AIRCONDITIONING AND REFRIGERATION INDUSTRY
HEALTH AND WELFARE
TRUST FUND

BASIC BENEFITS REFERENCE BOOKLET

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AIRCONDITIONING AND REFRIGERATION INDUSTRY HEALTH AND WELFARE TRUST FUND

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IMPORTANT INFORMATION REGARDING THIS BOOKLET

This Basic Benefits Reference Booklet provides an overview of the coverage available through the Airconditioning and Refrigeration Industry Health and Welfare Trust (the "Plan"). The booklet is comprised of excerpts of certain sections of the complete Summary Plan Description and is provided for your convenience only. It is not designed to be a complete recitation of the Plan's benefits and eligibility rules.

You should only use this booklet as a reference guide to your benefits, and you should consult the complete Summary Plan Description for additional details if you intend to obtain benefits provided under the Plan. In addition, this booklet does not contain information regarding COBRA coverage continuation rights or the Plan's claims and appeals procedures; such information can be found in the Summary Plan Description.

If there is any difference between this booklet and the Summary Plan Description, the Summary Plan Description will control. This booklet does not provide any benefit that is not contained in the Summary Plan Description.

Should you have any questions, or if you would like additional information, please visit the Trust's website by going to *www.acrtrust.org*. You may also contact the Trust Fund Office at the address and phone number above.

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ELIGIBILITY RULES FOR ACTIVE PARTICIPANTS

[Additional information regarding Eligibility Rules for Active Participants can be found in Section I of the Summary Plan Description]

INITIAL AND CONTINUING EMPLOYEE ELIGIBILITY

For Active Employees

If you are an active employee working for a Participating Employer covered under the terms of a Collective Bargaining Agreement with the Union or a participation agreement with the Trust, you will be eligible to participate in this Plan as an active Participant on the first day of the month following the month in which any contributions are due, provided contributions are received from your employer before that date. If contributions are not received prior to that date, you will be given retroactive eligibility to the date you should have been eligible as soon as the contributions are received. Contributions from your Employer are due in the month following the month in which hours are worked. For example:

- If hours are worked in January with contributions due and received in February, you will be eligible on the first day of March
- If hours are worked in January with contributions received in March or later you will receive retroactive eligibility to the first day of March as soon as the contributions are received.

Your initial eligibility as described above will be granted regardless of the number of hours worked in the first month in which you perform covered work. Thereafter, contributions for at least 100 hours per month must be reported and paid to this Plan to maintain continuous eligibility without reliance on an hour bank as described below.

An hour bank will not be established for the first six months of your eligibility. After six months of eligibility, an hour bank will begin to accumulate for all hours reported and paid to this Plan in excess of the 100 hours per month, subject to a maximum hour bank limitation of 600 hours.

ELIGIBLE DEPENDENTS

Your lawful spouse (as defined by federal law) is eligible as a Dependent. Your unmarried natural or legally adopted children, or children placed for adoption, stepchildren or dependents under a formal guardianship are also eligible as Dependents provided they are less than 19 years of age and dependent upon you for support and maintenance and satisfy certain other requirements.

Children born out of wedlock who meet the above requirements will be considered eligible Dependents if the eligible Participant can show satisfactory proof of parentage, i.e., a certified 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.

Benefits for your Dependents begin on the later of:

1. the date you become eligible;
2. for your lawful spouse, the date of your marriage;
3. for your natural children, the child’s date of birth;

4. for adopted children, the date of adoption or placement for adoption with you, whichever is earliest;
5. for stepchildren, the date of your marriage to the child's natural parent;
6. for children under a formal guardianship, the date you are appointed by the court as legal guardian.

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.

ELIGIBILITY FOR CHILDREN OF DIVORCED PARTICIPANTS

If you are divorced, your natural or adopted children of that marriage are eligible dependents if they meet all other requirements for eligibility. The divorced spouse of a Participant may also provide for eligibility of the natural or adopted children of that marriage by obtaining a Qualified Medical Child Support Order (QMCSO).

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order issued either by a court of competent jurisdiction or through an administrative process established under state law which has the force and effect of law in that state. See the Summary Plan Description for more information.

CONDITIONS UNDER WHICH PARTICIPANT ELIGIBILITY ENDS

1. After the second month of eligibility and before an hour bank is established, your eligibility will terminate if contributions for at least 100 hours per month are not reported and paid by your employer to this Plan.

2. After establishing an hour bank, your eligibility will terminate on the first day of the month in which the hours in your hour bank total less than 100.

   NOTE: all hours in your hour bank will be forfeited if the balance stays below 100 hours for 24 consecutive months.

3. Eligibility for you and your Dependents will cease on the day you start performing work in Non-Covered Air Conditioning and Refrigeration Service.

   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 working in Non-Covered Air Conditioning and Refrigeration Service, your benefits will be immediately suspended. The suspension will be final and binding on all persons affected by the decision, subject to the provisions for appeal as set forth in the Summary Plan Description.

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 will be suspended if the employer is delinquent in payment of any contributions due pursuant to the Collective Bargaining Agreement requiring contributions to this Trust. The suspension will remain in effect until such time as the delinquency is paid in full.

5. If you continue working for an employer that is delinquent in payment of any contributions due pursuant to the Collective Bargaining Agreement requiring contributions to this or any related Trust, and the Local Union has notified you in writing that you are to discontinue working for your employer because of its delinquency, your eligibility and your Dependents' eligibility for benefits will be suspended until the employer has paid all delinquencies in full, or until you are notified in writing that you may resume your employment by the Local Union, whichever first occurs.

CONDITIONS UNDER WHICH DEPENDENT ELIGIBILITY ENDS

Eligibility for your Dependents will terminate on the first day of the month following any of these events:

1. the date of entrance into full-time active duty with the Armed Forces of the United States;
2. the date your eligibility terminates;
3. the date they no longer meet the Plan's definition of a Dependent.

When your Dependents lose coverage under the Plan, they may be entitled to elect to continue coverage for up to 36 months under the COBRA option.

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:

1. divorce/final dissolution of marriage of the employee/spouse
2. legal separation of the employee/spouse
3. death of the Participant or Dependent
4. a dependent child over 19 who is no longer enrolled as a full-time student
5. a dependent is providing more than one half of his/her own support
6. a dependent being employed with his/her own health coverage
7. any other event which would make your Dependent not eligible for further coverage.

Notice of a change in Dependent status must be made in writing, signed by the Participant. Changing your designated beneficiary for death benefits is not an acceptable notification of divorce or other change in Dependent status.

> ***NOTE:*** ***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 he/she is eligible for and elects to purchase COBRA continuation coverage.***

In the event of your death as 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 were 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, you may be eligible to pay to continue coverage for yourself and your Dependents through COBRA Continuation Coverage. Please see the COBRA section in the Summary Plan Description for more information.

CREDIT FOR DISABILITY HOURS FOR ACTIVE PARTICIPANTS

If you become Totally Disabled due to an illness or injury while eligible, benefits for you and your eligible dependents will be continued without monthly deduction from your hour bank for the period of "Total Disability" but not for more than 12 months.

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 will be frozen and used to re-establish eligibility when you are no longer disabled.

ELIGIBILITY RULES FOR RETIRED PARTICIPANTS

[Additional information regarding Eligibility Rules for Retired Participants can be found in Section II of the Summary Plan Description]

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 self-payments, subject to all of the following:

1. You have at least fifteen (15) years accredited service with Participating Employers (as determined under the Retirement Trust Fund)
2. You were eligible as an active Participant immediately before the date of your retirement, except as set forth below

<u>If you fail to elect coverage at the time of your retirement, or later discontinue coverage at any time, you will not be allowed to reenroll in retiree coverage thereafter.</u>

When Retiree Coverage Terminates

If, as a retiree of the Airconditioning and Refrigeration Industry Retirement Trust Fund, you begin working in Non-Covered Employment the eligibility of yourself and all Dependents will immediately be terminated and any hours remaining in your hour bank will be forfeited. In addition, you will not be able to regain eligibility until you return to covered employment and have contributions made on your behalf for the same length of time as you were in Non-Covered Employment.

How Much Are The Monthly Retiree Self-Payments?

The retiree self-pay is determined by multiplying the current cost of retiree coverage by a "Self-Pay Percentage". The cost of coverage depends on whether the retiree is enrolled in the Fee-For-Service Plan or in an HMO (Blue Shield of California or Kaiser), and on whether the retiree is eligible for Medicare. If either you or your spouse have other insurance resulting in the Trust being secondary to the

other insurance, your self pay, if you are enrolled in the Fee-for-Service Plan, will be determined as if you and/or your spouse were Medicare eligible.

The Trust Fund Office will notify you annually of the current costs of coverage. Adjustments to the costs of coverage will be effective September 1 each year.

To determine your Self-Pay Percentage first start with the “Basic Percentage” of 50%. The Basic Percentage will be adjusted according to the following rules:

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 accredited service, subtract 2% from the Basic Percentage for each additional year of accredited service over 25 years.
3. If you have less than 25 years of accredited service, add 2% to the Basic Percentage for each year below 25 years. (This adjustment will not apply if you are receiving a Disability Pension as set forth below)
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 you are married, the Self-Pay Percentage will also apply to the cost of coverage for your spouse.

Calculation of Self-Pay Percentage for Disabled Retirees: The Self-Pay Percentage for a retiree that is receiving a Disability Pension will be calculated as set forth above, then modified as follows:

1. If the disabled retiree has no spouse or Dependent children, the Self-Pay Percentage will be one half (1/2) of the percentage determined above;
2. If the disabled retiree has a spouse but no Dependent children, the Self-Pay Percentage will be two thirds (2/3) of the percentage determined above;
3. If the disabled retiree has a spouse and Dependent children, the Self-Pay Percentage will be three fourths (3/4) of the percentage determined above;

The appropriate Self-Pay amount will be deducted from your monthly pension check. The Trustees reserve the right to change the amount of the required self-pay at any time and in any manner.

Are My Dependents Eligible?

For Those Receiving a Disability Pension

Your lawful spouse is eligible as a Dependent provided you have been married for at least one year and are not legally separated.

Your unmarried natural or legally adopted children, or children placed for adoption, stepchildren, or children under a formal guardianship are eligible as Dependents if they meet all the eligibility requirements as set forth above.

For Retirees Not Receiving a Disability Pension

Your lawful spouse is eligible as a Dependent provided you have been married for at least one year and are not legally separated.

Your unmarried natural children, legally adopted children or children placed for adoption, stepchildren, or children under a formal guardianship that are incapable of self-support because of being permanently physically or mentally incapacitated are eligible so long as they meet all the eligibility requirements as set forth on page 1 above.

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;
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; or
4. The first day of the month in which you work in Non-Covered Air Conditioning and Refrigeration Service.

When Will My Dependent's Eligibility End?

The rules for ending the eligibility for Dependents of retirees are the same as those for active Participants.

MEDICAL AND DENTAL PLAN CHOICES

[Additional information regarding Medical and Dental Plan Choices can be found in Section III of the Summary Plan Description]

MEDICAL PLAN CHOICES

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

1. **Two prepaid (HMO) health plans are currently provided through either Blue Shield of California or Kaiser**. You must live within the service area of the HMO's service providers in order to enroll in one of the HMO's. 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, prescriptions and supplies. However, the Fee-For-Service Plan will continue to provide you with Vision, Hearing Aid, and Chiropractic benefits. The Hearing Aid and Chiropractic benefits will be paid at Non-PPO Provider rates.

2. **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 all medical and prescription benefits. It is recommended that you go to a Preferred Provider Organization (PPO) facility. Doing so will reduce your out-of-pocket expenses, as explained below.

DENTAL PLAN CHOICES

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

1. **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. You must use only dentists that are contracted with United Concordia.

2. **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. The Trust Fund has contracted with Delta Dental for claim processing and administration services.

When to Make Your Health Plan Selections

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 once during any 12 consecutive month period.

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:

- Blue Shield of California HMO and United Concordia Dental Plan
- Kaiser and United Concordia Dental Plan
- Blue Shield of California HMO and Delta Dental Fee for Service Dental Plan
- Kaiser and Delta Dental Fee for Service Dental Plan
- Fee for Service Medical Plan and United Concordia Dental Plan
- Fee for Service Medical Plan and Delta Dental Fee for Service Dental Plan

FEE FOR SERVICE MEDICAL BENEFITS

[Additional information regarding Fee for Service Medical Benefits can be found in Section IV of the Summary Plan Description]

The medical benefits provided for you and your eligible Dependents are summarized in the following pages. The cost for these services and supplies will be reimbursed based on **Allowable Charges**. Please refer to the definition of "Allowable Charges" in the Summary Plan Description. 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.

<u>Lifetime Maximum Benefit</u>

The lifetime maximum benefit is $2,000,000 per person. This means that no more than $2,000,000 will be paid in medical benefits for a covered Participant or eligible Dependent.

Calendar Year Deductible and Out-of-Pocket Maximum

A deductible of $150 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.

Once the calendar year deductible is satisfied, 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 by a PPO contracted provider, including their deductible. Charges by Non-PPO providers do not apply towards the out-of-pocket maximum.

Services Received Outside United States

If you are enrolled in the Fee for Service Plan and you or your eligible Dependent receive medical services outside the United States, you must pay the provider directly then submit the claim to the Trust Office for reimbursement. The claim must be itemized and translated into English. If the claim would have been covered had the services been rendered in the United States, the Plan will reimburse you an amount in United States dollars equivalent to 90% of the Allowable Charges by a PPO contracted provider, and 60% of Allowable Charges by a Non-PPO contracted provider.

Use of PPO Providers

If you or any of your eligible Dependents obtain services from a hospital, physician, or other provider contracted with the Trust's Preferred Provider Organization (PPO) the percentage of covered expenses payable by the Plan will be higher, and your out-of-pocket expenses will be lower.

The contracted PPO network within California is Blue Shield of California. Outside of California the Trust's PPO network is the Blue Cross / Blue Shield network. See the Summary Plan Description on how to select a PPO provider.

Why Use PPO Physicians and Hospitals?

- The Plan will pay 90% of Allowable Charges if you use a PPO provider. You pay only the remaining 10% of the Allowable Charges.
- If you use a Non-PPO provider, the Plan will pay only 60% of Allowable Charges. In addition, charges for Non-PPO providers do not count toward your out-of-pocket maximum.
- PPO providers cannot charge you more for a covered service than the Allowable Charges, but Non-PPO providers can charge any amount they wish. This is important to remember because the Plan will only pay 60% of the *Allowable Charges* for the services by a Non-PPO provider. That means you will have to pay the *entire balance* of the amount billed. For example, if a Non-PPO provider charges $1,000 for a procedure that the Plan shows has an Allowable Charge of only $800, the Plan will pay 60% of the $800 Allowable Charge ($480), and you must pay the entire balance of $520. If you had used a PPO provider, the Plan would have paid 90% of the $800 Allowable Charge ($720) and you would have to pay only $80. A savings to you of $440.

IMPORTANT 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 contracted with the Trust's PPO network.

Claims of Non-PPO providers will be paid at 60% of the Allowable Charges unless the member and/or patient had no control over the selection of the Non-PPO provider. If so, the Trust will pay 90% of the allowable charges. Examples of the inability to control the selection of a Non-PPO provider are:

- An emergency room physician in a qualified emergency;
- The selection of an assistant surgeon or physician assistant by a surgeon;
- A physician ordering tests be done by a Non-PPO lab.

NOTE: This exception does not apply if the member and/or patient could have controlled the selection of the Non-PPO provider by proper planning.

Below is a brief summary of the benefits available to active and retired eligible Participants and their eligible Dependents.

If you are enrolled in the Fee for Service Medical and/or Dental Plan, please see Section III of the Summary Plan Description for detailed information on your benefits.

If you are enrolled in Blue Shield, Kaiser and/or the United Concordia Dental Plan, please refer to the booklets issued by those providers for additional information.

FEE FOR SERVICE MEDICAL PLAN BENEFITS

Medical Benefits

Inpatient Hospital

- 90% of Allowable Charges at a PPO contracting hospital
- 60% of Allowable Charges at a Non-PPO contracting hospital

Outpatient Hospital

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

Skilled Nursing Facility (Convalescent Hospital)

- 90% of Allowable Charges for PPO contracted facilities
- 60% of Allowable Charges for Non-PPO contracted facilities

NOTE: This benefit is limited to a maximum of 365 days per lifetime.

Physician Services

- 90% of Allowable Charges for PPO providers
- 60% of Allowable Charges for non- PPO providers

All Other Medical Services (unless otherwise stated)

- 90% of Allowable Charges for PPO providers
- 60% of Allowable Charges for Non-PPO providers

Benefits for Mental Health Services

Inpatient

- 90% of Allowable Charges for PPO providers
- 60% of Allowable Charges for non- PPO providers

Outpatient

- 90% of Allowable Charges for PPO providers
- 60% of Allowable Charges for non- PPO providers

Alcohol and Drug Abuse Benefits

Inpatient

- 90% of Allowable Charges for PPO providers
- 60% of Allowable Charges for non- PPO providers

Outpatient

- 90% of Allowable Charges for PPO providers
- 60% of Allowable Charges for non- PPO providers

Physician

- 90% of Allowable Charges for PPO providers
- 60% of Allowable Charges for non- PPO providers

Acupuncture Benefits

- 90% of Allowable Charges for PPO providers for the first 26 visits per calendar year. 10% of Allowable Charges for each additional visit to a PPO provider during the calendar year.
- 60% of Allowable Charges for non- PPO providers for a maximum of 26 visits per calendar year.

Chiropractic Benefits

- 90% of Allowable Charges for PPO providers for the first 26 visits per calendar year. 10% of Allowable Charges for each additional visit to a PPO provider during the calendar year.
- 60% of Allowable Charges for non- PPO providers for a maximum of 26 visits per calendar year.

Physical Therapy Benefits

- 90% of Allowable Charges for PPO providers for the first 26 visits per calendar year. 10% of Allowable Charges for each additional visit to a PPO provider during the calendar year.
- 60% of Allowable Charges for non- PPO providers for a maximum of 26 visits per calendar year (up to a maximum of $75 per visit) and nothing for more than 26 visits.

Prescription Drug Benefits (Provided by Express Scripts)

Mail Order Pharmacy (90 day supply)

- Participant Copayment:
  - $16 for generic drugs
  - $40 for formulary (preferred) brand name drugs
  - $80 for non-formulary brand name drugs

Retail Pharmacy (30 day supply)

- Participant Copayment:
  - 10% of cost for generic drugs with a $8 minimum and $20 maximum
  - 20% for formulary (preferred) brand name drugs with a $20 minimum and a maximum of $50
  - 40% for non-formulary brand name drugs with a $40 minimum

***NOTE:** 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 the generic equivalent the generic drug*

Vision Therapy Benefits (Subject to $500 lifetime maximum)

- 90% of Allowable Charges for PPO providers
- 60% of Allowable Charges for non- PPO providers

Hearing Aid Benefit

- A maximum of $2000 during any three year period

Benefits for Routine Physical Exams

- $300 per individual, per calendar year maximum for Participants and their eligible spouses only. This benefit is not subject to the annual deductible.

Wellness Program Benefits

Immunizations and Flu Shots

- 100% of Allowable Charges. The office visit is not covered.

Screening mammograms

- 100% of Allowable Charges, including the examination and test. This benefit is limited to once for women age 35-39, and once a year for women age 40 and over.

Prostate Screening

- 100% of Allowable Charges, including the examination and test. This benefit is limited to one rectal exam and PSA blood screening per calendar year for men age 50 and over.

Hospice Benefits

- 90% of Allowable Charges for PPO providers
- 60% of Allowable Charges for non- PPO providers

NOTE: Hospice benefits are limited to a lifetime maximum of $10,000

HMO MEDICAL PLAN BENEFITS

Basic Medical and Drug Benefits

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

Medical Benefits Provided by the Fee for Service Plan

The following benefits are provided by the Fee for Service Medical Plan even if you are enrolled in an HMO Plan. The benefits are:

Chiropractic Benefits

- 60% of Allowable Charges for a maximum of 26 visits per calendar year.

Hearing Aid Benefit

- A maximum of $2000 during any three year period

These benefits are subject to the $150 Fee for Service Plan deductible.

DENTAL BENEFITS

[Additional information regarding Dental Benefits can be found in Section VI of the Summary Plan Description]

While you and your spouse and/or Dependent children 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.

   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.** Delta Dental is the administrator for the Trust Fund Fee-For-Service Dental Plan. Under the Fee-For-Service Dental Plan, benefits will be processed by Delta Dental. 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 at the lesser of 100% of the Trust’s Schedule of Dental Procedures, the Delta Dental PPO contracted rate, or the Delta Dental Premier contracted rate, 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.

You have the option of going to any licensed dentist in the United States; however, if you use a Delta PPO or Delta Premier dentist, your out-of-pocket expenses for the service could be less.

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, dental implants or partial complete dentures.
Orthodontics	Procedures associated with straightening and realignment of the teeth and orthodontics are covered with a lifetime maximum of $2,400.

A schedule of dental procedures allowed under the Fee-For-Service Dental Plan is available at www.acrtrust.org.

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.

The following limitations apply to Covered Dental Expenses:

1. Full mouth x-rays are limited to every two years.
2. Bite-wing x-rays are limited to every six months.

VISION CARE BENEFITS

[Additional information regarding Vision Care Benefits can be found in Section VII of the Summary Plan Description]

Vision Care Benefits for You and Your Eligible Dependents

You and your eligible Dependents are also eligible for vision care benefits through Vision Service Plan (VSP) regardless of whether you are enrolled in the Fee for Service or HMO medical plan. Although you do not have to use a VSP provider, your savings will be greater if you do, as outlined below.

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. **Routine Eye Examination** A complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.

   NOTE: If you choose contact lenses, there is an additional exam that will need to be performed. The additional exam is not covered by the Plan, but VSP providers will give you a 15% discount on the cost of the additional exam.

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. This benefit also includes contact 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.

   NOTE: You will not be able to have both contact lenses and frames in the same 12 month period.

4. **Benefit Amount for Active Participants** The Plan will pay the following for Active Participants and their eligible Dependents:

Benefit	Frequency	VSP Provider	Non-VSP Provider
Eye Exam	Every 12 months	100% after $20 copay	Up to $45
Single Vision Lenses	Every 12 months	100%	Up to $45
Lined Bifocal Lenses	Every 12 months	100%	Up to $65
Lined Trifocal Lenses	Every 12 months	100%	Up to $85

Tints	Every 12 months	100%	$5
Frames	Every 12 months	Up to $120	Up to $47
Contact Lenses	Every 12 months	Up to $120	Up to $105

5. **Benefit Amount for Retired Participants** The Plan will pay the following for Retired Participants and their eligible Dependents:

Benefit	Frequency	VSP Provider	Non-VSP Provider
Eye Exam	Every 12 months	100% after $30 copay	Up to $45
Single Vision Lenses	Every 12 months	100%	Up to $45
Lined Bifocal Lenses	Every 12 months	100%	Up to $65
Lined Trifocal Lenses	Every 12 months	100%	Up to $85
Frames	Every 24 months	Up to $120	Up to $47
Contact Lenses	Every 12 months	Up to $120	Up to $105

ACCIDENT AND SICKNESS WEEKLY BENEFITS FOR ACTIVE PARTICIPANTS

[The information contained below regarding Accident and Sickness Benefits for Active Participants is identical to the information in Section VIII of the Summary Plan Description]

This Benefit is available to **Active Participants Only**.

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

Total Disability resulting from the pregnancy of a female Participant 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 medical doctor. 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.

NOTE: This benefit does not apply to COBRA or Retired Participants.

VACATION AND HOLIDAY BENEFITS

[The information contained below regarding Vacation and Holiday Benefits is identical to the information in Section XVIII of the Summary Plan Description]

For each active participant, each participating employer shall pay to the Health and Welfare Trust Fund a monthly Vacation and Holiday contribution as provided in the Master Service Collective Bargaining Agreement. Such payments shall be held in separate accounts (Vacation and Holiday Accounts) for the benefit of each participant.

Participating Employers shall treat payments for the Vacation and Holiday Benefit as wages and shall make all legal payroll withholdings for State and Federal income tax, Social Security, unemployment insurance, etc., from the participant's wages before transmitting the full amount of the Vacation and Holiday contribution each month.

Choice of Distribution Methods

Participants may choose either monthly direct deposits to their bank account or bi-annual distributions by check.

Monthly Direct Deposits: In order to be eligible for monthly direct deposits, Participants must provide the Trust Office a voided check or deposit slip for the account to which the deposit is to be made. The Participant must be the owner or a co-owner of the account. The voided check or deposit slip must be received by the Trust Office by the 20th day of the month in order for a direct deposit to be made for the following monthly distribution.

The Trust Office will initiate a direct deposit to the account on or about the third business day of each month. The amount deposited will be the balance of the Participant's Vacation and Holiday Account, less administrative fees and authorized PAC donations.

> **IMPORTANT: The account must be open and capable of receiving deposits at the time of the direct deposit.** If not, the funds will be returned to the Trust and unavailable to the Participant until the earlier of:
>
> 1. The next bi-annual distribution as described below, or
> 2. The third business day of the month following the receipt by the Trust Office of a voided check or deposit slip for a valid account.

Bi-Annual Distributions by Check: Those Participants that fail to provide a voided check or deposit slip for direct deposits will receive bi-annual distributions by check. The checks will be mailed on or before the third business day of April and December of each year.

Checks will be for the balance of the Participant's Vacation and Holiday Account, less administrative fees and authorized PAC donations.

<u>NOTE</u>: Emergency withdrawals are not allowed.

<u>Changing Distribution Methods</u>

Participants may change their distribution method at any time. You may choose the direct deposit method simply by providing the Trust Office a voided check or deposit slip by the 20th of the month. If so, you will receive a direct deposit with the following monthly distribution.

Participants can change from the monthly direct deposits to the bi-annual check method by notifying the Trust Office in writing. There is no limit on the number of times a Participant can change distribution methods.

When no transactions have taken place in a Participant's account for three (3) years, the monies in such Vacation and Holiday Account shall be used to pay necessary administrative expenses.

When a Participant dies, any monies in the Participant's Vacation and Holiday Account shall be paid as follows:

a) To the Participant's spouse. If none;

b) To the Participant's probate estate. If none;

c) To the Participant's heirs in accordance with the intestate succession laws of the state where the decedent was domiciled at the time of death.

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