the glasses. Reimbursement benefits are not assignable.

NOTE: When you obtain service from a doctor who is not a VSP Panel Member and/or obtain glasses from a dispensing optician, be sure to send your itemized statement of charges and receipts along with your benefit form to the VSP address listed on the back of your benefit form.

LIMITATIONS

Extra Cost—This Plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following and your VSP doctor does not receive prior authorization, there will be an extra charge:

1. A frame that requires oversized lenses;
2. Coated lenses;
3. Contact lenses;
4. Blended or progressive multi-focal lenses;
5. Photochromic or tinted lenses other than Pink 1 or 2;
6. A frame that costs more than the plan allowance; or
7. Two pairs of glasses in lieu of bifocals.

What Benefits Are Not Covered?

There are no benefits for professional services or materials connected with:

1. Orthoptics or vision training, subnormal vision aids, aniseikonia lenses, plano (non-prescription) lenses, or glasses obtained when there is no prescription change.
2. Lenses and frames furnished under this program which are lost or broken. They will not be replaced except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes; such treatment may be covered under the medical provisions of the Plan.
4. Services or materials provided as a result of any Workers' Compensation Law, or similar legislation, or obtained through or required by any government agency or program whether Federal, State or any subdivision thereof.
5. Any eye examination required by an employer as a condition of employment; or any service or material provided by any other vision care plan, or group benefit plan containing benefits for vision care.

ALSO SEE GENERAL EXCLUSIONS SECTION ON PAGE 56.

XIV. VISION THERAPY BENEFITS

For All Eligible Active and Retired Participants and Dependents Enrolled in the Fee-For-Service Medical Plan

While you are eligible, should you or your eligible Dependents have amblyopia, strabismus and other eye coordination problems, this special benefit is available to cover such problems. The treatment plan must be approved in advance. Your physician has the forms to submit for approval. Benefits will be payable at 60% for such expense up to a lifetime maximum payment of \$500.

XV. ACCIDENT AND SICKNESS WEEKLY BENEFITS

For Active Participants Only—Not Available to Retired or COBRA Participants

Benefits

If you become Totally Disabled as a result of an injury or an illness, you will be entitled to an Accident and Sickness Weekly Benefit as follows:

Non-Occupational—Weekly Benefit Amount:	\$150 (net after taxes)
Accident Benefits commence with the:	1st day
Sickness Benefits commence with the:	8th day

Occupational—Weekly Benefit Amount:	\$150 (net after taxes)
Benefits commence with the:	1st day

Maximum Period of Payment During any Disability:	26 weeks
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Total Disability resulting from the pregnancy of a female employee will be considered an illness, with benefits beginning on the eighth day of Total Disability.

Your benefits will be paid for a maximum number of 26 weeks for any one period of disability whether due to one or more causes. For purposes of the Accident and Sickness Weekly Benefit only, successive periods of Total Disability, separated by less than two weeks of full-time active employment or availability for work, will be considered one period of disability.

For each day during partial weeks of disability, you will be paid one-fifth of the weekly benefit.

In order to collect the Accident and Sickness Weekly Benefit, you must be under the care of a physician. To receive this benefit, you must obtain an application form from the Trust Fund Office and it must be completed and returned within 12 months from the initial date of the disability.

XVI. DEATH AND DISMEMBERMENT BENEFITS

For All Eligible Active and Retired Participants

While you are eligible for benefits under the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund, you and your Dependents will be eligible for death benefits under this Plan as follows:

Death of an Active Participant (excluding COBRA Participants):

Payable to your designated beneficiary

- Resulting from natural causes \$35,000
- Resulting from accidental causes \$45,000

Death of a Dependent of an Active Participant (excluding COBRA Participants):

Payable to Participant

- Spouse \$ 1,000
- Child—birth to age 19 years \$ 1,000

Dismemberment Benefits For the Active Participant (excluding COBRA Participants):

- Loss of 1 hand, foot or eye \$ 5,000
- Loss of 2 hands, feet, eyes or combination thereof \$10,000

Death of a Retired Participant (excluding COBRA Participants):

Payable to your designated beneficiary

- Resulting from natural or accidental causes \$10,000

Dismemberment Benefits For the Retiree (excluding COBRA Participants):

- Loss of 1 hand, foot or eye \$ 5,000
- Loss of 2 hands, feet, eyes or combination thereof \$10,000

The Dismemberment Benefit is payable subject to the following provisions:

1. Loss of a hand or foot means the dismemberment by severance through or above the wrist or ankle joint respectively.
2. Loss of an eye means the entire and irrecoverable loss of sight of the eye.
3. This benefit does not apply to sickness or disease, or medical or surgical treatment therefor, except pyogenic infection that occurs through an accidental cut or wound.

Beneficiaries

The Death and Dismemberment Benefit will be paid to you or to the beneficiary you have designated in writing on a beneficiary form provided by the Trust Fund Office.

If no beneficiary form is on file with the Trust Fund Office, your surviving spouse will be paid first. If you are not married or your spouse predeceases you, then the benefit will be paid to your heirs at law, and, if none, then the benefit will revert to this Trust.

A beneficiary form will be supplied by the Trust Fund Office if you wish to change your beneficiary at any time.

Extension Of Death Benefit If Disabled

If, on the date your coverage terminates, you are Totally Disabled, your Death Benefit will be paid to your beneficiary if:

1. Your death occurs within twelve months of the date your coverage terminated.
2. You were Totally Disabled from the date of termination of coverage continuously to the date of death.
3. Sufficient proof that these conditions have been met is submitted to the Trust Fund Office within one year of the date of death.

Exclusions And Limitations

1. With respect to the benefit payable upon the death of a Dependent, if both you and your spouse are Participants, only one of you will be eligible for a benefit upon the death of a Dependent child. There is no benefit upon the death of a Dependent for Retired Participants.
2. You will not be eligible for any benefit under this section with respect to any loss caused or contributed to by sickness or injuries sustained while in military service.
3. The Accidental Death Benefit will be payable only when death results from an accidental bodily injury, directly and independently of all other causes, and occurs within 90 days after the date of the accident. The benefit is not payable if death results in whole or in part from sickness, disease, or medical or surgical treatment therefore, except pyogenic infection that occurs through an accidental cut or wound.

ALSO SEE GENERAL EXCLUSIONS SECTION ON PAGE 56.

XVII. GENERAL EXCLUSIONS

In addition to the exclusions listed under the specific benefits in this Booklet, the Plan will not provide benefits for:

1. Any condition arising out of occupational injuries or illnesses, even though you fail to claim your right to such benefits, or for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Workers' Compensation or occupational disease law.
2. Treatment, services or supplies that are not a covered expense under this Plan; however, the Plan reserves the right to waive certain Plan benefit limitations in order to cover more cost-effective care that would otherwise not be considered an eligible expense.
3. Any treatments, supplies or services:
 - a. That are not medically necessary except for preventive care as provided for in this Plan;
 - b. Performed by a practitioner not acting within the scope of his or her license;
 - c. Incurred by you or your Dependent when ineligible under the Plan;
 - d. For which no charge is made;
 - e. For which the eligible individual is not required to pay in the absence of this Plan;
 - f. Furnished by a hospital or facility owned or operated by the United States Government or any State Government or any authorized agencies thereof, or furnished at the expense of such Governments or Agencies;
 - g. That are provided without cost by any municipal, county or other political subdivision; or
 - h. Provided in connection with court-ordered care.
4. Medical charges incurred by or for step-children or children under legal guardianship (except when covered by an HMO plan.)
5. Any services, procedures or supplies which are, in the sole and absolute discretion of the Board of Trustees, considered experimental or investigational in nature or are not within the standards of generally accepted medical or dental practice. The term "experimental/investigational" includes any medical, surgical or other health care treatment or procedure and any medication which is determined by the Plan to meet any one of the following criteria:
 - a. It is not generally accepted by the medical or dental community as proven and effective for their treatment of the diagnosis in question;
 - b. The scientific assessment of the treatment, procedure or medication or its application for a particular diagnosis has not been completed;
 - c. Any required governmental approval of the treatment, procedure, device or medication for the diagnosis in question has not been granted at the time the services are rendered or the medication prescribed;
 - d. The treatment, procedure or medication or its application for a particular diagnosis has been granted approval only for use in connection with an experimental study; or
 - e. With respect to medications, the medication has not been approved by the Food and Drug Administration for the specific diagnosis.

In applying the foregoing definition, the Plan will rely on literature contained in established medical or dental texts and journals, the opinions of medical or dental professionals, and where appropriate, the opinions of specialists in the medical or dental field in question. It should be understood that this is an area

in which differing opinions are common. Accordingly, ***IT IS STRONGLY ADVISED THAT YOU SEEK PRE-CERTIFICATION FROM THE PLAN BEFORE PROCEEDING WITH A COURSE OF TREATMENT THAT COULD POSSIBLY BE CONSIDERED EXPERIMENTAL.***

Some services and/or procedures are excluded from coverage because they are not rendered in accordance with the generally accepted professional standards for the diagnosis or treatment of the illness or injury in question.

The Plan may, on occasion, request that a patient have an independent medical or dental evaluation to determine the reasonableness and necessity of the services being provided.

6. The treatment of varicose veins except when there is a medical condition which is substantiated with documentation by the attending physician and prior authorization is obtained.
7. Intentionally self-inflicted injuries or sicknesses.
8. Conditions caused by or arising out of an act of war, declared or undeclared, armed invasion or aggression.
9. Charges for injuries incurred during the covered person's commission of a crime, or for care or treatment while incarcerated in any penal institution, jail facility or jail ward.
10. Any bodily injury or sickness for which you are not under the care of a physician.
11. Charges for services performed by your spouse, or a child, brother, sister or a parent of you or your spouse.
12. Charges for any service not specifically covered by the Plan.
13. Any charges over the Plan's maximum Allowable Charges.
14. Services or supplies in connection with organ transplants that are not covered by the Plan.
15. Fees to complete claim forms.
16. Charges by a provider who has performed unnecessary services, billed in an inappropriate manner, or has engaged in any questionable, unethical or fraudulent billing practices as determined in the sole and absolute discretion of the Board of Trustees. The Board of Trustees reserves the right to determine that a provider is an ineligible provider and that no Plan benefits will be payable for services or supplies provided by that provider on this basis.

XVIII. CLAIMS PROVISIONS

Proof of claim must be given to the Trust Fund Office within 90 days after the occurrence or commencement of any loss, or as soon thereafter as is reasonably possible, not to exceed one year.

For death claims, a certified copy of the death certificate must also be submitted to the Trust Fund Office.

The Trust, at its own expense, shall have the right and opportunity to arrange for the examination of any individual whose injury or sickness is the basis of a claim to determine the extent of loss.

HOW TO FILE A CLAIM

1. You must complete, sign and date the employee's portion of the claim form.
2. Have your physician or dentist complete their portion of the claim form in detail.
3. Upon completion of the claim form, attach itemized bills and send your claim to the Trust Fund Office at:

Airconditioning & Refrigeration
Industry Health & Welfare Trust Fund
1380 S. Sanderson Avenue
Anaheim, CA 92806
(714) 917-6100

4. For claims assistance, write or telephone the Trust Fund Office at (714) 917-6100.
5. All claims must be filed with the Trust within 90 days of the date they are incurred, or as soon thereafter as is reasonably possible, but not more than one year from the date the expense was incurred.
6. All benefits will be payable to you unless you have signed the authorization on the claim form to pay the provider directly. If you use an Affiliated Health Funds, ppoNEXT or Interplan provider, benefits will be paid directly to that provider.

How to Appeal If Your Claim is Denied

If your claim is denied in whole or in part, you have the right to file an appeal with the Board of Trustees (see the Information Required By ERISA Section, item 15, entitled "Claims and Appeals Procedures" on page 70.)

XIX. COORDINATION OF BENEFITS

This Plan has been designed to help you meet the cost of disease or injury, and one way to ensure you receive the maximum amount of benefits available to you is by “coordinating benefits.” If you or your eligible Dependent have group coverage other than the benefits payable under this Plan, such information should be given on the claim form when submitted for payment. “Coordination” means that this Plan will work together with any other plan under which you may have coverage, enabling you to receive the full amount of benefits to which you are entitled under both plans. In other words, by “coordinating” the benefits of this Plan with the benefits of another plan, you may receive full payment of your medical expenses (but not more than 100% of Allowable Charges) rather than partial payment.

The following information explains how benefits are determined when the Coordination of Benefits provision is applied.

One of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. If this Plan is the Primary Plan, it pays benefits first and without consideration of the other plans. If this Plan is the Secondary Plan, the primary plan will pay first—this Plan will then pay the remaining benefits as though it was primary, not to exceed 100% of the Allowable Charges incurred when the amount paid by this Plan is added to the amount paid by the other plan. No plan will pay more than it would have paid without this special provision. (If one plan has no Coordination of Benefits provision, it is automatically Primary.)

For purposes of this Coordination of Benefits provision, the term “Plan” includes the benefits payable under the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund and any other plan (excluding individual policies or contracts other than franchise coverage) providing benefits or services for, or by reason of, medical or dental care or treatment under an insurance policy; any governmental programs or coverage required or provided by any statute; or any coverage (1) provided under hospital, medical or dental service plans, union welfare plans, employer organization plans or employee benefit organization plans; or (2) sponsored by, or provided through, a school or other educational institution.

In order to determine which plan is the Primary Plan and which plan is the Secondary Plan, the following rules have been established:

1. The plan which covers the claimant, but does not contain a Coordination of Benefits provision shall determine its benefits before the benefits of a plan which has a Coordination of Benefits provision.
2. The benefits of a plan which covers the claimant as an active employee will be determined before the benefits of a plan which covers such person as a laid-off or retired employee or as a Dependent.
3. The benefits of a plan which covers the claimant as a Dependent of an active employee will be determined before the benefits of a plan which covers such person as a Dependent of a laid-off or retired employee.
4. When both plans cover the claimant as a Dependent child of an active employee, or when both plans cover the claimant as a Dependent child of a laid-off or retired employee, the benefits of the plan which covers the parent whose birthday (month and day only) occurs first during a calendar year will be determined before the benefits of the plan which covers the parent whose birthday (month and day only) occurs later in the year, except that in the event a father and mother are legally separated or divorced, the following rules will apply:
 - a. The benefits of a plan which covers the claimant as a Dependent child of the parent with financial responsibility for the child’s medical expenses by virtue of a court decree will be determined first;

- b. If there is no court decree, the benefits of a plan which covers the claimant as a Dependent child of the parent with legal custody will be determined first;
- c. If there is no court decree and the parent with legal custody has remarried, the order of benefit determination will be as follows:
 - (1) The plan which covers the parent with legal custody;
 - (2) The plan which covers the step-parent with legal custody if step-children are covered by that plan; and
 - (3) The plan which covers the parent without legal custody.
- 5. When these rules do not establish an order of benefit determination, the benefits of a plan which has covered the claimant for the longer period of time will be determined before the benefits of a plan which has covered such person the shorter period of time.
- 6. When this Coordination of Benefits provision operates to reduce the total amount of benefits otherwise payable to a person covered under this Plan, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of this Plan.
- 7. Special rules apply to persons who are eligible for or enrolled in Medicare. See the "Medicare and Plan Benefits" section on page 61.

XX. MEDICARE AND PLAN BENEFITS

The term “Medicare” means the program established under Title XVIII of the Social Security Act.

Medicare provides a broad program of health insurance for people 65 or older, people who have been totally disabled continuously for two years, even if under age 65, and people with end-stage renal disease undergoing dialysis or kidney transplant.

Medicare is a two-part program. Part A covers hospitalization and certain follow up services. Part B helps pay doctor bills and other medical bills. A monthly premium is required for Part B coverage. *It is most important that you enroll promptly in this extensive program of health insurance.*

THE PLAN WILL NOT PAY FOR ANY BENEFITS THAT COULD HAVE BEEN AVAILABLE TO YOU UNDER MEDICARE HAD YOU BEEN ENROLLED IN BOTH PART A AND PART B.

How to Enroll in Medicare

If you are approaching age 65, you will **not** automatically be enrolled in Medicare unless you have filed an application and established eligibility for a monthly Social Security benefit. If you have not applied for Social Security benefits, you must file a Medicare application during the three month period prior to the month in which you become age 65 in order for coverage to begin at the start of the month in which you reach age 65. Call or write your nearest Social Security Office 90 days prior to your 65th birthday and ask for an application.

Medicare and Plan Benefits

1. Participants Age 65 and Over:

The Airconditioning and Refrigeration Industry Health and Welfare Trust Fund will provide full Plan benefits for active Participants age 65 and over and eligible Dependent spouses age 65 and over. Medicare may provide back-up coverage for some care if the Plan does not pay the full cost. In technical terms, the Plan is “primary” for your covered hospital and medical expenses, and Medicare is “secondary.”

2. Other Participants Eligible for Medicare:

This Plan generally will be the “secondary” payer for active Participants and Dependent spouses who are under age 65 and Medicare-eligible because of disability. For individuals who are Medicare-eligible because of end-stage renal disease (ESRD), the Plan will pay “primary” to Medicare during the first 30 months of Medicare eligibility, in accordance with current law.

If you are eligible for Medicare, but have not enrolled, Plan benefits will be coordinated as if you have Medicare coverage.

In order to coordinate with Medicare payments, the Trust will need the Explanation of Benefit form sent by Medicare to each patient. In addition, in some circumstances copies of medical bills may be required. Without this form, the Plan will estimate the amount payable by Medicare when calculating the benefits payable under this Plan.

Medicare + Choice Plans

If a Participant enrolls individually in a Medicare + Choice plan not provided by this Trust Fund, and is enrolled in the Fee-For-Service Plan through the Trust Fund, then no payments will be made for covered services under this Plan that would have been covered under the Medicare + Choice plan if the Participant had used the plan correctly. The Plan will only pay 20% of your medical expenses.

XXI. MISCELLANEOUS

MEDICAL EXAMINATION

No medical examination is required for coverage. If you are an eligible active or retired Participant, you and your eligible Dependents will be covered regardless of physical condition.

ACTS OF THIRD PARTIES

If you receive a recovery against a third party (auto accident, Workers' Compensation or others) the Plan is entitled to recover the amount of benefits paid under the Plan.

Benefits will be provided under the Plan due to injury or illness caused by the act or omission of another only on the condition that you:

1. Agree, before any benefits are paid, to reimburse the Plan to the extent of benefits provided by the Plan, immediately upon receipt of payments made by or on behalf of persons causing such injury. This provision shall be binding on the heirs, beneficiaries, personal representatives or estate of the injured person whether such payments are a result of judgment, settlement, compromise or otherwise; and
2. Execute and deliver to the Plan a lien to the extent of the dollar amount of benefits provided by the Plan. Such lien shall be a lien upon any proceeds which shall be received by the injured person, his heirs, beneficiaries, personal representatives or estate, and which proceeds are paid by reason of any judgment, settlement, compromise or otherwise. Such lien may be filed with any person, organization, or otherwise, including any court of competent jurisdiction, to protect the interests of the Plan.

The Participant and/or injured person, his or her heirs, beneficiaries, personal representatives, attorneys or estate shall execute such documents as the Trustees of the Plan may require in order to acknowledge and evidence the rights of the Plan as set forth in this section, and shall do nothing to prejudice such rights.

DISCLAIMER

The Fee-For-Service benefits described in this Booklet are not insured by any contract of insurance, and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Trust collected and available for such purposes.

The only source of authorized information is the Plan Booklet, Trust Agreement, the Plan Administrator, and the contracts from the prepaid provider organizations.

If you are eligible for the Plan's benefits, your rights can only be determined by the agreements with Vision Service Plan, Express Scripts, Kaiser, PacifiCare, or United Concordia Dental Services, and the Plan's Booklet relating to the hospital, doctor, medical, and dental benefits provided directly by the Plan.

Participants and their Dependents have no accrued or vested rights to benefits under this Plan. In the event this Plan is terminated by the Board of Trustees, the rights of all Participants covered under the Plan with respect to any benefits available subsequent to termination, will be determined by the Board of Trustees.

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the most equitable possible benefits for all Participants, the Board of Trustees reserves the right at any time and from time to time, in its sole and absolute discretion:

1. To terminate or amend the eligibility conditions with respect to any benefit, to terminate or change any benefit, or to add or modify any self-payment, even though such changes may affect claims which have already been incurred;
2. To terminate this Plan even though such termination affects claims which have already been incurred;
3. To alter or postpone the method of payment of any benefit; or
4. To amend or rescind any other provisions of the Plan.

No lawsuit or action of any kind may be brought against the Trust based upon a denial of a claim for benefits hereunder without first exhausting the Claims and Appeals Procedures described in this Booklet on page 70.

ALTERNATIVE TREATMENT

The Board of Trustees expressly reserves the right, in its sole and absolute discretion in accordance with procedures specified in the Trust Agreement, to provide Plan coverage for services and supplies which are not ordinarily covered under the terms of the Plan if the Trustees determine that such services or supplies may be provided in lieu of services or supplies ordinarily covered under the terms of the Plan, and that providing Plan coverage for such services and supplies is in the best interests of the Plan.

XXII. VACATION AND HOLIDAY BENEFITS
For Active Participants Only—Not Available to Retired or COBRA Participants

There has been established a joint Vacation and Holiday Account for the purpose of collecting vacation and holiday pay deposited to the account of a Participant.

The Participating Employer shall pay to the Trust Fund the amounts as provided in the Master Collective Bargaining Agreements for the Vacation and Holiday Benefit.

The Participating Employer shall treat such payments for the Vacation and Holiday Benefit as wages and shall make all legal payroll withholding for income tax, Social Security, unemployment insurance, etc., from the total of wages, and shall then transmit the full amount of the Vacation and Holiday contribution each month.

On or about December 1st of any year, the Participant shall be paid all amounts credited to the Participant for hours worked in January through June and for which the Participating Employer has made contributions. On or about April 1st of any year, the Participant shall be paid all amounts credited for hours worked in July through December, for which the Participating Employer has made contributions.

In addition to the December 1st and April 1st Vacation and Holiday Benefit payouts, a Participant may make *two emergency withdrawals per calendar year* of Vacation and Holiday Benefit amounts which have accumulated on his/her behalf at the time of the Participant's written request for an emergency withdrawal. Emergency withdrawals may be made at any time during the year except between November 15th to December 7th, and from March 15th to April 7th. Emergency withdrawals will only be permitted when the Participant is working for a Participating Employer bound to a current agreement requiring contributions to the Plan, or the Participant is on the out-of-work list at the Local Union and is available for work, or the Participant is disabled. However, any interest which may have been payable on the withdrawn amount is automatically forfeited upon emergency withdrawals. In addition, the Trust's policy of two emergency withdrawals per calendar year will be strictly enforced and there will be no provision for a third emergency withdrawal within a calendar year, no matter how severe the circumstances for requesting it may be.

When no transactions have taken place in a Participant's account for three (3) years, the monies in such account shall be used to pay necessary administrative expenses of the Fund. If no such money is available, a uniform amount shall be deducted from interest or dividends of all Participants' accounts for such administrative expenses.

When a Participant dies, any monies on deposit for the Participant are paid to the Participant's spouse, or, if none, to the deceased Participant's estate.

The Vacation and Holiday Benefit is covered under the Health and Welfare Trust Fund.

XXIII. INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

1. Name of Plan.

This Plan is known as the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund.

2. Plan Administrator and Sponsors.

The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan Participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974.

The Plan Sponsors are:

Airconditioning and Refrigeration Contractors
Association of Southern California and
Other Signatory Employers
3602 Inland Empire Boulevard, Suite B-206
Ontario, California 91764
Telephone: (909) 477-4515

Airconditioning and Refrigeration Fitters
Division, Local #250, United Association
18355 South Figueroa Street
Gardena, California 90248
Telephone: (310) 660-0045

3. Names, Titles and Addresses of the Board of Trustees.

The Board of Trustees consists of an equal number of employer and union representatives, selected by the employers and unions, in accordance with the Agreement and Declaration of Trust which relates to this Plan. As of October 2003, the Trustees of this Plan are:

Labor Trustees

Paul Evans
Local Union 250
18355 S. Figueroa Street
Gardena, CA 90248

Jack Ferrara
So. Calif. Pipe/Dist. Council 16
501 Shatto Place, Suite 400
Los Angeles, CA 90020

James Green
Mesa Energy Systems
5 Vanderbilt
Irvine, CA 92618

Arthur Guzman
Local Union 250
18355 S. Figueroa Street
Gardena, CA 90248

Donald Tanaka
Local Union 250
18355 S. Figueroa Street
Gardena, CA 90248

Daniel Wheeler
Local Union 250
18355 S. Figueroa Street
Gardena, CA 90248

Management Trustees

Peter Buongiorno
Barr Engineering
12612 Clark Street
Santa Fe Springs, CA 90670

D.S. O'Brien
Cal-Air Conditioning Service
12393 Slauson
Whittier, CA 90606

Richard J. Sawhill
ARCA/MCA
3602 Inland Empire Blvd, Suite B-206
Ontario, CA 91764

David G. Smith
Key Industrial Refrigeration
10905 Laurel Avenue
Santa Fe Springs, CA 90670

Joseph F. Urban
Thermalair, Inc.
1140 Red Gum Street
Anaheim, CA 92806

Kenneth B. Westphal
ACCO Engineered Systems
6265 San Fernando Road
Glendale, CA 91201

The Trustees have engaged a full-time staff (the "Trust Fund Office") to perform the routine administration of the Plan. The Plan Administrator is:

Bonnie L. Maraia
Airconditioning and Refrigeration Industry
Health and Welfare Trust Fund
1380 S. Sanderson Avenue
Anaheim, CA 92806
Telephone: (714) 917-6100

You may also use this address and phone number if you wish to contact the Board of Trustees.

4. IRS Identification Numbers.

The number assigned to the Plan by the Internal Revenue Service is 95-6041105. The plan number is 501.

5. Agent for Service of Legal Process.

The name and address of the agent designated for the service of legal process is:

Bonnie L. Maraia
Administrator
Airconditioning and Refrigeration Industry
Health and Welfare Trust Fund
1380 S. Sanderson Avenue
Anaheim, CA 92806
Telephone: (714) 917-6100

Legal process may also be served on a Plan Trustee.

6. Collective Bargaining Agreement.

Contributions to this Plan are made on behalf of each employee in accordance with Collective Bargaining Agreements between the Airconditioning and Refrigeration Contractors Association of Southern California and Airconditioning and Refrigeration Fitters Division, Local 250, United Association, and Participation Agreements.

The Trust Fund Office will provide you, upon written request, a copy of the Collective Bargaining Agreement. The Collective Bargaining Agreement is available for examination at the office of the Plan Administrator.

7. Source of Contributions.

The benefits described in this section are provided through employer contributions to this Plan. The amount of employer contributions to this Plan is determined by the provisions of the Collective Bargaining Agreements with employer representatives. The Collective Bargaining Agreements require contributions to this Plan at a fixed rate per hour worked.

The Trust Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants under a Collective Bargaining Agreement or Participation Agreement, and if so, the employer's address.

8. Type of Plan.

This Plan is maintained for the purpose of providing Vacation-Holiday, Death, Accidental Death and Dismemberment, Hospital/Medical, Weekly Accident and Sickness, Dental, Drug, Physical Examination, Wellness, and Vision Care benefits in the event of sickness or accident for Active Journeymen, Apprentices, Apprentice Trainees, Retirees, and their covered Dependents and beneficiaries.

9. Funding Medium.

The Plan's assets and reserves are held in trust by the Board of Trustees (item number 3) of the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund, and are invested in various bank savings accounts and short-term bank investments, government and corporate bonds and certain other investments approved by the Trustees.

10. Identity of Provider of Benefits.

All benefits described in this Booklet are provided directly by the Plan itself, or through providers with which the Plan has contracted. The Plan has administrative service agreements with Express Scripts, VSP, Continuum, AHF, ppoNEXT, and Interplan Corporation. Optional medical programs are provided by PacifiCare and Kaiser, and an optional dental program is provided by United Concordia Dental Plan. PacifiCare, Kaiser and United Concordia pay claims and handle claims appeals related to their programs of benefits.

PacifiCare, Kaiser and United Concordia will supply you, upon request, written materials concerning the nature of services provided, conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the Plan) and circumstances under which such services may be denied, the procedures to be followed in obtaining such services, and the procedures available for the review of claims for services which are denied in whole or in part. Requests for such materials may be addressed to the Trust Fund Office at 1380 S. Sanderson Avenue, Anaheim, CA 92806.

HEALTH PROVIDERS FOR THE PLAN

Airconditioning and Refrigeration Industry Joint Trust Funds *

1380 S. Sanderson Avenue
Anaheim, CA 92806

Administers the fee-for-service medical and dental plans; does not guarantee payment of benefits.

Affiliated Health Funds

100 East Corson Street
Pasadena, CA 91103

Administers preferred provider contracting program for the fee-for-service medical plan; does not guarantee payment of benefits.

Continuum

10920 Via Frontera
San Diego, CA 92127-1704

Administers routine physical exam benefits; does not guarantee payment of benefits.

Express Scripts *

P.O. Box 2205
Walnut, CA 91788

Administers prescription drug plan for the fee-for-service medical plan; does not guarantee payment of benefits.

Interplan Corporation

2575 Grand Canal Boulevard, Suite 200
Stockton, CA 95207

Administers preferred provider contracting program for the fee-for-service medical plan; does not guarantee payment of benefits.

Kaiser Permanente*

Walnut Center
393 East Walnut Street
Pasadena, CA 91188

Provides prepaid medical benefits, with guaranteed payment of these benefits.

MDIA

20700 Ventura Boulevard
Woodland Hills, CA 91364

Administers MRI and CAT scan benefits; does not guarantee payment of benefits.

MEDFOCUS Radiology Network

2811 Wilshire Blvd, #900
Santa Monica, CA 90403

Administers MRI and CAT scan benefits; does not guarantee payment of benefits.

PacifiCare *

5856 Corporate Avenue
Cypress, CA 90630

Provides prepaid medical benefits, with guaranteed payment of these benefits.

ppoNEXT

6702 N. Inglewood Ave., Suite G
Stockton, CA 95207

Administers preferred provider contracting program for the fee-for-service medical plan; does not guarantee payment of benefits.

PHM Diagnostics

20700 Ventura Blvd., Suite 100
Woodland Hills, CA 91364

Administers MRI and CAT scan benefits; does not guarantee payment of benefits.

United Concordia *

21700 Oxnard Street, Suite 500
Woodland Hills, CA 91367

Provides prepaid dental benefits, with guaranteed payment of benefits.

Vision Service Plan *

3333 Quality Drive
Rancho Cordova, CA 95670

Administers vision plan; does not guarantee payment of benefits.

** These providers process and pay claims and handle claims appeals related to their programs of benefits.*

11. Fiscal Plan Year.

The fiscal records of the Plan are kept separately for each Fiscal Plan Year. The Fiscal Plan Year begins January 1 and ends December 31.

12. The Plan's Requirements with Respect to Eligibility for Participation and Benefits.

The eligibility requirements are specified in this Booklet.

13. Circumstances Resulting in Disqualification, Ineligibility or Denial or Loss of Benefits.

Loss of eligibility is described in this Booklet.

14. Procedure to Follow for Filing a Claim.

The procedure to be followed in filing a claim for benefits is described in this Booklet. If you are covered by PacifiCare, Kaiser, or United Concordia Dental Plan, refer to their benefits booklets for information on how to obtain services.

15. Claims and Appeals Procedures.

The following rules apply to the Fee-For-Service Medical and Dental Plans. For PacifiCare, Kaiser and United Concordia Dental Plan, refer to the claims appeals procedures in the benefits booklets issued by these organizations.

Types of Claims. When a Claim for specific Health Plan benefits (a "Claim," as defined on page 23) is submitted to the Trust Fund Office, it is identified as a Pre-Service Claim, an Urgent Care Claim, a Post-Service Claim, or a Concurrent Care Claim.

A Pre-Service Claim is a Claim for a benefit for which the Plan requires approval before medical care is obtained. An example would be a request for prior approval of an organ transplant.

An Urgent Care Claim is a pre-service Claim for medical care or treatment that, if normal "pre-service" Claim standards are applied, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A Concurrent Care Claim is a Claim to continue a previously approved ongoing course of treatment. Examples would be (i) a claim to reinstate a previously approved five-day inpatient hospital stay after the Trust Fund Office determined, upon review of the claim, that it was appropriate to reduce the hospital stay to three days; or (ii) a claim to extend to eight days an inpatient hospital stay originally approved for five days.

A Post-Service Claim is a Claim for benefits that is not a Pre-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim. An example would be a Claim for benefits for physician services already provided.

Initial Benefit Determination. Claims are processed according to the Plan's rules. The initial determination of your Claim, made by the Trust Fund Office, will be provided in writing. As described below, in the case of Urgent Care Claims, notification may initially be provided orally and then confirmed in writing. The initial determination will be provided to you according to the following time frames and will include detailed information concerning the basis for the decision and your appeal rights.

Urgent Care Claims. The Trust Fund Office will notify a claimant of an initial determination regarding an Urgent Care Claim within 72 hours after receipt of the Claim. If notification is provided orally, the claimant will be provided with written confirmation within 3 days after oral notification. If the Trust Fund Office notifies the claimant within 24 hours of receipt of the Claim that additional information is needed to make a determination on the Claim, the claimant will have 48 hours to respond. The deadline for the initial determination will then be suspended for 48 hours or until the information is received.

Pre-Service Claims. The Trust Fund Office will notify a claimant of an initial determination regarding a Pre-Service Claim within 15 calendar days after receipt of the Claim (30 days if the Trust Fund Office notifies the claimant prior to the end of the initial 15-day period that additional information is needed). If additional information is needed from the claimant, the claimant will have 45 days to provide such information. If the Trust Fund Office requests additional information from the claimant, the claimant will be notified of the decision within 15 days after the additional information is received or the end of the 45-day response period, whichever is earlier.

Post-Service Claims. The Trust Fund Office will notify a claimant of an initial determination regarding a Post-Service Claim within 30 calendar days from receipt of the Claim (45 days if the Trust Fund Office

notifies the claimant prior to the end of the initial 30-day period that additional information is needed). If additional information is needed from the claimant, the claimant will have 45 days to provide such information. If the Trust Fund Office requests additional information from the claimant, the claimant will be notified of the decision within 15 days after the additional information is received or the end of the 45-day response period, whichever is earlier.

Concurrent Care Claims. In the event of a decision to *reduce or terminate* a previously approved ongoing course of treatment, the Trust Fund Office will notify the claimant early enough to allow the claimant to have an appeal of such decision decided before the benefit is reduced or terminated. If a request is made to *extend* a course of treatment beyond the period of time or number of treatments previously approved, and the treatment *does not involve urgent care*, the request will be treated as a new benefit claim and decided within the time frames applicable to Pre-Service Claims or Post-Service Claims. If a request is made to *extend* a course of treatment that *does involve urgent care*, the request will be acted upon by the Trust Fund Office within 24 hours of receipt of the claim, provided the Claim is received at least 24 hours prior to the expiration of the approved treatment. If the request to extend a course of treatment involving urgent care is not received at least 24 hours prior to the expiration of the approved treatment, the request will be treated as an Urgent Care Claim and will be processed in accordance within the time frames applicable to such claims.

First Appeal of Adverse Benefit Determination. If you receive from the Trust Fund Office an answer to a Claim with which you disagree, you or a duly authorized representative of your choice may request a review of the decision. The request for review must be in writing and submitted to the Trust Fund Office (with the exception of urgent care appeals, which may be oral). The request for review must be received by the Trust Fund Office within 180 days from the date of your receipt of the answer with which you disagree. Late requests may be rejected as untimely. You may submit any additional evidence or argument to support your position. You may also be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your Claim for benefits.

A review will then be made by the Benefits Committee, which is a Committee of the Board of Trustees of the Plan whose members are appointed by the Board. The Benefits Committee will independently consider all comments, documents, records and other information submitted by you or your authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. In addition, if the initial benefit determination was based in whole or in part on a medical judgment, the Benefits Committee will consult with an independent health care professional who was not consulted for the initial benefit determination. The name and address of any medical or vocational expert consulted in connection with your denied claim will be provided to you upon request.

You will be advised in writing of the decision of the Benefits Committee. This will include a written explanation giving detailed reasons for any denial, specific reference to the Plan provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary, and a description of the Plan's review procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following completion of the Plan's appeals procedures.

The explanation of the Committee's decision will be provided to you within the following time frames:

Urgent Care Claims: Within 72 hours after receipt of the first appeal.

Pre-Service Claims: Within 15 days after receipt of the first appeal.

Post-Service Claims: Within 30 days after receipt of the first appeal.

Concurrent Care Claims: Same as Initial Benefit Determination (see Concurrent Care Claims.)

Second Appeal of Adverse Benefit Determination. The determination of the Benefits Committee is appealable to the Appeals Committee. The Appeals Committee is a Committee of the Board of Trustees of the Plan whose members are appointed by the Board. The Appeals Committee and the Benefits Committee are composed of different individuals; there is no overlap. After the written explanation concerning the Benefits Committee's determination is received, if you believe you are adversely affected by such decision you or a duly authorized representative of your choice may file a request for an appeal to the Appeals Committee.

The request for appeal must be in writing and submitted to the Trust Fund Office. The request for appeal must be received by the Trust Fund Office within 180 days from the date of your receipt of the written explanation of the Benefits Committee's determination. Late requests may be rejected as untimely. You may submit any additional evidence or argument to support your position. You may also be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your Claim for benefits.

The request for appeal must contain an outline of the matter involved along with any issues, comments or explanations of the claimant's position. Additional written documentation may also be submitted. The claimant may also request that the claimant and/or the claimant's authorized representative be present at the Appeals Committee meeting. A notification of the meeting date and time will then be sent to the claimant who asks for an appearance. Additional evidence can be presented at the Appeals Committee meeting.

The Appeals Committee will independently consider the appeal using the written application presented by you, and/or by hearing the appeal of the individual who has requested a personal appearance at the Appeals Committee hearing. You will be advised in writing of the decision of the Appeals Committee. This will include a written explanation giving detailed reasons for any denial; specific reference to pertinent Plan provisions or documents on which the decision is based; a statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and a statement of your right to bring a civil action under Section 502(a) of ERISA.

The decision of the Appeals Committee will be given to you within the following time frames:

Urgent Care Claims: Within 15 days after receipt of the first appeal.

Pre-Service Claims: Within 15 days after receipt of the second appeal.

Post-Service Claims: Within 30 days after receipt of the second appeal.

Concurrent Care Claims: Same as Initial Benefit Determination (see Concurrent Care Claims)

The decision of the Appeals Committee is final and binding upon the claimant.

This appeals procedure shall be the sole and exclusive procedure available to an individual who is dissatisfied with a Claim or eligibility decision of any kind relating to a covered Claim. The Plan's appeals

procedures must be exhausted before the claimant can avail himself of any procedure outside of the rules and regulations of the Plan itself. However, with respect to Urgent Care Claims only, claimants need not file an appeal with the Appeals Committee before resorting to outside procedures; in such instances the decision of the Benefits Committee shall be considered the final decision of the Plan binding upon the claimant.

16. Your Rights Under ERISA.

As a Participant in the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage.
- Receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another plan. To receive such a reduction or elimination, you must present a certificate of creditable coverage. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Obligations of Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

Obligations of Employers

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.

Enforcing Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Trust Fund Office at (714) 917-6100. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Fund Office, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration at (866) 275-7922.

This Booklet contains a summary in English of your Plan rights and benefits under the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund. If you have difficulty understanding any part of this booklet, contact the Trust Fund Office, located at 1380 S. Sanderson Avenue, Anaheim, CA 92806. The office hours are from 8:00 a.m. to 4:00 p.m., Monday through Friday. You may also call the Trust Fund Office at (714) 917-6100 for assistance.

Nothing in the foregoing Statement of ERISA Rights is meant to interpret or extend or change in any way the provisions expressed in the Plan.

The Board of Trustees reserves the right to amend, modify or discontinue all or part of this Plan at any time and for any reason, in its sole and absolute discretion in accordance with procedures specified in the Trust Agreement. The provisions of the Plan cannot be modified or amended in any way by any statement or promise made by any other person, including employees of the Union or any employer. The Board of Trustees has full discretion and authority to determine questions concerning the interpretation or administration of the Plan including, without limitation, all questions relating to eligibility for Plan benefits, and the determinations of the Board shall be conclusive and binding as to all persons and for all purposes.