SECOND AMENDMENT TO THE SUMMARY PLAN DESCRIPTION REVISED MAY 2017 FOR ACTIVE AND RETIRED EMPLOYEES - AIRCONDITIONING AND REFRIGERATION INDUSTRY HEALTH AND WELFARE TRUST FUND

The Summary Plan Description revised May 2017 for Active and Retired Employees – Airconditioning and Refrigeration Industry Health and Welfare Trust Fund is hereby amended as follows:

1. Effective January 1, 2015, the subsection entitled "Certificate of Former Group Health Plan Coverage" under Section XVI, Miscellaneous, is hereby deleted in its entirety.

2. Effective for claims filed after April 1, 2018, the subsection entitled "Types of Claims" under Section XII, Claims and Appeals Procedures, is hereby revised as follows:

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, a Concurrent Care Claim, or a Disability 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.

A Disability Claim is a Claim for benefits involving a determination by the Plan that you or your Dependent is Totally Disabled when there is insufficient proof that you or your Dependent has been awarded disability benefits under the State Disability Insurance program.

3. Effective for claims filed after April 1, 2018, the subsection entitled "Initial Benefit Determination" under Section XII, Claims and Appeals Procedures, is hereby revised as follows:

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.

Disability Claims. The Trust Fund Office will notify a claimant of an initial determination regarding a Disability Claim within 45 calendar days from receipt of the Claim. 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 period to provide additional information, whichever is earlier.

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. In the case of a Disability Claim, you will also be provided with a discussion of the decision, including an explanation of the basis for disagreeing with or not following any Social Security Administration disability determination, or the views of the health care or vocational professionals presented by you or obtained by the Plan, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, or other information relevant to the claim for benefits, and a copy of the internal rule, guidelines, protocols, or similar criteria of the Plan relied upon in making the adverse determination or a statement that such information does not exist.

4. Effective for claims filed after April 1, 2018, the subsection entitled "Appeal of Adverse Benefit Determination" under Section XII, Claims and Appeals Procedures, is hereby revised as follows:

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 also be provided, free of charge and sufficiently in advance of the denial date, any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim and/or any new or additional rationale for the denial.

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. In the case of a Disability Claim, you will also be provided with a discussion of the decision, including an explanation of the basis for disagreeing with or not following any Social Security Administration disability determination, or the views of the health care or vocational professionals presented by the

claimant or obtained by the Plan, a description of any contractual limitations period that applies to your right to bring an action under ERISA and the calendar date on which the limitations period expires, and a copy of the internal rule, guidelines, protocols, or similar criteria of the Plan relied upon in making the adverse determination or a statement that such information does not exist.

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 and Disability 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.

CERTIFICATE OF ADOPTION OF AMENDMENT

The undersigned Chairman and Secretary of the Board of Trustees of the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund do hereby certify that the foregoing Amendment was duly adopted by the Board of Trustees at a meeting duly called and held on May 15, 2018.

Glenn Santa Cruz, Chairman

Richard J. Sawhill, Secretary