AIRCONDITIONING AND REFRIGERATION INDUSTRY HEALTH AND WELFARE TRUST FUND

ESTABLISHED BY AIRCONDITIONING AND REFRIGERATION FITTERS 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 MAY 2017

AIRCONDITIONING AND REFRIGERATION INDUSTRY
HEALTH AND WELFARE TRUST FUND

3500 W. Orangewood Avenue
Orange, CA 92868
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.

Should you have any questions, please contact the Trust Fund Office at the address and phone number above.

Sincerely,

BOARD OF TRUSTEES

AIRCONDITIONING AND REFRIGERATION INDUSTRY
HEALTH AND WELFARE TRUST FUND

3500 W. Orangewood Avenue
Orange, CA 92868
Telephone: (714) 917-6100

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Provider	Website	Tel. No.
Blue Shield of California	www.blueshieldca.com	(800) 642-6155
Kaiser Permanente (HMO)	www.kaiserpermanente.org	(800) 464-4000
Navitus	www.navitus.com	(866) 333-2757
United Concordia (Prepaid Dental Plan)	www.unitedconcordia.com	(800) 937-6432
Delta Dental	www.deltadentalins.com	(800) 765-6003
Vision Service Plan	www.vsp.com	(800) 877-7195
Trust Fund Office	www.acrtrust.org	(714) 917-6100

GLOSSARY OF ABBREVIATED TERMS:

COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
ERISA	Employee Retirement Income Security Act of 1974
FMLA	Family Medical Leave Act of 1993
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
PPACA	Patient Protection and Affordable Care Act of 2010
PPO	Preferred Provider Organization
QMCSO	Qualified Medical Child Support Order
USERRA	Uniformed Services Employment and Reemployment Rights Act of 1994

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I. ELIGIBILITY RULES FOR ACTIVE PARTICIPANTS

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 300 hours.

ELIGIBILITY AND COVERAGE RULES FOR ORGANIZATIONAL EMPLOYEES

The standard eligibility and coverage rules described above also apply to employees classified as “organizational” employees, as determined by the Union.

In general, “organizational” employees are employees who formerly worked in Non-Covered Air Conditioning and Refrigeration Service and who are now working or going to work as journeymen, apprentices, tradesmen, or MES (mechanical equipment servicemen) for a signatory employer.

ELIGIBLE DEPENDENTS

Your Spouse is eligible as a Dependent. Your 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 younger than 26 years of age.

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.

NOTE: If your spouse has medical coverage available to him/her through his/her employer and declines that coverage, you may be subject to a Spousal Surcharge. Please see rules beginning on page 2 regarding the Spousal Surcharge.

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

Benefits for your Dependents begin on the later of:

1. the date you become eligible;
2. for your 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.

FOR DEPENDENT SPOUSES, AN EMPLOYMENT VERIFICATION AFFIDAVIT MUST ALSO BE ON FILE WITH THE TRUST OFFICE.

Spousal Surcharge

If your spouse is currently eligible to enroll in employer-provided medical coverage, but he or she opts out of that coverage, and enrolls in or continues coverage under the Airconditioning and Refrigeration Industry Health and Welfare Plan, a Spousal Surcharge will apply. This means if a spouse declines his/her employer-sponsored coverage and wishes to remain on this Plan (with this coverage as primary coverage), then you must pay a Spousal Surcharge to this Plan in order for your spouse to maintain Plan coverage.

The Spousal Surcharge will be equal to 100% of the Plan's total health and welfare cost of a dependent spouse as calculated by the Plan's consultants annually. The surcharge includes the cost of medical, dental, and vision coverage, and will depend on the medical and dental plan elected by the Participant. The entire amount of the Spousal Surcharge, as calculated above, will apply regardless of whether a spouse has access to employer-provided dental and/or vision coverage.

Employer-provided coverage includes access to medical benefits (regardless of whether that coverage includes dental or vision coverage) provided directly through the employer (or a plan providing coverage to employees of the employer) that constitute minimum essential coverage (i.e. in the form of an insured or fee-for-service medical benefit plan), and does not include an employer subsidy to provide coverage on the Marketplace (public exchange).

The Trust Office will collect the Spousal Surcharge on a monthly basis. Payment may be made by check or direct-debit. Please contact the Trust Office for additional details regarding payment options. The Spousal Surcharge is due and must be received by the Trust Office by the last day of the month for the next month's coverage.

Payments not received by the 5th day of the coverage month are considered delinquent. If a delinquent payment is not received by the 20th day of the coverage month, your spouse's coverage will terminate and he/she will not be eligible to re-enroll for a period of six months. For example, coverage for May is due by April 30th. If payment is not received by May 5th, the payment is considered delinquent. This delinquent payment must be received by May 20th in order for the spouse to continue coverage. If the delinquent payment is not received by that date, the spouse's coverage will be terminated retroactively to May 1st and he or she will not be able to re-enroll for coverage until November.

It is the member's responsibility to re-enroll a Dependent Spouse by contacting the Trust Office. The Trust Office will not automatically re-enroll a Dependent Spouse. The Plan allows one delinquent payment per calendar year. The second delinquent payment in a calendar year will result in termination of coverage for the Dependent Spouse for a period of six months. The spouse will not be eligible to re-enroll in this Plan until the six-month period has elapsed, and a timely surcharge payment has been received.

The Spousal Surcharge does NOT apply if:

1. The Dependent Spouse does not have access to employer-provided medical coverage.
2. The Dependent Spouse elects his/her employer-provided medical coverage as primary coverage.

NOTE: A Dependent Spouse may enroll for or continue secondary coverage under this Plan. The Coordination of Benefits will depend on the type of Primary Coverage elected by the Dependent Spouse. Additionally, Participants enrolled in the Blue Shield HMO Plan or Kaiser Plan must follow the delivery rules of the respective plan in order for benefits to be coordinated.

The Trust Office will notify you annually in March of each year of the current costs of coverage. Adjustments to the cost of coverage will be effective May 1 of each year. It is your responsibility to notify the Trust Office of any changes to your Dependent Spouse's access to employer-provided coverage within 30 days of any change in access to employer-provided medical coverage.

The Trust Office will request information from you on an annual basis regarding the employment status of your Spouse and their access to employer-provided medical coverage, and reserves the right to do so more frequently. Failure to respond to any requests for information may result in termination of coverage for your Dependent Spouse.

If the Trust Office determines the Spousal Surcharge was due but not paid at any time, you will be financially responsible for any and all amounts that would have otherwise been due, including but not limited to payment of the surcharge amount for all unpaid months, interest, attorney's fees and costs of litigation if a lawsuit is filed to recover the money. Coverage for your Dependent Spouse will terminate until all amounts are paid in full.

> ***NOTE:** In addition to any other recovery rights it may have, the Plan shall have the right to collect the unpaid surcharge amount from any future benefits payable to you or your Dependent(s). This includes, but is not limited to, withholding claim payments payable to you or your Dependent(s), and/or suspending eligibility for your Dependent Spouse until payment obligations are fulfilled.*

Extension of Coverage for Incapacitated Children

If your Dependent child is incapable of self-support because of being permanently physically or mentally incapacitated on the date the child's coverage would otherwise terminate because of age, coverage will be continued so long as:

(i) you continue to provide over one-half of the child's support each year;

(ii) you submit to the Trust Fund Office satisfactory proof of the child's incapacity within 31 days;

(iii) the incapacity can be expected to result in death, or has lasted or can be expected to last for at least 12 months.

The Plan may subsequently require proof of his or her continued incapacity. If proof is required more often than annually, the Plan will pay the expense of obtaining such proof.

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. It directs the Plan to cover the participant's child for benefits under the medical, dental, and/or vision plans, if available. Federal law provides that a Medical Child Support Order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order. Coverage under the plan pursuant to a QMCSO won't become effective until the Plan determines that the order is a QMCSO. You may request a copy of the Plan's QMCSO procedures from the Trust Fund Office.

SPECIAL ENROLLMENT RIGHTS OUTSIDE OF OPEN ENROLLMENT

If you decline enrollment for yourself or your Dependents because of other group health insurance coverage, and you or your Dependents subsequently lose eligibility for such coverage, (or if the employer stops contributing toward your or your Dependents' other coverage, or if your or your Dependents' COBRA period is exhausted), then you and your eligible Dependents have a right to Special Enroll in this Plan. In order to do so, you must request enrollment from the Trust Office within 30 days after the other coverage ends (or after the employer stops contributing towards the other coverage, or the COBRA period is exhausted), provided that the Participant has maintained eligibility (or is on COBRA continuation coverage) under the Plan upon the loss of that other coverage.

If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you and your Dependent will have a right to Special Enroll in the Plan provided that you request Special Enrollment with the Trust Fund Office within 30 days after the marriage, birth, adoption, or placement for adoption. If you timely request to Special Enroll in the Plan due to birth, adoption or placement for adoption of a dependent child, the coverage will become effective as the date of the child's birth, or in the case of adoption, the date of adoption or

placement for adoption, whichever is earliest. If a timely Special Enrollment request is made due to marriage, coverage under the Plan will become effective as of the first day of the month after the month in which the Special Enrollment was made.

If you and/or your dependent's Medicaid or State Children's Health Insurance Program coverage ("CHIP") is terminated due to a loss of eligibility, or if you and/or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, then you and/or your Dependents may have the right to Special Enroll in the Plan during the Plan year, within 60 days after such event.

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 as defined on page 82. Your hour bank will be suspended and reinstated only if a signatory employer reports and pays contributions for 1,000 hours or more within twelve consecutive calendar months following the date on which the prohibited work in Non-Covered Air Conditioning and Refrigeration Service ceases. If your coverage is suspended as set forth above, you will be treated in all respects as having no hours accumulated in an hour bank and 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, all 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.

   The suspension will be final and binding on all persons affected by the decision, subject to the provisions for appeal as 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 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, including any amounts assessed pursuant to the Policy for Reporting and Collection of Contributions for Fringe Benefits approved by the Board of Trustees. If your coverage is suspended as set forth above, you will be treated in all respects as having no hours accumulated in an hour bank and neither you nor your Dependents will have any right to COBRA continuation coverage.

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, including any amounts assessed pursuant to the Policy for Reporting and Collection of Contributions for Fringe Benefits approved by the Board of Trustees, 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 (see page 63.)

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 Participant/Spouse
2. legal separation of the Participant/Spouse
3. death of the Participant or Dependent
4. any other event which would make your Dependent not eligible for further coverage.

Changing your designated beneficiary for death benefits is not an acceptable notification of divorce or other change in Dependent status. If you are divorced or legally separated, a copy of the divorce decree or decree of legal separation is required.

> ***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.***

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 a court ordered decree of legal separation.

If any claim or premium is paid on behalf of any individual based on his or her status as your Dependent and it is later found that such individual was not eligible, you and/or the individual will be responsible for reimbursing the Plan for all amounts paid, including interest, attorney's fees and costs of litigation if a lawsuit is filed to recover the money.

NOTE: ***In addition to any other recovery rights it may have, the Plan shall have the right to recoup the overpayment from any future benefits payable to you or your Dependent(s). This includes, but is not limited to, withholding claim payments payable to you or your Dependent(s), withholding Vacation benefits payable to you, and suspending eligibility for you and/or your Dependent(s) until reimbursement obligations are fulfilled.***

The Plan reserves the right to periodically verify the status of your Dependent(s). You are required to provide any requested information in order to maintain coverage for your Dependent(s). Failure to respond to any requests for information may result in the termination of coverage for any or all of your Dependent(s).

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 (see "Credit for Disability Hours for Active Participants" 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 63 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 Dependents' eligibility for benefits will also terminate on the date he or she enters full-time active duty with the Armed Forces of the United States. 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 Forces, 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. A 24 month period beginning on the date the Participant's absence from employment with a Participating Employer begins

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.

FAMILY AND MEDICAL LEAVE ACT OF 1993

If your Participating Employer approves of your leave under the Family and Medical Leave Act of 1993, ("FMLA"), you and your eligible Dependent will continue to be covered under this Plan provided you were eligible when FMLA leave began. Coverage will be continued while you are absent from work on an FMLA leave as if there were no interruption of active employment and as if you were continuing to work the number of hours required for coverage, provided your Employer contributes 100 hours per month on your behalf during your FMLA leave. It is not the role of the Plan or Trust Fund Office to determine whether or not an employee is entitled to FMLA leave. Your Employer must report FMLA leave to the Trust Fund Office in order for your benefits to continue. Any disputes regarding entitlement to FMLA leave with continuing coverage must be resolved with your Employer.

If you are reported by your Employer to be on an approved FMLA leave of absence, coverage will continue until the earlier of the expiration of the FMLA leave or the date you give notice to your Employer that you do not intend to return to work at the end of the leave. If you do not return to work after an FMLA-approved leave of absence, your Employer may require you to reimburse the Employer for the contributions it paid during your FMLA leave to the extent allowed by law.

CREDIT FOR DISABILITY HOURS FOR ACTIVE PARTICIPANTS

If you become Totally Disabled (see definition on page 83) 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.

II. ELIGIBILITY RULES FOR RETIRED PARTICIPANTS

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

   Exception: If you leave covered employment after accruing 25 years or more of Pension Credit without retiring under the Airconditioning and Refrigeration Industry Retirement Trust Fund, and thereafter work continuously until retirement from the Airconditioning and Refrigeration Industry Retirement Trust Fund in a position not covered by the Collective Bargaining Agreement for an employer contributing to this Trust Fund, you will be eligible to receive retiree Health and Welfare benefits at the time of retirement.

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.

When Retiree Coverage Terminates

If, as a retiree of the Airconditioning and Refrigeration Industry Retirement Trust Fund ("Retirement Trust"), 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.

Your coverage under this Plan will also be permanently terminated if your retirement benefits from the Retirement Trust are suspended in accordance with the terms of the Retirement Trust for failing to timely provide the Retirement Trust with any requested information (including any tax documents). If your retiree coverage under the Health and Welfare Trust Fund is terminated, you will not be eligible to re-enroll in retiree coverage, even if you later provide the requested documents, and you will not be eligible for COBRA coverage.

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.)

The Self-Pay Percentage will also apply to the cost of coverage for your Dependents.

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?

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

The rules for eligibility of Dependent children of retirees are the same as those for active Participants, including the extension of coverage for incapacitated children.

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.

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. Once you have an hour bank balance of at least 100 hours, you will be eligible as an active employee on the first day of the following month.

> ***NOTE: All work must have the approval of the Board of Trustees prior to the starting of work.***

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.

What Happens To My Spouse If I Pass Away?

If you and your Spouse are covered under the Plan and you pass away, your Spouse will be eligible to continue to receive health and welfare benefits so long as he/she receives a Pension from the Airconditioning and Refrigeration Retirement Trust.

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

The amount of the monthly Self-pay required by your Spouse to continue benefits after your death will be determined according to the same Self-pay schedule as set forth on page 10.

III. MEDICAL AND DENTAL PLAN CHOICES

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.

If you and/or your eligible Dependents have a Special Enrollment Right while you are eligible for benefits as an Active Participant or are on COBRA continuation coverage under the Plan, you and your Dependents may have the right to Special Enroll in any benefit plan option for which you are eligible under the Plan. (For example, if you are enrolled in the Fee-For-Service Medical Plan and subsequently obtain a new Dependent, you have the option of enrolling your Dependent in the Fee-For-Service Medical Plan with you, or enrolling you and your eligible Dependent in one of the HMO options, provided that you are otherwise eligible to enroll in an HMO option).

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

A complete description of the various medical and dental benefits provided by the Fee for Service Plans 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 Blue Shield of California, Kaiser, and United Concordia. Complete listings of their providers are also available.

In addition, you may also obtain information on the various plans by visiting www.acrtrust.org.

IV. FEE FOR SERVICE MEDICAL BENEFITS

The medical benefits provided for you and your eligible Dependents are explained on the following pages. The cost for all of the following services and supplies will be reimbursed based on **Allowable Charges**. Please refer to the definition of "Allowable Charges" on page 80. 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.

All fee-for-service medical claims must be filed with the Trust within 90 days of the date the expenses are incurred, or as soon thereafter as reasonably possible, but not more than one year from the date the expense was incurred. For additional information on the amount of time you have to submit a claim (or appeal a denied claim), please refer to the Claims and Appeals Procedures beginning on page 50. For specific information on the amount of time to bring legal action against the Plan, please refer to the section entitled "Appeal of Adverse Benefit Determination" (in the Claims and Appeals Procedures) beginning on page 53 of this SPD.

Annual Maximum Benefit

The overall annual maximum benefit is $2,000,000 per person for claims incurred prior to January 1, 2014. For such claims incurred prior to January 1, 2014, this means that no more than $2,000,000 will be paid in medical benefits for a covered Participant or eligible Dependent in a calendar year. Effective January 1, 2014 there is no overall annual maximum limit on medical benefits.

Calendar Year Deductible and Out-of-Pocket Maximum

A deductible of $350 ($150, if you are a Medicare-eligible retired participant) applies separately to all family members until at least three members of the family incur $350 ($150, if you are a Medicare-eligible retired participant) 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, will also be credited toward the deductible for the next calendar year. This deductible also applies to chiropractic and hearing aid benefits used by HMO Participants. Charges by Non-PPO providers apply toward the calendar year deductible.

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 $3,000 of out-of-pocket Allowable Charges, and until a family has paid $6,000 of out-of-pocket Allowable Charges by a PPO contracted provider, including their deductible. Thereafter, the Plan pays 100% of Allowable Charges incurred by the individual or family during the remainder of the calendar year, up to the annual maximum benefit. Remember, charges by Non-PPO providers do not apply towards the out-of-pocket maximum.

There is a separate deductible for the prescription drug program for active participants, and retired participants who are not eligible for Medicare. Please see the Prescription Drug Benefit section for more information.

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 80% of the Allowable Charges by a PPO contracted provider, and 50% 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.

What are PPO Networks?

PPO networks are a group of hospitals, physicians, and other providers that have agreed to reduce the cost of medical care for this and other large trust funds. These organizations help save you and the Plan money.

How do I Select a PPO Provider?

There are several ways you can choose a PPO contracted provider.

- Simply ask the provider at the time you make an appointment if they are a Blue Shield provider;
- Search for providers by visiting www.blueshieldca.com/findaprovider;
- Contact the Trust Office for a Blue Shield of California provider directory.

If you are referred to a specialist or hospital, be sure to remind your doctor that you want to use a provider contracted with the Trust's PPO network.

**Blue Shield of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.*

Why Use PPO Physicians and Hospitals?

- The Plan will pay 80% of Allowable Charges if you use a PPO provider. You pay only the remaining 20% of the Allowable Charges.
- If you use a Non-PPO provider, the Plan will pay only 50% 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 50% 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 50% of the $800 Allowable Charge ($400), and you must pay the entire balance of $600. If you had used a PPO provider, the Plan would have paid 80% of the $800 Allowable Charge ($640) and you would have to pay only $160. 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 50% 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 80% 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.

Covered Services and Supplies

Preventive Care

The Plan will cover 100% of Allowable Charges for certain preventive care services. This means that these services will not be subject to any deductible, and you will not have to pay any cost sharing (copay or coinsurance) if you use a PPO Provider.

The preventive care services covered will include many of the services provided by your Physician at a routine annual physical exam (or by a pediatrician during a routine well-baby or well-child visit) including but not limited to the following:

- Blood pressure, diabetes, and cholesterol tests;
- Many cancer screenings, including mammograms and colonoscopies;
- Limited counseling concerning such topics as smoking cessation, weight loss, healthy eating, treatment for depression and reduction of alcohol use;
- Routine vaccinations against diseases such as measles, polio or meningitis;
- Flu and pneumonia shots;
- Counseling, screening, and vaccines to ensure healthy pregnancies;
- Regular well-baby and well-child visits, from birth to age 21;
- Prenatal and postnatal visits (for all other maternity related services including ultrasounds and delivery fees, the plan will continue to pay normal benefits). As a reminder, no coverage is provided for delivery expenses of pregnant Dependent Children under the Indemnity PPO Plan;
- Breast pump and supplies;
- Breastfeeding support and counseling; and
- Female contraceptives and sterilization

Please note that preventive care services provided by a Non-PPO Provider are covered at 100% of Allowable Charges, however you are responsible for any billed amounts in excess of the Allowable Charges. In addition, an office visit is not covered at 100% of Allowable Charges unless the primary purpose of the visit is preventive care. The Plan's cost sharing provisions will apply to any non-preventive services, even if the non-preventive services are received during a preventive office visit, or due to a condition diagnosed during a preventive care visit. The Plan reserves the right to impose other reasonable medical management techniques (such as age or frequency limits) to the provision of preventive care services.

For a complete list of preventive care services or for more information (such as age or frequency limits), please contact the Trust Office.

Hospital Services

The Plan will pay for the following hospital services at 80% of Allowable Charges for PPO hospitals and 50% of Allowable Charges for Non-PPO hospitals. 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.

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 (called a semi-private room) at 80% of Allowable Charges if you use a PPO hospital and 50% 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.

PPO contracted Convalescent hospital room and board charges are paid at 80% of Allowable Charges. Convalescent services other than hospital room and board are paid at 50% 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 80% of Allowable Charges if you use a PPO hospital, and 50% of Allowable Charges if you use a Non-PPO hospital.

IMPORTANT REMINDER: ***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 contracted with the PPO network. It is your responsibility to ask for PPO providers, or you (and the Plan) may end up paying more.***

Emergency Care

If you have a "Qualified Emergency" (as defined on page 80), the Plan will pay benefits for covered charges in excess of any applicable deductible at 80% of Allowable Charges for PPO providers, and 80% of Allowable Charges for Non-PPO providers. If it is a "Qualified Emergency," your share of the charges will count toward the calendar year out-of-pocket maximum. However, amounts billed by a Non-PPO provider in excess of the Allowable Charge will not count toward the out-of-pocket maximum.

After the calendar year out-of-pocket maximum has been reached, the Plan will pay 100% of the applicable Allowable Charge for covered charges regardless of whether or not the hospital is contracted with the PPO network.

If you have a "Non-Qualified Emergency" (as defined on page 81) (e.g., 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 80% of Allowable Charges for PPO providers, and 50% of Allowable Charges for Non-PPO providers, and your share of the Non-PPO charges will not count toward the calendar year out-of-pocket maximum.

Outpatient Hospital Care

Charges for medically necessary services and supplies will be payable at 80% of Allowable Charges if you use a PPO provider, and 50% 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 calendar year 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.

Surgical Services

Charges for medically necessary services and supplies will be payable at 80% of Allowable Charges if you use a PPO provider. If you use a Non-PPO provider benefits will be paid at 50% of Allowable charges or $4,000 per treatment, whichever is less.

Anesthesia Benefits

The fees of an anesthesiologist are covered at 80% of Allowable Charges if:

1. The surgeon and hospital are both PPO providers, or
2. The member had no control over the selection of the anesthesiologist (see page 16).

The fees of an anesthesiologist will be covered at 50% of Allowable Charges if neither of the above two situations are met.

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 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 80% of Allowable Charges if you use a PPO provider, and 50% of Allowable Charges if you use a Non-PPO provider, up to a lifetime maximum of 30 days.

Skilled Nursing Facilities (Convalescent Hospitals)

Charges for skilled nursing facilities will be payable at 80% of Allowable Charges if you use a PPO provider, and 50% of Allowable Charges if you use a Non-PPO provider. Payment of claims at the rates above is limited to a lifetime maximum of 365 days. Thereafter, charges will be paid at 10% of the Allowable Charges if you use a PPO provider. No additional benefits will be provided beyond the 365 days if you use a non-PPO provider.

Mental Health Benefits

Charges for medically necessary services and supplies will be payable at 80% of Allowable Charges if you use a PPO provider, and 50% of Allowable Charges if you use a Non-PPO provider.

Alcohol and Drug Abuse Benefits

Charges for medically necessary services and supplies will be payable at 80% of Allowable Charges if you use a PPO provider, and 50% of Allowable Charges if you use a Non-PPO provider.

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

Acupuncture Benefit

If you or your eligible Dependent receives acupuncture treatment performed in or outside a hospital, the Plan will pay 80% of Allowable Charges if you use a PPO provider, and 50% of Allowable Charges if you use a Non-PPO provider up to a maximum of 26 visits per calendar year. For the remainder of the calendar year the Trust will pay 10% of the Allowable Charges, but only if you use a PPO provider. No additional benefits will be provided beyond the 26 visits per calendar year if you use a Non-PPO provider.

Chiropractic Benefit

If you or your eligible Dependent receives chiropractic treatment performed in or outside a hospital by a Chiropractor, the Plan will pay 80% of Allowable Charges if you use a PPO provider, and 50% of Allowable Charges if you use a Non-PPO provider up to a maximum of 26 visits per calendar year. For the remainder of the calendar year the Trust will pay 10% of the Allowable Charges, but only if you use a PPO provider. No additional benefits will be provided beyond the 26 visits per calendar year if you use a Non-PPO provider. The Plan deductibles apply to the Chiropractic benefit for both Fee-For-Service and HMO Participants.

Hearing Aid Benefit

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% of the Allowable Charges for a PPO provider, or 100% of billed charges for a Non-PPO provider for such expense up to a maximum payment of $2,000 during any three-year period. The hearing exam and fitting exam will be paid at 80% of Allowable Charges if you use a PPO provider, and 50% of Allowable Charges if you use a Non-PPO provider. The exam expenses are not included in the $2,000 maximum. The Plan deductibles apply to the hearing aid benefit for both Fee-For-Service and HMO Participants.

<u>Excluded Expenses</u> 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.

Physical Therapy

If you or your eligible Dependent receives physical therapy treatment in a PPO outpatient facility, the Plan will pay 80% of the Allowable Charges for the first 26 visits per calendar year provided you use a PPO provider. For the remainder of the calendar year the Trust will pay 10% of the Allowable Charges of a PPO provider.

If you use a Non-PPO provider, the charges will be paid at 50% of Allowable Charges for a maximum of 26 visits per calendar year and nothing for more than 26 visits.

Speech Therapy

If you or your eligible Dependent receives speech therapy treatment in an outpatient facility, the Plan will pay 80% of the Allowable Charges for the first 26 visits per calendar year provided you use a PPO provider. For the remainder of the calendar year the Trust will pay 10% of the Allowable Charges of a PPO provider.

If you use a Non-PPO provider, the charges will be paid at 50% of Allowable Charges for a maximum of 26 visits per calendar year and nothing for more than 26 visits.

Pain Management

For pain management services, the Plan will pay 80% of Allowable Charges for PPO facilities, and 50% of Allowable Charges for Non-PPO facilities, up to the following maximums:

- Hospital maximum benefit (per treatment): $900
- Surgery center maximum benefit (per treatment): $800
- Physician's office maximum benefit (per treatment): $700
- Lifetime maximum: $10,000

Sleep Apnea

For the diagnosis of sleep apnea, the Plan will pay 80% of Allowable Charges for PPO facilities, and 50% of Allowable Charges for Non-PPO facilities, up to the following maximums:

- Facility maximum benefit (per treatment): $1,000
- Physician maximum benefit (per treatment): $1,000
- Lifetime maximum: $2,000

MRI and CAT Scans

If you or your eligible Dependent use a PPO facility the Plan will pay 80% of Allowable Charges. If you or your eligible Dependent use a Non-PPO facility the Plan will pay 50% of Allowable Charges.

Vision Therapy

Should you or your eligible Dependents have amblyopia, strabismus and other eye coordination problems, a special benefit is available to you. The treatment plan must be approved in advance. Your physician has the forms to submit for approval. Benefits will be payable at 80% for PPO providers and 50% for Non-PPO providers up to a lifetime maximum payment of $500.

Certified Nurse-Midwives

Allowable Charges for the services of a certified Nurse-Midwife will be payable at 50%, up to a maximum payment of $600 per delivery.

Birthing Centers

Allowable Charges made by a birthing center are payable at 50%. 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.

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.

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.

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.

The Plan does not pay benefits for surrogate mothers where the mother receives a medical service or obtains a medical supply for purposes of generating a profit,

fee or other compensation. A surrogate mother is a woman who agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Organ Transplant Provision

Charges for medically necessary services and supplies will be payable at 80% of Allowable Charges. **However, you must first obtain pre authorization from Blue Shield of California.** You should contact the Trust Office for assistance in obtaining pre authorization.

Routine Patient Costs for Participation in Approved Clinical Trials

This Plan covers routine patient costs for qualifying individuals participating in approved clinical trials (as those terms are defined under PPACA), but only to the extent required under PPACA.

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 80% of Allowable Charges if you use a PPO provider and 50% 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, when prescribed by a 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 80% 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.

Prior Authorization

Participants, Dependents, or their providers must call the Blue Shield Customer Service telephone number indicated on the back of the Participant's identification card for prior authorization for the services listed in this section. By doing so, they can determine before the service is provided whether a procedure or treatment program is a covered service. For all other services, the Participant, Dependent, or their provider should consult the "Covered Services and Supplies" section of this booklet to determine whether a service is covered.

Failure to obtain prior authorization for the services described below may result in non-payment if the Plan determines that the service is not Medically Necessary.

1. Admission into an approved Hospice Program
2. Home Health Care Benefits from Non-Preferred Providers
3. Home Infusion/Home Injectable Therapy Benefits from Non-Preferred Providers
4. Durable Medical Equipment Benefits, including but not limited to motorized wheelchairs, insulin infusion pumps, and Continuous Glucose Monitoring Systems (CGMS), except breast pumps (prior authorization not required)
5. Reconstructive Surgery
6. Hemophilia home infusion products and services
7. The following radiological procedures when performed in an Outpatient setting on a non-emergency basis: CT (Computerized Tomography) scans, MRIs (Magnetic Resonance Imaging), MRAs (Magnetic Resonance Angiography), PET (Positron Emission Tomography) scans, and any cardiac diagnosis procedure utilizing Nuclear Medicine
8. Hospital and Skilled Nursing Facility admissions

This list is subject to change. Other specific services and procedures may require prior authorization. A current list of services and procedures requiring prior authorization can be obtained by you or your provider by going to http://www.blueshieldca.com or by calling the Customer Service telephone number indicated on the back of the Participant's identification card.

Out of Area Programs

Benefits will be provided for covered services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Plan calculates the Participant's copayment either as a percentage of the Allowable Charges or a dollar copayment, as defined in this Booklet. When covered services are received in another state, the Participant's copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers. See the BlueCard Program section in this Booklet.

Blue Shield of California has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan

Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

When you access covered services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. The Plan's payment practices in both instances are described in this Booklet.

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to the Plan for payment. The Plan will notify you of its determination within 30 days after 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). The Plan will pay you at the Non-PPO Provider benefit level. Remember, your copayment is higher when you see a Non-PPO Provider. You will be responsible for paying the entire difference between the amount paid by the Plan and the amount billed.

Charges for services which are not covered, and charges by Non-PPO Providers in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in copayment calculations.

To receive the maximum benefits of your Plan, please follow the procedure below.

When you require covered services while traveling outside of California:

1. call *BlueCard Access*® at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,
2. visit the Participating Physician or Hospital and present your membership card.

The Participating Physician or Hospital will verify your eligibility and coverage information by calling *BlueCard Eligibility* at 1-800-676-BLUE. Once verified and after services are provided, a claim is submitted electronically and the Participating Physician or Hospital is paid directly. You may be asked to pay for your applicable copayment and Plan deductible at the time you receive the service.

You will receive an explanation of benefits which will show your payment responsibility. You are responsible for the copayment and Plan deductible amounts shown in the explanation of benefits.

For services received outside of California, prior authorization is required for all inpatient Hospital services and notification is required for inpatient emergency services. In addition, for services outside of California, prior authorization is required for selected inpatient and outpatient services, supplies and durable medical equipment. To receive prior authorization from the Plan, the out-of-area provider should call the customer service number noted on the back of your identification card.

If you need emergency services, you should seek immediate care from the nearest medical facility. The benefits of this Plan will be provided for covered services received anywhere in the world for emergency care of an illness or injury.

Care for Covered Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for covered urgent and emergency services received outside of the United States, Puerto Rico, and U.S. Virgin Islands if the claim would have been covered had the services been rendered in the United States. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center at either the toll-free BlueCard Access number (1-800-810-2583) or collect (1-804-673-1177), 24 hours a day, seven days a week. In an emergency, go directly to the nearest Hospital. If your coverage requires precertification or prior authorization, you should also call the Plan at the customer service number noted on the back of your identification card. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center.

When you receive services from a Physician, you will have to pay the Physician and then submit a claim.

Before traveling abroad, call your local Customer Service office for the most current listing of providers world-wide or you can go on-line at www.bcbs.com and select “Find a Doctor or Hospital” and “BlueCard Worldwide.”

BlueCard Program

Under the BlueCard® Program, when you obtain covered services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant’s liability (e.g., copayment and Plan deductible amounts shown in the Booklet). However the Host Plan is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain covered services outside of California from a healthcare provider participating with a Host Plan, where available. The participating healthcare provider will automatically file a claim for the covered services provided to you, so there are no claim forms for you to fill out. You will be responsible for the copayment and deductible amounts, if any, as stated in this Booklet.

Whenever you access covered services outside of California and the claim is processed through the BlueCard Program, the amount you pay for covered services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your covered services; or
2. The negotiated price that the Host Plan makes available to Blue Shield of California.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction

modifications noted above. However, such adjustments will not affect the price the Plan's uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered services according to applicable law.

Claims for covered services are paid based on the Allowable Charges as defined in this Booklet.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

Negotiated (non-BlueCard Program) Arrangement

If Blue Shield has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan on your behalf, Blue Shield will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

Definitions

Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Participant's healthcare needs across the continuum of care.

Care Coordinator: An individual within a provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

Negotiated Arrangement: An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Provider Incentive: An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

Value-Based Program (VBP): An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Incentives

If you and your Dependents are enrolled in the Fee-for-Service medical plan, the Plan offers the following incentives to help you with your out-of-pocket costs for medical care under the Plan, and to deliver your health care in a more efficient manner.

Best Doctors Incentive Plan

The Fee-for-Service medical plan offers an incentive for using the Best Doctors program ("Best Doctors"). Best Doctors provides participants access to world-renown medical experts who provide a 'second-opinion' review at no cost to the member.

Who is Eligible to Receive the Incentive?

A Participant or eligible Dependent enrolled in the Fee-for-Service medical plan at the time of the InterConsultation review by Best Doctors is eligible to receive an incentive under the Plan. An InterConsultation is an in-depth analysis of your case by an expert of your particular condition. Best Doctors must agree to review your case through their InterConsultation service and you must participate in the review. You are not required to follow Best Doctors recommendations in order to receive the incentive. The incentive does not apply to other services provided by Best Doctors. All incentives must be pre-authorized by the Trust Office. You must contact the Trust Office prior to the review so that the Trust Office can approve your eligibility for the incentive. As described in further detail below, the Participant or eligible Dependent must also submit Incentive Claim Form(s) to the Trust Office in order to receive his/her reimbursement.

What is the Incentive?

Reimbursement of Out-of-Pocket Expenses

- The Plan will reimburse the Participant or eligible Dependent for all eligible out-of-pocket medical and pharmacy expenses incurred by the Participant or eligible Dependent within a 12 month period, up to a maximum of $2,000 per calendar year. The Participant and eligible Dependent can elect when the 12 month reimbursement period will begin, except that this period must begin no earlier than six months prior to the date the Trust Office pre-authorizes the review, and no later than the date of the pre-authorization. For example, if the Trust Office pre-authorizes the incentive on August 1st and the review occurs August 8th, you may elect to be reimbursed for eligible out-of-pocket expenses for a 12 month period that will begin on any date you elect between February 1st (six months before the pre-authorization date) and August 1st. For example, if you chose to begin the reimbursement period on February 1, it would end 12 months later, on January 31 of the following year. If you chose to begin the reimbursement period on May 12, it would end on May 11 of the following year. If you chose to begin the reimbursement period on August 1 (the pre-authorization date), it would end on July 31 of the following year. Reimbursements will not be paid until the Best Doctors review is completed.
    - Eligible expenses include:
        - Co-payments to providers and hospitals or facilities
        - Co-payments for prescriptions

Note: Eligible expenses are not limited to co-payments related to the approved procedure. Eligible expenses may include co-payments for unrelated medical and pharmacy expenses.

- The Participant or eligible Dependent must submit proof-of-payment with the Incentive Claim Form. An acceptable proof-of-payment must contain the provider, hospital, or pharmacy name, the date of service, name of patient, and the payment amount.

How to Receive the Incentive

In order to receive the reimbursement incentive(s) described above, the Participant or eligible Dependent must submit Incentive Claim Form(s) to the Trust Office. You may submit multiple claim forms until you have exhausted the entire approved incentive amount. Please contact the Trust Office to receive an Incentive Claim Form. The Trust Office will process reimbursements within 4 weeks of receiving all required items. The Trust Office will not consider any incentive requests which were not pre-authorized.

Centers of Excellence Incentive Plan

The Fee-for-Service medical plan offers an incentive for using "Centers of Excellence" for certain approved procedures. A Center of Excellence is a facility that has a proven track-record for positive outcomes for a certain procedure when compared to facilities without such a designation of excellence. The Fee-for-Service plan only recognizes the Blue Cross/Blue Shield "Blue Distinction Centers" as Centers of Excellence. To find a Blue Distinction Center, please visit www.bcbs.com/innovations/bluedistinction/center-list/selector-map.html.

A Participant or eligible Dependent may be eligible for the incentive(s) described below with respect to certain procedures related to the following, when performed at a Blue Distinction Center:

1. Cardiac Care:

   - Cardiac Surgery (Coronary Artery Bypass Graft – CABG)
   - Percutaneous Coronary Intervention (PCI)

2. Treatment for Complex and Rare Cancers:

   - Bladder cancer
   - Bone cancer – primary
   - Brain cancer – primary
   - Esophageal cancer
   - Gastric cancer
   - Head and neck cancers
   - Liver cancer – primary
   - Ocular melanoma
   - Pancreatic cancer
   - Rectal cancer
   - Soft tissue sarcomas
   - Thyroid cancer – medullary or anaplastic
   - Acute leukemia (inpatient/non-surgical)

3. Spine Surgery:

   - Laminectomy Inpatient
   - Spinal Fusion (Anterior) Inpatient
   - Spinal Fusion (Posterior) Inpatient

4. Transplants:

   - Heart, Liver, Bone Marrow/Stem Cell (Adult and Pediatric)
   - Lung and Pancreas (Adult Only)

For more information on specific procedures that are eligible for an incentive when performed at a Blue Distinction Center, please contact the Trust Office at (714) 917-6100.

Who Is Eligible to Receive the Incentive?

A Participant or eligible Dependent enrolled in the Fee-for-Service Medical Plan at the time of the procedure is eligible to receive an incentive under the Plan. All incentives must be pre-authorized by the Trust Office. You must contact the Trust Office prior to the procedure so that the Trust Office may determine if the applicable procedure is eligible for an incentive. As described in further detail below, the Participant or eligible Dependent must also submit Incentive Claim Form(s) to the Trust Office in order to receive his/her reimbursement.

What Is the Incentive?

You can choose from one of the two incentives available below:

Incentive 1 – Reimbursement of Out-of-Pocket Expenses

- The Plan will reimburse the Participant or eligible Dependent for all eligible out-of-pocket medical and pharmacy expenses incurred by the Participant or eligible Dependent within the 12 month period beginning on the date the Plan pre-authorizes the procedure at a Blue Distinction Center, up to a maximum of $2,000 per calendar year. Co-payments for services performed prior to the authorized procedure but after the pre-authorization was received for such procedure are eligible for reimbursement as long as the entire reimbursement period does not exceed 12 months. Reimbursements will not be paid until the authorized procedure is performed.
  - Eligible expenses include:
    - Co-payments to providers and hospitals or facilities
    - Co-payments for prescriptions
      Note: Eligible expenses are not limited to co-payments related to the approved procedure. Eligible expenses may include co-payments for unrelated medical and pharmacy expenses.
  - The Participant or eligible Dependent must submit proof-of-payment with the Incentive Claim Form. An acceptable proof-of-payment must contain the provider, hospital, or pharmacy name, the date of service, patient name, and the payment amount.

Incentive 2 – Reimbursement of Travel Expenses

- The Plan will reimburse the Participant or eligible Dependent for travel expenses to and from a Blue Distinction Center that is more than 50 miles from the Participant's or eligible Dependent's home for an authorized procedure. The

Plan will reimburse travel expenses for the patient and one additional individual, up to a maximum of $2,000 per calendar year.

- The following items will be reimbursed:
  - Transportation-related expenses to and from the Participant's or eligible Dependent's home to the Blue Distinction Center. Examples are:
    - Airfare or train fare
    - Taxi expenses to/from an airport and to/from the Blue Distinction Center
    - Rental car expenses
    - Airport parking expenses
  - Lodging expenses for a hotel near the Blue Distinction Center, limited to the room rate plus applicable taxes. (Lodging expenses do not include other hotel fees such as internet access, in-room movies, laundry services, etc.)
  - A meal allowance of $25 per person per day, including eligible travel days. (The Plan does not require meal receipts.)
- One travel day is allowed both before and after the procedure. For example, if the approved procedure is performed on Monday, the Plan will reimburse transportation, lodging and meal expense for Sunday through Tuesday.
- The Participant or eligible Dependent must submit original receipts for all items (except for meals) with the Incentive Claim Form. Acceptable receipts should include the date, name of traveler and relation to the patient (when applicable) and amount of payment.

NOTE: If there is no Blue Distinction Center within 50 miles of the Participant's or eligible Dependent's home, he/she is eligible for both Incentive 1 and Incentive 2, for a maximum of $4,000 per calendar year.

How to Receive the Incentive

In order to receive the reimbursement incentive(s) described above, the Participant or eligible Dependent must submit Incentive Claim Form(s) to the Trust Office. You may submit multiple claim forms until you have exhausted the entire approved incentive amount. Please contact the Trust Office to receive an Incentive Claim Form. The Trust Office will process reimbursements within 4 weeks of receiving all required items. The Trust Office will not consider any incentive requests which were not pre-authorized.

V. PRESCRIPTION DRUG BENEFITS

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 are provided by the Trust's Prescription Drug Manager (PBM), which is currently Navitus, and your mail order benefits are currently provided by Costco.

The Plan allows two means for obtaining your medications. The 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 Navitus, provide "walk-in" services to meet your immediate needs for acute drug therapy. Both walk-in and mail order prescription drugs are subject to the copayment described below.

All prescription drug claims must be filed with Navitus within 90 days of the date the expenses are incurred, or as soon thereafter as reasonably possible, but not more than one year from the date the expense was incurred. For additional information on the amount of time you have to submit a claim (or appeal a denied claim), please refer to the Claims and Appeals Procedures beginning on page 50. For specific information on the amount of time to bring legal action against the Plan, please refer to the section entitled "Appeal of Adverse Benefit Determination" (in the Claims and Appeals Procedures) beginning on page 53 of this SPD.

Your Copayments

Mail Order Prescription Drugs (90-day supply for maintenance drugs)

- $16 for generic drugs;
- $40 for formulary (preferred) brand name drugs;
- $80 for non-formulary brand name drugs

NOTE**: **When you use the mail order program, you save because of the lower copayment.

Walk-in Prescription Drugs (30-day supply)

- 10% of cost for generic drugs with a minimum of $8 and a maximum of $20
- 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

Walk-in Prescription Drugs (90-day supply)

- 10% of cost for generic drugs with a minimum of $24 and a maximum of $60
- 20% for formulary (preferred) brand name drugs with a $60 minimum and a maximum of $150
- 40% for non-formulary brand name drugs with a $120 minimum

NOTE: FOR ACTIVE PARTICIPANTS AND RETIRED PARTICIPANTS WHO ARE NOT ELIGIBLE FOR MEDICARE - If you purchase a brand name drug, and there is a generic equivalent available, you will have to pay the brand name

copayment plus the difference in cost between the brand name and generic drug, even if your physician prescribes "Dispense as Written."

You may obtain a list of formulary (preferred) drugs by visiting www.navitus.com.

Your Deductible

For active participants, and retired participants who are not eligible for Medicare, there is a separate deductible of $100 per person. The prescription drug deductible applies to brand name drugs received through both the mail order pharmacy program and walk-in pharmacy program. The prescription drug deductible does not apply if you are a Medicare-eligible retired participant.

Your Out-of-Pocket Maximum

Once the calendar year deductible is satisfied (if applicable), the copayments listed on page 32 will be in effect until an individual has paid $3,600 in out-of-pocket copayments, and until a family has paid $7,200 in out-of-pocket copayments. Thereafter, the Plan pays 100% of eligible prescription drug charges incurred by the individual or family during the remainder of the calendar year.

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. ***They also save you money because of the lower copayment.***

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.

Reminder: Tell your doctor that you would like a prescription for a generic drug and save money.

Walk-In Pharmacy Program

If you need a supply of 30 days or less for a non-maintenance or "acute" therapy drug, take your prescription along with your Navitus I.D. card to one of the many conveniently located participating pharmacies. You must pay your copayment to the dispensing pharmacy.

You may also fill a 90-day supply of maintenance medications at most participating pharmacies.

For more information, you may call Navitus at (866) 333-2757.

Costco Mail Order Pharmacy Program

Mail order services are provided through Costco. The Costco mail order program is an option provided for convenience and savings.

You may receive up to a 90-day supply of prescription drugs through this program. Your 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 Costco, it will be filled by a pharmacist and checked to insure that it was filled correctly. A shipper will then check it before shipping it to you. Costco generally ships your prescription within 24 - 48 hours of receipt, but you should allow at least 14 days from receipt of the prescription by Costco until delivery of your medication. Costco provides a toll-free phone number to answer any of your questions or concerns regarding your prescription. The toll-free phone number is (800) 607-6861.

Using the Mail Order Pharmacy

To obtain your mail order prescriptions from Costco you will need to create an account by doing one of the following:

- Enroll online at www.costco.com
- Enroll via telephone at 1-800-607-6861
- Download an Enrollment Form at www.costco.com. Complete the Enrollment Form and mail to:

  Costco Mail Order Pharmacy
  215 Deininger Circle
  Corona, CA 92880-9911

Please note, you do NOT need a Costco membership to use the mail-order service.

Once you have created an account you may mail your original prescriptions with a Mail-In Form and your payment to the address above. Be sure to ask your doctor to prescribe a 90-day supply plus three refills, if appropriate.

Once Costco has begun to fill your prescriptions, you may order refills 24 hours/7 days a week by calling 1-800-607-6861. You may also order refills online at www.costco.com.

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:
   a. Insulin and Diabetic Supplies, including: Injectables, Insulin Needles and Syringes, Lancets and Devices, Glucose Testing Strips, Blood Monitoring Units, Urine Testing Strips, and Glucagon Injectables.
   b. Emergency Allergic Reaction Kits (Epipen)

3. New drugs that are approved by the FDA may be considered for coverage under this plan. As the drugs become available, the Plan will consider the drugs and whether

they should be covered under the Plan, in its sole discretion with or without the advice of a third party.

4. The following preventive care drugs are covered at 100% of Allowable Charges, with no co-payment or cost-sharing, if your Physician prescribes the medication and you obtain the medication at a participating (i.e., in-network) pharmacy:

    a. Aspirin for men from ages 45 to 79 years of age, and for women from ages 55 to 79 years of age (1 pill per day).
    b. Vitamin D (2 per day) for men and women age 65 years and over and residing in a community-dwelling location.
    c. Fluoride supplementation for children from ages zero months to five years of age.
    d. Folic acid supplements (including prenatal vitamins) for women who may become pregnant.
    e. Liquid iron supplements for infants ages zero months to one year in age.
    f. Oral contraceptives and contraceptive devices for women. (Excludes abortifacients, IUD's and implants.)
    g. Smoking cessation medication and products.
    h. Immunizations for adults and children.

    Note: All preventive care drugs will be covered at 100% of Allowable Charges ONLY for generic drugs, unless there is no generic available. If you choose to fill a brand name prescription, you may incur a co-payment.

What Drugs Are Not Covered?

1. Drugs or medications not requiring a physician's or dentist's prescription (except certain immunizations.)
2. Certain injectable drugs (except insulin), blood and blood plasma.
3. Multiple and non-therapeutic vitamins, cosmetics, dietary supplements (except when prescribed, and a prior authorization received), 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 (with the exception of 4.b. in the "What Drugs are Covered?" section above).
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.

NOTE: The general exclusions described in Section X also apply to drug benefits.

VI. DENTAL BENEFITS

While you and your Dependents 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. If you are enrolled in the United Concordia Dental Plan, please refer to the Summary of Benefits provided by them for the benefits that apply to you. Call United Concordia at (866) 357-3304 or visit www.unitedconcordia.com 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.** 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 as listed below, at the lesser of 100% of the Delta Dental PPO contracted rate, or the Delta Dental Premier contracted rate or the fee actually charged. The maximum aggregate amount payable for Covered Dental Expenses for you or your Spouse in any calendar year or portion thereof is $1,750 per person, except that there is no maximum applicable to pediatric dental check-ups. A pediatric dental check-up includes the oral evaluation, prophylaxis, fluoride, and bite-wing x-rays.

Delta Dental has contracted with over 92% of the dentists in California to participate in their Premier network. These dentists have agreed to accept as payment in full, the allowances that have been spelled out in their contract with Delta Dental. Similarly, many of these dentists have also agreed to participate in Delta Dental's PPO Dental network and agreed to accept even

lower fees as payment in full for dental procedures.

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.

All dental claims must be filed with Delta Dental within 90 days of the date the expenses are incurred, or as soon thereafter as reasonably possible, but not more than one year from the date the expense was incurred. For additional information on the amount of time you have to submit a claim (or appeal a denied claim), please refer to the Claims and Appeals Procedures beginning on page 50. For specific information on the amount of time to bring legal action against the Plan, please refer to the section entitled "Appeal of Adverse Benefit Determination" (in the Claims and Appeals Procedures) beginning on page 53 of this SPD.

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.

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. 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, dental benefits will be extended for expenses incurred within three (3) months of the date of the accident for repair of, or alleviation of damage to natural teeth caused by the accident. 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.

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.

NOTE: The general exclusions described in Section X also apply to dental benefits.

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.

VII. VISION CARE BENEFITS

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.

All vision claims must be filed with Vision Service Plan within 365 days of the date the expenses are incurred. For additional information on the amount of time you have to submit a claim (or appeal a denied claim), please refer to the Claims and Appeals Procedures beginning on page 50. For specific information on the amount of time to bring legal action against the Plan, please refer to the section entitled "Appeal of Adverse Benefit Determination" (in the Claims and Appeals Procedures) beginning on page 53 of this SPD.

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

How Do I Use The Vision Plan?

1. Contact a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member; provide your identification 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. Using a doctor from the VSP list 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 pages 39 and 40. However, there is no assurance that the schedule will be sufficient to pay for the examination or the glasses. Reimbursement benefits are not assignable. You must 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 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 (not a covered benefit for Retired Participants and their eligible Dependents);
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.

NOTE: The general exclusions described in Section X also apply to vision benefits.

VIII. ACCIDENT AND SICKNESS WEEKLY BENEFITS FOR ACTIVE PARTICIPANTS

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

A Participant that is totally disabled as the result of a pregnancy, will be entitled to the foregoing 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

IX. DEATH AND DISMEMBERMENT BENEFITS

Death and dismemberment benefits for all Eligible Active and Retired Participants and their eligible Dependents are as follows:

Death of an Active Participant

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

Death of a Dependent of an Active Participant

- Spouse $1,000
- Child $1,000

Dismemberment Benefits for the Active Participant

- 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

- Resulting from natural or accidental causes $10,000

Dismemberment Benefits for the Retiree

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

NOTE: The Dismemberment Benefit is payable subject to the following provisions:

a) Loss of a hand or foot means the dismemberment by severance through or above the wrist or ankle joint respectively.

b) Loss of an eye means the entire and irrecoverable loss of sight of the eye.

c) This benefit does not apply to sickness or disease, or medical or surgical treatment therefore, except pyogenic infection that occurs through an accidental cut or wound.

Payment of Benefits

Benefits for the death of a Dependent will be paid to the Participant. Benefits for dismemberment will also be paid to the Participant. Benefits for the death of a Participant will be paid to the Participant's Designated Beneficiary as described below.

Designated Beneficiary

A Participant may designate one or more persons or entities ("Designated Beneficiary") to receive benefits payable under the Trust as a result of the his or her death. Such designation must be made in writing on a form provided by Trust, and shall be subject to any spousal consent requirements contained herein. The last such designation shall supersede all prior designations.

If the Participant has not designated a beneficiary as described above, the benefit shall be paid as follows:

a) To the decedent's Spouse. If none;

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

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

A beneficiary form will be supplied by the Trust Fund Office and you may 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 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 Death and Dismemberment Benefit is not be payable for any intentionally self-inflicted injury, dismemberment, or death.

NOTE: The general exclusions described in Section X also apply to Death and Dismemberment benefits.

X. GENERAL EXCLUSIONS

In addition to the exclusions listed under 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. That are provided without cost by any municipal, county or other political subdivision;
    g. Provided in connection with court-ordered care; or
    h. Provided to a person for a procedure which results in the person being paid a fee or compensation, or such person otherwise profits from such procedure or supply, including but not limited to, medical expenses relating to donation of plasma in exchange for a fee or medical expenses relating to a participant's decision to carry a child for the benefit of another person in exchange for a fee (surrogacy).

4. 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, except that the Plan will cover routine patient costs for qualifying individuals participating in approved clinical trials (as those terms are defined under PPACA), but only to the extent required under PPACA. 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.

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. PLEASE REFER TO THE SECTION OF THIS BOOKLET REGARDING CLAIMS AND APPEALS PROCEDURES WHICH DISCUSSES THE PROCEDURES FOR SUBMITTING PRE-SERVICE CLAIMS.

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.

5. 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.

6. Intentionally self-inflicted injuries or sicknesses, except to the extent such injury or sickness results from domestic violence or an underlying medical condition.

7. Conditions caused by or arising out of an act of war, declared or undeclared, armed invasion or aggression.

8. 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, unless such charge is for treatment of injury resulting from domestic violence or an underlying medical condition.

9. Any bodily injury or sickness for which you are not under the care of a physician.

10. Charges for services performed by your Spouse, or a child, brother, sister or a parent of you or your Spouse.

11. Charges for any service not specifically covered by the Plan.

12. Any charges over the Plan's maximum Allowable Charges.

13. Services or supplies in connection with organ transplants that are not covered by the Plan.

14. Fees to complete claim forms.

15. 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.

16. Medical Expense Benefits will not be payable for:

    a. Medical examinations, services or supplies, including the duplication of diagnostic testing, which is not necessary for the treatment of an injury or sickness, except as specifically provided.
    b. Inpatient diagnostic testing, unless medically necessary.
    c. Any operation or treatment in connection with the fitting or wearing of dentures or treatment of the teeth or gums except:
        i. where such operation or treatment is necessary as a result of tumors and
        ii. 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.
    d. Charges in connection with the pregnancy of a Dependent child, except to the extent such charge constitutes a preventive care service as set forth in Section IV of this Plan.
    e. Temporomandibular joint syndrome and myofunctional therapy and procedures associated therewith.
    f. Stand-by personnel in connection with Cesarean sections.
    g. Expenses incurred in connection with prognathism, retrognathism or micrognathism.
    h. Cosmetic surgery, except surgeries necessary to repair disfigurement due to a congenital abnormality, accident or medical condition, or surgeries necessary to provide Medically Necessary transgender related treatment to the extent required under Section 1577 of the Affordable Care Act. With respect to cosmetic surgery necessary to repair disfigurement due to an accident, the accident must have occurred while covered under the Plan and the surgery must be performed within two years of the accident, unless the surgery cannot be performed within two years due to medical complications.
    i. Expenses in connection with the reversal of sterilizations.
    j. Rest cures and custodial care.
    k. Expenses incurred in connection with radial keratotomy, radial keratoplasty, or any other procedure performed only to improve visual acuity.
    l. Eye refractions, eye glasses, the fitting of eye glasses.
    m. Charges for any hospital care, medical, vision or dental services or supplies paid for under any other benefits provided under this Plan.

n. Drugs dispensed by a physician in his office.
o. Expenses incurred in connection with weight reduction, or complications from any procedures performed in connection with weight reduction.
p. Charges related to treatment of infertility.
q. Charges for treatment of impotency or erectile dysfunction.

17. Any charges related to and/or which constitute a Never Event or Hospital Acquired Condition.

XI. RECOVERY INCENTIVE PROGRAM

The Recovery Incentive Program is designed to encourage you to carefully review and audit your medical and dental bills. The Trust will pay you a cash incentive if you discover and arrange for recovery or reversal of overcharges made on your medical or dental bills, which in turn result in savings for the Plan. The program rules are as follows:

1. The cash incentive you will receive will be based on the amount of the overcharge that is reversed of what the Plan recovers from the provider.
2. When an overcharge of $25 or more is recovered, 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.
3. All overcharge reimbursements will be on a per family per calendar year basis to a maximum reimbursement per family of $500 per calendar year except by Board approval.
4. 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.
5. 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.
6. 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.

The following sets forth specific suggestions for a careful and complete review of a hospital bill:

1. Before leaving the hospital, make sure the hospital either provides or arranges to send an itemized bill;
2. List everything that happens while in the hospital by reconstructing events, either daily or immediately upon discharge
3. Match your list from 2 above against bills to detect any discrepancies;
4. Check the bill carefully for charges that represent any treatments, services, or supplies that were not received;
5. 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
6. 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.

XII. CLAIMS AND APPEALS PROCEDURES

The following rules apply to the Fee-For-Service Medical and Dental Plans, except that if you go to a Delta PPO or Delta Premier dentist, you do not need to file a Claim since your dentist will seek payment directly from the Trust through Delta Dental. For Blue Shield of California HMO, Kaiser and United Concordia Dental Plan, refer to the claims and appeals procedures in the benefits booklets issued by these organizations.

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. Proof of Claim for the Fee-for-Service Dental program must be submitted to Delta Dental 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. Obtain a claim form from the Trust Fund Office. There is a separate Delta Dental claim form for dental services provided under the Fee-For-Service Dental Plan, and the medical services provided under the Fee-For-Service Medical Plan.
2. The employee must complete, sign and date the employee's portion of the claim form.
3. Have your physician/dentist complete their portion of the claim form in detail.
4. Upon completion of the claim form, attach itemized bills and send your claim form as follows:
   a. If your Claim is for medical services, send your claim form to the Trust Fund Office at:

Airconditioning & Refrigeration
Industry Health & Welfare Trust Fund
3500 W. Orangewood Avenue
Orange, CA 92868
(714) 917-6100

   b. If your Claim is for dental services, send your claim form to the Delta Dental Office at:

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
(800) 765-6003

5. For medical claims assistance, write or telephone the Trust Fund Office at the address/telephone number listed above. For dental claims assistance, write or telephone Delta Dental at the address/telephone number listed above.

6. All Medical 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. All Dental Claims must be filed with Delta Dental 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.
7. 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 a PPO provider, benefits will be paid directly to that provider. If you use a Delta Dental PPO or Premier provider, benefits will be paid directly to the provider. If you use a non-Delta provider all benefits will be paid directly to you.

TYPES OF CLAIMS

When a Claim for specific Health Plan benefits (a "Claim," as defined on page 80) 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 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.

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.

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.

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.

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.

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.

You will be advised in writing of the decision of the Trust Fund Office. This will include a written explanation giving detailed reasons for any denial, the denial code (if any) and its corresponding meaning, a statement regarding the availability of the diagnosis and treatment codes upon request, 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, 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, and an explanation of the available external review procedures, including time limits, and a statement about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman. Also, if an internal rule, guideline or protocol or other similar criteria was relied upon in deciding your Claim, you will receive either a copy of the rule, guideline, protocol or other similar criteria, or a statement that it is available upon request at no charge, and if the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your Claim, or a statement that it is available upon request at no charge.

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 an appeal of the decision. The appeal will be reviewed by the Appeals Committee, which is a Committee of the Board of Trustees of the Plan whose members are appointed by the Board. 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. In addition, you will automatically be provided with any and all new information generated in connection with your appeal. You will be offered the opportunity for a full and fair review on appeal.

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 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 Appeals 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 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; the denial code (if any) and its corresponding meaning; a statement regarding the availability of the diagnosis and treatment codes upon request; 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; a statement of your right to bring a civil action under Section 502(a) of ERISA and the available external review procedures; and a statement about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman. In addition, if an internal rule, guideline, protocol or similar criterion was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge, and if the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your appeal, or a statement that it is available upon request at no charge.

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

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

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

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

Post-Service Claims: The Appeals Committee holds a regularly scheduled meeting at least quarterly. The Appeals Committee will make a determination regarding a request for review no later than the date of the first such meeting which occurs at least thirty (30) days following receipt of the request for review; but if special circumstances require an extension of time for processing, the benefit determination shall be rendered not later than the third meeting following receipt of the request. The claimant shall be notified of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

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.

Once the Plan's appeals procedures have been exhausted, the statute of limitations for bringing legal action against the Plan is two years from the date a final adverse determination is received.

EXTERNAL REVIEW

Request for External Review. Once you exhaust the appeals procedures, you have four months from the date you receive the final adverse benefit determination to file a request for an external review. If the deadline would fall on a Saturday, Sunday or Federal holiday, the deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday.

You may request external review for any denied Claims that involve a question of medical judgment, decisions about medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, a determination that a treatment is experimental or investigational, or a denial due to a rescission of coverage (meaning a retroactive termination of coverage). External review is not available for any other types of denials, including Claims related to eligibility or claims related to life/death benefits or disability benefits, or a legal or contractual interpretation of the plan's terms.

Requests for external review should be sent to the Trust Fund Office.

Preliminary Review of Request. Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the external review request to determine whether:

1. You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

2. The adverse benefit determination that is being appealed does not relate to your failure to meet the applicable eligibility requirements, or to a legal or contractual interpretation of the Plan's terms;
3. You have exhausted the Trust's internal claims appeal process; and
4. You have provided all the information and forms required to process an external review.

Within one business day after completion of this preliminary review, the Plan will issue notification of its decision to you. If the request is not eligible for external review, the notice will explain the reasons for its ineligibility and provide any other information required, including contact information for the Employee Benefits Security Administration. If the request for external review is incomplete, the Plan will identify what is needed and you will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an Independent Review Organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization.

The Plan will ensure independence of such IROs, will contract with at least three IROs for assignments, and will rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The assigned IRO will use legal experts where appropriate to make coverage determinations under the plan.

Review by IRO. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Within 5 business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify you and the Plan.

Upon receipt of any information submitted by you, the assigned IRO will within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan, and the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. Your medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, you or your treating provider;
4. The terms of the Plan;
5. Appropriate practice guidelines;
6. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this section to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The IRO will provide written notice of the final external review decision to the Plan and you within 45 days after the IRO received the request to review. The assigned IRO's decision notice will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the availability of diagnosis codes and their corresponding meaning, the availability of treatment codes and their corresponding meaning, the denial codes (if any); and the reason for the previous denial);
2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision; References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
3. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards, considered in reaching its decision;
4. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the plan or to the claimant;
5. A statement that judicial review may be available to you; and contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six years. The IRO will make such record available for examination by you, the Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State and Federal privacy laws.

Expedited External Review. You may request an expedited external review if you receive:

1. A claim determination involving a medical condition for which the time frame for completion of the Plan's expedited internal review process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
2. An appeal, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but has not been discharged from a facility.

If the Plan receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify you of its determination. If the Plan determines that you are eligible for a standard external review, the Plan will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by telephone or facsimile or by any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review.

The IRO will notify the Plan and you of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request or an expedited external review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO will provide written confirmation of the decision to you and the Plan.

XIII. 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 provided on the claim form when submitted for payment by the provider. "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 the parents 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:

i. The plan which covers the parent with legal custody;

ii. The plan which covers the step-parent with legal custody if step-children are covered by that plan; and

iii. 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 below.

IMPORTANT: CHANGES IN THE AVAILABILITY OF ALTERNATE INSURANCE COVERAGE

It is the Participant's and/or Dependent's responsibility to notify the Trust Fund Office immediately when alternate insurance coverage becomes available to you or your Dependents (or when such coverage is terminated).

If you or your Dependents have alternate insurance, you must submit a copy of the insurance card showing the effective date of coverage of the alternate insurance in order for the Trust Fund Office to determine which insurance is the Primary Plan.

If any claim or premium is paid on behalf of you, or your Dependents and it is later found that an alternate Primary insurance was available, you and/or the Dependents will be responsible for

reimbursing the Plan for all amounts paid, including interest, attorney's fees and costs of litigation if a lawsuit is filed to recover the money.

> ***NOTE:*** ***In addition to any other recovery rights it may have, the Plan shall have the right to recoup the overpayment from any future benefits payable to you or your Dependent(s). This includes, but is not limited to, withholding claim payments payable to you or your Dependent(s), withholding Vacation benefits payable to you, and suspending eligibility for you and/or your Dependent(s) until reimbursement obligations are fulfilled.***

The Plan reserves the right to periodically verify the status of any alternate insurance coverage for you or your Dependent(s). You are required to provide any requested information in order to maintain your coverage for you or your Dependent(s). Failure to respond to any requests for information may result in the termination of coverage for you and any or all of your Dependent(s).

XIV. 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.

The relevant sections of Medicare are: Part A which covers hospitalization and certain follow up services; Part B which helps pay doctor bills and other medical bills; and Part D which provides for prescription drug benefits.

Which sections of Medicare you must enroll in depends on whether you are an active Participant or retired. It also depends on whether you choose the Fee for Service Plan or one of the HMO Plans as follows. Below is a guide as to the parts in which you must enroll:

Active Participants in the Fee for Service Plan:

You should enroll in Part A only. It is important that you not enroll in Part D because you will receive your prescription drug benefit from the Trust and that benefit is equal to or better than the benefit under Medicare.

Active Participants in an HMO Plan:

You will need to contact your HMO provider for directions on the parts in which you must enroll.

Retired Participants in the Fee for Service Plan:

You should enroll in Parts A and B. If you fail to do so, your out-of-pocket costs will increase. You will be automatically enrolled in Part D. You will be given an opportunity to opt out of Part D, however your self-pay premium may increase if you opt out unless you have alternate primary prescription coverage available.

Retired Participants in an HMO Plan:

You must enroll in Parts A and B as well as the providers’ Medicare supplemental program. You will also need to contact your HMO provider for directions on whether or not you must enroll in Part D.

NOTE: ***THE PLAN WILL NOT PAY WHAT MEDICARE WOULD HAVE PAID HAD YOU BEEN ENROLLED AS STATED ABOVE.***

How to Enroll in Medicare

If you are approaching age 65, you will **not** automatically be enrolled in Medicare Part B 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. **Active Participants Age 65 and Over:**

   The Plan will provide full Plan benefits for **active** Participants age 65 and over and eligible 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, medical expenses and prescription drug, and Medicare is "secondary." Your active coverage will not be terminated solely because you enroll in Medicare under this paragraph.

2. **Retired Participants Age 65 and Over:**

   The Plan generally will be the "secondary" payer for Participants and Spouses who are over age 65 and Medicare eligible.

3. **Other Participants Eligible for Medicare:**

   This Plan generally will be the "secondary" payer for Participants and 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 as stated above, Plan benefits will be coordinated as if you have Medicare coverage. This means that you will be required to pay what Medicare would have paid.

If you are enrolled in the Fee for Service Plan, your provider must submit the claim and a copy of the Medicare Explanation of Benefits to Blue Shield of California so that we may coordinate payments with Medicare.

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, 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. In this case, the Plan will only pay 20% of the Allowable Charges.

XV. 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 as set forth in Sections I and II.

You and/or your eligible Dependents will be required to pay for COBRA continuation coverage on 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. You may request information concerning premium amounts and payment deadlines from the Trust Fund Office.

There may be other coverage options available for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as your Spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

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 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 5) you and your Dependents will not be eligible for COBRA 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.

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. Your parents divorce or legally separate;
5. The retirement of the Participant parent.

For purposes of this rule, a "Dependent" means any person who was a covered Dependent immediately before the Participant had a COBRA qualifying event, or a child who would have qualified as an eligible Dependent but was born to or adopted by the Participant while the Participant was covered under 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, or the death of the participant, the participating 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 later of (1) the date you would lose coverage because of a qualifying event or (2) the date you receive your COBRA Election Form to inform the Trust Fund Office by completing and submitting the Election Form that you want continuation coverage. Your continuation coverage will be effective as of the date you would otherwise have lost coverage under the Plan. If you first waive continuation coverage and later revoke that waiver, within your 60-day-election period, your continuation coverage will be effective on the date you revoke your waiver. If you do not choose continuation coverage, your group health coverage will end.

Please call or write to:

Trust Fund Office
Attn: Eligibility Department
Airconditioning and Refrigeration Industry Health and Welfare Trust Fund
3500 W. Orangewood Avenue, Orange, CA 92868
(714) 917-6100

Payment Obligations

Payment for the required COBRA 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. However, this initial payment will be accepted up to 45 days from the Participant's election date.
3. 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.
4. After the initial COBRA payment is made, payments must be made each month to continue coverage. Monthly payments must be postmarked by the 20th day of the month preceding each coverage month. 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 is identical to the group health coverage provided under the Plan to similarly situated employees or family members. However, you will not be provided continuation coverage for life insurance, accidental death and dismemberment (AD&D), or disability benefits.

You may select only one of the following coverages:

1. Medical coverage only
2. Medical, dental, and vision coverage.
    - You cannot select dental and vision coverage without also selecting medical 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 up to 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 continuation coverage, and by the end of the initial eighteen (18) months of continuation coverage 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 date of the first qualifying event. This extension is available to the Spouse and Dependent children who are enrolled in continuation coverage if the Participant dies, enrolls in Medicare, or is divorced or legally separated during the initial 18-month period. 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;
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;
6. The former employee performs work in Non-Covered Air Conditioning and Refrigeration Service. If this occurs, COBRA coverage will terminate for the former employee and any eligible Dependents.

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

More Information

In considering whether to elect continuation coverage, 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 one of the qualifying event listed above in the COBRA continuation coverage section. You will also have the same special enrollment right at the end of COBRA continuation coverage if you maintain continuation coverage for the maximum time available to you.

For more information about your rights under ERISA, including COBRA, HIPAA, the Patient Protection and Affordable Care Act (PPACA) and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

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.

XVI. 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

No benefits are paid or are payable under the terms of the Plan for healthcare expenses incurred by you or your Dependent(s) for an injury or illness which was in any way caused by the act of a third party who may be legally liable or responsible for the injury or illness. However, the Plan will advance payment for benefits in connection with such injury or illness caused by a third party so long as you do all of the following:

1. Provide the Plan with a written notice of any claim at the time the claim is made against any third party for damages resulting from an injury or an illness;

2. Before the Plan will advance any benefit, you must agree in writing to reimburse the Plan from the Recovery (as defined below) up to the amount of any benefits advanced by the Plan when the Recovery is obtained from the third party or from an insurer of any third party;

3. Agree to pay interest on any amount advanced but not reimbursed from the Recovery at the rate then in effect from the date of the Recovery until you fully reimburse the Plan;

4. Execute a lien on the Recovery in favor of the Plan, on a form provided by the Plan, for the full amount of benefits advanced by the Plan in connection with the injury or illness resulting from the acts of a third party;

5. Keep any Recovery whether in your possession or control or in the possession or control of your attorneys or other representatives received from a third party or from any insurer of a third party, segregated and not commingled with any other funds until paid to the Plan;

6. Agree in writing that the portion of the Recovery required to satisfy the lien of the Plan shall be held in trust for the sole benefit of the Plan until such time as it is paid to the Plan;

7. Direct any legal counsel retained by you or any other person acting on your or your Dependent's behalf to hold that portion of the Recovery to which the Plan is entitled in trust for the sole benefit of the Plan, to comply with the terms of the Plan, and to facilitate the reimbursement to the Plan of the amount of benefits advanced by the Plan;

8. To supply the Plan with all requested information about any claim, legal action or administrative proceeding, and respond to periodic requests for information from the Plan or the Plan's representative regarding the status of the claim against any third party;

9. Notify the Plan, in writing, within ten (10) days after any Recovery has been obtained; and

10. Reimburse the Plan from any Recovery for the full amount of benefits advanced by the Plan.

Unless you and/or your Dependent(s) comply with each of the conditions listed above, no benefits will be paid or are payable by the Plan with respect to the injury or illness. If benefits have already been advanced by the Plan, and the Plan determines any of these conditions have not been met, the Plan shall be entitled to recoup the full amount of benefits advanced in error directly from you or your Dependent(s).

The Plan shall have a first right of recovery. You are required to reimburse an amount equal to the benefits actually advanced by the Plan in connection with the injury or illness up to but not exceeding the Recovery. If the full amount owed to the Plan is not reimbursed from the Recovery then you and your Dependent(s) shall continue to owe the Plan the full amount of benefits advanced, together with interest until paid. This provision shall also be binding upon your and your Dependent's heirs, beneficiaries, personal representatives or estates.

If you or your Dependent(s) fail to reimburse the Plan, the amount of benefits advanced by the Plan, together with interest accruing from the date of your Recovery may be deducted from future benefits payable to you, or your Dependent(s), or on behalf of you or your Dependent(s), until such time as the full amount owed to the Plan is reimbursed.

Requiring that you reimburse the Plan out of the monies you receive from the third party helps contain the cost of benefits for all Participants and reduces the amount of benefits applied to you or your Dependent's lifetime maximum benefit under the Plan.

> **Recovery** - The term "Recovery" for purposes of this section shall mean any amount awarded or received pursuant to or by way of court judgment, arbitration award, formal or informal settlement proceedings, mediation or negotiations, surrogacy agreement, plasma donation agreement or any other arrangement, from any third party or a third party insurer, or from your own uninsured or underinsured motorist coverage in anyway related to or based upon the illness or injury sustained by you or your Dependent(s), without reduction for attorneys fees paid or owed by you or on your behalf, and without regard to whether you or your Dependent(s) have been made whole by the Recovery.
>
> Your Recovery includes all monies received either directly by you or by your Dependent(s) as well as any monies held in an account or trust on your or your Dependent's behalf, such as an attorney-client trust account, or structured settlement.

You or your Dependent's acceptance of payment of benefits, whenever such payments are made, shall constitute acceptance of all the terms and conditions of the Plan, including the agreement to reimburse the Plan for all benefits paid up to the full amount of the Recovery Your acceptance shall further act as a waiver of any defense to full reimbursement of the Plan from the Recovery, including any defense that you or your Dependent(s) have not been made whole by the Recovery, or that the amount payable by the Plan must be reduced by the amount of attorneys fees and costs which you are required to pay, or that the Plan should pay a pro-rata share of your attorneys fees and costs.

In the event the Plan is required to pursue recovery of unreimbursed benefits advanced to you or your Dependent(s), or enforce its lien on you or your Dependent's Recovery, the Plan shall

be entitled to recover in addition to the full amount of benefits advanced and accrued interest, all attorneys fees and costs incurred.

The Board of Trustees shall have full discretion and authority to interpret and apply these provisions relating to reimbursement of benefits advanced where an injury or illness results from the act of a third party.

Fraudulent Claims/Non-Cooperation

If the Trustees in good faith determine that you or a dependent negligently or intentionally made a false factual statement to induce payment of Plan benefits that otherwise would not be payable, or if you or any of your Dependents assist, cooperate, or permit anyone else to do so, (i) your and your dependents' coverage will cease immediately, (ii) you will not be entitled to a return of any contributions you have paid or agreed to pay, (iii) you and your dependents will never thereafter be eligible for the Plan, and (iv) the Trustees and the Plan shall retain any other additional remedies and rights they may have for dealing with the false claim, including a retroactive termination (i.e. rescission) of your coverage, but only to the extent permitted by law (i.e. in the event of fraud or an intentional misrepresentation of material fact). The same also will be true if you, any dependent, or anyone acting with or for you or your dependent, such as an attorney, fails to take any action the Trustees or their attorneys or agents request to help the Plan recover a benefit overpayment or to enforce its subrogation or related rights (such as by refusing to reimburse the Plan for benefits it paid in connection with injuries in an automobile accident that you later recover from a third party as damages), with the first such failure being treated as if it were a false factual claim for the purpose of applying the preceding sentence. The same will be true, and no benefits will thereafter be payable, if you or your dependent seeks a jury trial of a Plan-related claim.

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 Trust Fund Office, 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, Blue Shield of California, 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 in Section XII (except to the extent the Plan fails to follow its internal claims and appeals process or when the Plan's process should be otherwise deemed exhausted as required by law).

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.

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.

As required by HIPAA, 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 request a certificate while you are covered under the Plan or within 24 months after losing coverage. This request also can be made by another individual on behalf of you or your Dependents. For example, an individual who was previously covered under the Plan may authorize a subsequent health plan in which the individual is enrolled to request a certificate of the individual's creditable coverage from the Plan. An individual is entitled to receive a certificate upon request even if the plan has previously issued a certificate to that individual.

A request for a certificate of former plan coverage should be addressed to the Trust Fund Office, Attn: Eligibility Department, Airconditioning and Refrigeration Industry Health and Welfare Trust Fund, 3500 W. Orangewood Avenue, Orange, CA 92868, (714) 917-6100. Telephone requests will be accepted only if the coverage certificate is mailed to the address that the Plan has on file for the individual for whom the certificate is requested. Other requests must be made in writing.

- All requests must include:
    - The name of the individual for whom the coverage certificate is requested;
    - The last date that the individual was covered under the Plan;
    - The name of the participant that enrolled the individual in the Plan; and
    - A telephone number where the individual requesting the coverage certificate may be reached.

Requests that are required to be made in writing must also include:

- The name of the person making the request and evidence of that person's authority to request and receive the coverage certificate on behalf of the individual;
- The address to which the coverage certificate should be mailed;
- And the requester's signature.

After receiving a request that meets these requirements, the Plan will provide a coverage certificate within a reasonable time.

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.

- Reconstruction of the breast on which the mastectomy has been performed.

- Surgery on and reconstruction of the non-diseased breast to produce symmetry between the breasts.

- Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

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.

If you would like more information on this benefit, contact the Trust Fund Office at the address and telephone number listed in this book.

Nondiscrimination

The Health Plan does not discriminate on the basis of race, color, national origin, sex, age, or disability. The Health Plan provides free aids and services (such as qualified interpreters and information in alternate formats) when necessary to ensure equal opportunity for individuals with disabilities, and free language assistance services (such as translated documents and oral interpretation) when necessary to provide meaningful access to individual with limited English proficiency. If you need these services, contact the Health Plan's Civil Rights Coordinator at:

Mail: Airconditioning and Refrigeration Industry Health and Welfare Trust Fund
3500 W. Orangewood Ave.
Orange, CA 92868
Attn: Civil Rights Coordinator

Phone: (714) 917-6100
Fax: (714) 917-6065

If you believe the Health Plan has failed to provide these services or has otherwise discriminated on the basis of race, color national origin, sex, age, or disability, you may file a written grievance with the Health Plan's Civil Rights Coordinator as soon as possible at the address listed above. If you need help filing a claim, please contact the Civil Rights Coordinator for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-714-917-6100.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-714-917-6100。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-714-917-6100.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-714-917-6100 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-714-917-6100.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-714-917-6100.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-714-917-6100.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-714-917-6100.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-714-917-6100.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-714-917-6100.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-714-917-6100 まで、お電話にてご連絡ください。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-714-917-6100.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-714-917-6100.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-714-917-6100.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-714-917-6100 تماس بگیرید.

XVII. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan will use and disclose Protected Health Information ("PHI") to the extent permitted and in accordance with HIPAA, and the regulations issued thereunder, as amended, including, without limitation, those regulations at 45 C.F.R. Parts 160 through 164. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. The Plan's use and disclosure of PHI is also subject to the Plan's Notice of Privacy Practices which is posted at www.acrtrust.org. A Participant may also obtain a paper copy of the Plan's Notice of Privacy Practices by contacting the Plan's Privacy Officer, Kristi Wagner at: Airconditioning and Refrigeration Industry Health and Welfare Trust Fund, 3500 W. Orangewood Avenue, Orange, CA 92868, (714) 917-6100.

For purposes of complying with HIPAA, the Plan is a "Hybrid Entity" (as such term is defined in HIPAA) because it has both health plan and non-health plan functions. The Plan designates that this Section XVII applies to its health care components (e.g., medical benefit program, dental benefit program, employee member medical assistance program, vision program, and prescription drug program) that are covered by the HIPAA privacy regulations and not other Plan function or benefits.

Subject to obtaining written certification as required below and the limitations on the disclosure of PHI to the Plan Sponsor and the use and disclosure of PHI by the Plan Sponsor set forth in this Section XVII below, the Plan may disclose PHI to the Plan's Board of Trustees (the "Plan Sponsor"), provided the Plan Sponsor does not use or disclose such PHI except:

- To perform administrative functions which the Plan Sponsor performs for the Plan
- To obtain premium bids from insurance companies, HMOs or other health plans for providing group insurance coverage under the Plan;
- To modify, amend, or terminate the Plan; or
- As permitted by the Plan, or as required by law.

In no event shall the Plan Sponsor be permitted to use or disclose PHI, or the Plan be permitted to disclose PHI to the Plan Sponsor, in a manner that is inconsistent with 45 CFR §164.504(f). The Plan shall not disclose PHI to the Plan Sponsor unless the Plan Sponsor agrees to:

- Not use or further disclose the PHI other than as permitted by the Plan, or as required by law.
- Ensure that any agent who receives PHI from the Plan agrees in advance to the same restrictions and conditions that apply to the Plan Sponsor with respect to the PHI.
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted herein.

- Make available to a Participant his or her PHI in accordance with 45 CFR §164.524.

- Make available PHI for amendment to a Participant who requests an amendment to his or her PHI, and incorporate any amendments to his or her PHI in accordance with 45 CFR §164.526.

- Make available to a Participant who requests an accounting of disclosures of his or her PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

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

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

- Ensure that the adequate separation required by 45 CFR §164.504(f)(2)(iii) between the Plan and the Plan Sponsor exists.

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(ii), and that the Plan Sponsor agrees to the conditions of disclosure described above.

Notwithstanding any other provision herein, but subject to the limitations on the use of genetic information for underwriting purposes pursuant to 45 CFR § 164.502(a)(5)(i), the Plan may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:

- Obtaining premium bids from health plan providers for providing health insurance coverage under the Plan; or

- Modifying, amending, or terminating the Plan.

Notwithstanding any other provision herein, the Plan (or the applicable health insurer or HMO with respect to the Plan) may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the Plan Sponsor, provided such enrollment and disenrollment information is only used by the Plan Sponsor for the purpose of performing administrative functions that the Plan Sponsor performs for the Plan.

The Plan Sponsor shall only allow access to PHI to the Privacy Officer, the Administrator, employees on the Administrator's benefits staff and accounting staff with responsibility for supporting and performing administrative functions for the Plan, and members of the Plan's Board of Trustees. Such persons shall only have access to and use such PHI to the extent necessary to perform the appropriate supporting and administrative functions that the Plan Sponsor performs for the Plan. In the event that any such person does not comply with the

provisions of this Section, the Plan Sponsor shall take appropriate action for resolving the non-compliance, including disciplinary action, if appropriate.

The Plan Sponsor will reasonably and appropriately safeguard electronic PHI ("ePHI") created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan. Accordingly, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation required by 45 CFR § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- Ensure that any agent to whom the Plan Sponsor provides such ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident (as such term is defined in 45 CFR § 164.304) of which the Plan Sponsor becomes aware.

For purposes of this Amendment, the following terms shall have the meaning described below unless otherwise provided by the Plan:

- "Protected Health Information" of "PHI" means, subject to 45 CFR § 160.103, information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member, and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Protected Health Information includes information of persons living or deceased for 50 years or less. Protected Health Information also includes genetic information (as such term is defined at 45 CFR § 160.103).
- "Summary Health Information" means, subject to 45 CFR § 164.504(a), information that may be individually identifiable health information, and: (i) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and (ii) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

XVIII. PAID TIME OFF FUND

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

Participating Employers shall treat payments for the Paid Time-Off Fund 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 Paid Time-Off 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 Paid Time-Off 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 Paid Time-Off Account, less administrative fees and authorized PAC donations.

> **NOTE: Emergency withdrawals are not allowed.**

Changing Distribution Methods

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 Paid Time-Off Account shall be used to pay necessary administrative expenses.

When a Participant dies, any monies in the Participant's Paid Time-Off 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 Paid Time-Off Fund is covered under the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund.

XIX. 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 50 and claims and appeals procedures described on page 53. To be considered a Claim, the following elements must exist:

1. Written or electronically submitted communication to the Trust Fund Office or Delta Dental (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;
4. The communication must name a specific treatment, service or product for which approval or payment is requested;
5. The communication must specify the cost for a treatment, service or product; and
6. The communication must name the provider of the treatment, service or product.

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.

POLICY FOR REPORTING AND COLLECTION OF CONTRIBUTIONS FOR FRINGE BENEFITS: See separate policy maintained at the Trust Office.

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.

DEPENDENT: A Spouse or child of a Participant who meets all the eligibility requirement of the Plan. For a complete description, refer to page 1.

EMERGENCY: A "Qualified Emergency" is defined by the Plan as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that (i) places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) causes serious impairment to bodily

functions, or (iii) causes serious dysfunction of any bodily organ or part. Examples of medical conditions that would constitute a "Qualified Emergency" are:

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

A "Non-Qualified Emergency" is defined as any medical condition that does not constitute a "Qualified Emergency" as defined above.

ESSENTIAL HEALTH BENEFITS: In accordance with the Patient Protection and Affordable Care Act, Essential Health Benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

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.

HOSPITAL ACQUIRED CONDITION: A condition that (i) was not present on admission, (ii) could have been reasonably prevented, and (iii) constitutes a "Hospital Acquired Condition" according to the Center for Medicare & Medicaid Services.

MEDICALLY NECESSARY: Medically Necessary means any treatment, procedure, service, supply, drug, medicine or equipment that the Fund determines to be:

1. appropriate for the symptoms, diagnosis or treatment of a medical condition, and

2. provided for the diagnosis or the direct care and treatment of the medical condition, and
3. within the standards of good medical practice within the organized medical community of the United States of America, and
4. not primarily for the convenience of the patient, the treating Physician or other provider of care, and
5. the most appropriate procedure, supply, equipment or level of service that can be safely provided and that satisfies the following requirements:
    - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, service, supply, drug, medicine or equipment are clinically significant. The evidence also must demonstrate that there is a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than possible alternatives; and
    - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    - For Hospital stays, acute care as an inpatient is necessary due to the kind of service the patient is receiving, the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

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

NEVER EVENT: An event that is (i) preventable, serious, and unambiguously adverse to the individual that should not occur, and (ii) constitutes a "Serious Reportable Event" according to the National Quality Forum.

NON-COVERED AIR CONDITIONING AND REFRIGERATION SERVICE: Non-Covered Air Conditioning and Refrigeration Service means work in the same industry, the same trade or craft and in the same geographic area covered by the Plan for a Non-Participating Employer.

PARTICIPANT: An individual who meets all eligibility requirements of the Plan. For a complete description, refer to page 1.

PARTICIPATING EMPLOYER: An employer required by a Collective Bargaining Agreement or Participation Agreement with the Union, 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 15.

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:

- A Medical Doctor (M.D.)
- A Doctor of Osteopathy (D.O.)
- A Chiropractic Doctor (under limited conditions.)
- A Doctor of Medical Dentistry (D.M.D.)
- A Doctor of Dental Surgery (D.D.S.)
- A Doctor of Podiatry (D.P.M.)
- A Physical Therapist.
- A Psychologist (Ph.D.)
- A Master of Social Work (L.C.S.W., M.S.W., and M.F.C.C.)
- An Ophthalmologist (M.D.) or an Optometrist (O.D.)
- An Acupuncturist.
- A certified Nurse-Midwife.
- An Occupational Therapist (O.T.)
- A Registered Nurse as First Assistant (R.N.F.A.)
- A Physician Assistant (P.A.) (under limited conditions.)
- A Nurse Practitioner.
- A certified Nurse Anesthetist.
- A Home Health Agency.

SPECIAL ENROLL, SPECIAL ENROLLMENT OR SPECIAL ENROLLMENT RIGHT: The right you and/or your eligible Dependents have to enroll in the Plan outside the Open Enrollment Period upon the occurrence of certain events.

SPOUSE: The person to whom a Participant is legally married, as recognized under the laws of the state or jurisdiction in which the marriage was entered.

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.

UNION: The Southern California Pipe Trades District Council #16.

XX. GENERAL INFORMATION

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

United Association of Journeymen and Apprentices of the
Plumbing and Pipefitting Industry of the United States and Canada,
Local Union 250
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 May 1, 2017, the Trustees of this Plan are:

Labor Trustees

Jack Ferrara
United Association Local 250
18355 S. Figueroa Street
Gardena, CA 90248-4219

Tom Morton
United Association Local 250
18355 S. Figueroa Street
Gardena, CA 90248-4219

Management Trustees

John Baker
Air Conditioning Solutions, Inc.
2223 El Sol Ave.
Altadena, CA 91001

Robert H. Carder
Air-Ex Conditioning
157 Gentry St.
Pomona, CA 91767-2184

Brandon Mortorff
United Association Local 250
18355 S. Figueroa St.
Gardena, CA 90248-4219

Robert A. Lake
Emcor Service
2 Cromwell
Irvine, CA 92618-2011

Glenn Santa Cruz
United Association Local 250
18355 S. Figueroa St.
Gardena, Ca 90248-4219

James Reynolds
South Coast Mechanical, Inc.
2283 E. Via Burton
Anaheim, CA 92806

Jerry Trevino
So Calif. Pipe/Dist Council 16
501 Shatto Pl. #400
Los Angeles, CA 90020-1748

Richard J. Sawhill
ARCA/MCA
3602 Inland Empire Blvd.
Ontario, CA 91764-4900

Lonnie Wright
United Association Local 250
18355 S. Figueroa St.
Gardena, CA 90248-4219

Michael Tobin
Western Mechanical, Inc.
26382 Ruether Ave.
Santa Clarita, CA 91350

4. IRS Identification Numbers.

The number assigned to the Trust Fund 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:

Kristi Wagner, Administrator
Airconditioning and Refrigeration Industry Health and Welfare Trust Fund
3500 W. Orangewood Avenue
Orange, CA 92868
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 Southern California Pipe Trades District Council No. 16, 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 Trust Fund Office.

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 a welfare benefit plan under ERISA, maintained for the purpose of providing Medical, Prescription Drug, Dental, Accidental Death and Dismemberment, Weekly Accident and Sickness, and Vision Care benefits for Active Journeymen, Apprentices, Apprentice Trainees, Retirees, and their covered Dependents and beneficiaries.

9. Type of Administration.

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

Kristi Wagner
Airconditioning and Refrigeration Industry
Health and Welfare Trust Fund
3500 W. Orangewood Avenue
Orange, CA 92868
Telephone: (714) 917-6100

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

10. Funding Medium.

The Plan's assets and reserves are held in trust by the Board of Trustees (see 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.

11. 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, Blue Shield of California, and Delta Dental. Optional medical programs are provided by Blue Shield of California and Kaiser, and an optional dental program is provided by United Concordia Dental Plan. Blue Shield of California, Kaiser and United Concordia pay claims and handle claims appeals related to their programs of benefits.

Blue Shield of California, 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 3500 W. Orangewood Avenue, Orange, CA 92868

12. Termination and Amendment of the Plan.

The Board of Trustees reserves the right to amend or terminate this Fund, or any part of it, at any time. Amendments may be made in writing by the Board of Trustees and become effective on such date as specified in the document amending the Fund.

13. Statement of Trust Fund Rights.

The Trust Fund makes no representation that coverage under the Fund is guaranteed for any period of time.

The Board of Trustees, as Plan Sponsor, intends that the terms of this Fund described in this document, including those relating to coverage and benefits, are legally enforceable, and that each plan is maintained for the exclusive benefit of Participants, as defined by law.

Any written or oral statement, other than a written statement provided by the Board of Trustees, that is contrary to the provisions of this book is invalid, and no prospective, active or former employee should rely on any such statement.

14. Discretionary Authority of the Board of Trustees and Other Fiduciaries.

In carrying out their respective responsibilities under the Fund, the Board of Trustees, other Fund fiduciaries and individuals to whom responsibility for the administration of the Fund has been delegated, have discretionary authority to interpret the terms of the Fund and to determine eligibility and entitlement to Fund Benefits in accordance with the terms of the Fund. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

15. Plan Year.

This Plan is maintained on a calendar year basis (January 1 – December 31)

16. Statement of ERISA Rights.

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, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

<u>Receive Information about Your Plan and Benefits</u>

- Examine, without charge, at the Trust Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Trust, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the Fund with the U.S. Department of

Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. If you wish to examine any of the Plan documents outside the Trust Fund's office, you must submit a written request to:

Administrator
Airconditioning and Refrigeration Industry
Health and Welfare Trust Fund
3500 W. Orangewood Avenue
Orange, CA 92868

You will be sent a copy of the Plan documents you request.

- Obtain, upon written request to the Trust Fund Office, copies of all documents governing the Trust, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest Annual Report (Form 5500 Series) and updated Summary of Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Trust's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself or your Dependents if there is a loss of coverage under the Fund as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your 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. 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 plan benefit or exercising your rights under ERISA.

Enforce 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 Trust and do not receive them within 30 days, you may file suit in 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 Plan 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 Fund'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 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 a fee if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.