

INLAND

Refrigeration & Air Conditioning

Health & Welfare Trust Fund

Health and Vacation Plan of Benefits Summary Plan Description

Amended and Restated Effective February 1, 2010

Trust Fund Office:

Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor, Los Angeles, CA 90020
(213) 385-6161 (800) 595-7473 (213) 385-2767 (fax)

TABLE OF CONTENTS

	<u>Page</u>
I. INTRODUCTION.....	1
II. ELIGIBILITY REQUIREMENTS.....	2
A. Participants.....	2
B. Dependents.....	3
C. Non-Bargaining Unit Members.....	6
III. SUMMARY OF PLAN BENEFITS	7
IV. VACATION BENEFITS	7
A. Annual Payment of Vacation Benefits	7
B. Interim Withdrawals.....	7
C. Beneficiary	8
D. Forfeiture of Vacation Benefits.....	8
V. GENERAL INFORMATION ABOUT THE PLAN.....	8
A. Plan Administration.....	11
B. Plan Interpretation.....	11
C. Worker’s Compensation Not Affected.....	11
D. Trust Agreement.....	11
E. Circumstances Which May Affect Benefits.....	11
F. Plan Amendment and Termination.....	11
G. No Contract of Employment	11
H. Coordination of Benefits	12
I. Acts of Third Parties (Subrogation)	12
J. Medicare Election at Age 65.....	12
K. Reciprocity with Other Pipe Trades Plans.....	12
VI. CLAIMS AND APPEALS PROCEDURES.....	12
A. Applicability.....	12
B. Claims	13
C. Appeals.....	13
D. Use of an Authorized Representative	14
E. Other Important Information about Your Rights.....	15
VII. RIGHTS UNDER FEDERAL LAW	15
A. Certificates of Creditable Coverage	15
B. Qualified Medical Child Support Orders.....	15
C. Maternity Coverage.....	15
D. Mastectomy Coverage.....	16
E. Leave under Family and Medical Leave Act (FMLA).....	16
F. Privacy of Health Information.....	16
VIII. CONTINUATION COVERAGE RIGHTS UNDER COBRA	17
A. What Benefits Can Be Continued Under COBRA?.....	17
B. What are COBRA Qualifying Events?.....	17
C. When Does COBRA Coverage Begin?.....	18
D. How Long Does COBRA Coverage Last?.....	18
E. Adding Dependents to Your COBRA Coverage.....	19
F. Your Responsibility to Notify the Plan	20
G. Deadline to Elect COBRA Coverage	21
H. Paying for COBRA Coverage	21
I. Termination of COBRA Coverage.....	21
J. Certification of Coverage when Coverage Ends	22
K. Conversion to Individual Coverage Option (applicable only to HMO participants).....	22
L. If You Have Questions about COBRA	22
M. Keep Your Plan Informed of Address Changes	22
IX. STATEMENT OF ERISA RIGHTS.....	23

I.

INTRODUCTION

The Board of Trustees of the Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund (the “Trust Fund”) maintains this health and welfare benefits plan (the “Plan”) for the exclusive benefit of eligible participants and dependents. The Plan provides benefits through the following component benefit programs:

- Medical, including hospital and prescription drug benefits
- Dental
- Vision
- Life Insurance
- Accidental Death & Dismemberment
- Dependent Life Insurance
- Vacation

The vacation benefit is described in Section IV below. All of the other component benefit programs are summarized in separate material prepared by UnitedHealthcare/PacifiCare, Delta Dental, Vision Service Plan, and the Union Labor Life Insurance Co. (ULLICare). This material may be obtained from the Trust Fund Office.

Questions:

If you have any general questions regarding the Plan, your eligibility for Plan benefits, or the vacation benefit, please contact the Trust Fund Office at:

Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund
c/o Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, CA 90020
(213) 385-6161 (800) 595-7473 (213) 385-2767 (fax)

If you have any questions regarding the medical, dental, vision, life insurance, accidental death and dismemberment, or dependent life insurance benefits, please contact the appropriate company. The addresses and telephone numbers are provided in this booklet under Section V: General Information about the Plan.

IMPORTANT DISCLAIMER: These benefits hereunder are provided pursuant to insurance/HMO contracts, as well as a governing plan document adopted by the Trust Fund. If the terms of this Summary Plan Description, including any enclosed booklets, conflict with the terms of such insurance/HMO contracts and the governing plan document, then the terms of the insurance/HMO contracts and the governing plan document will control, rather than this Summary Plan Description. Participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan will always govern.

II.

ELIGIBILITY REQUIREMENTS

Please note that if you are eligible for benefits, you (and your eligible Dependents, if any) will be covered under all of the component benefit programs provided by the Plan; you cannot pick and choose between the individual benefits. Similarly, if your eligibility terminates, you (and your Dependents, if any) will lose coverage under all of the component benefit programs.

A. Participants

- Initial Eligibility. You will become eligible for benefits as a Participant on the first day of the second calendar month following the date on which you have been credited by a contributing employer(s) with at least 500 hours of work within a period of not less than three (3) nor more than six (6) consecutive calendar months.
- Continuation of Eligibility. Once you have established your initial eligibility, 100 hours will be deducted from your account on the first day of each month that you are covered.

After the 100 hours have been deducted, all hours worked and credited on your behalf for the prior month will be added to your account. The maximum number of hours credited to your account may never exceed 600. These hours in your account may be drawn upon to maintain your eligibility during months when you work less than 100 hours.

If your eligibility has terminated because of insufficient credited hours, you will again become eligible when your account shows a total of at least 100 hours within the six (6) month period following the date you lose your eligibility. The reinstatement of your eligibility will be effective on the first day of the second calendar month following the date this requirement is met. The running of the six (6) month period will be tolled during any period in which a Participant is unable to work due to a work-related illness or injury for which the Participant is receiving workers compensation benefits, as determined by the Board of Trustees on the basis of acceptable evidence.

- Termination of Eligibility. Your eligibility shall cease and coverage shall no longer be purchased on your behalf if, on the first day of any month, you have fewer than 100 hours in your account. For example, if you have 100 hours in your account as of January 31, 100 hours will be deducted from your account on February 1 for coverage in February. If, on the other hand, you only have 99 hours in your account as of January 31, you will not be eligible for benefits in February.
- Note Regarding USERRA. Your eligibility terminates on the date you enter full-time active duty in the uniformed services of the United States. Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), the hours in your account are automatically preserved until you are able to return to covered employment after termination of your service. During that time (for up to 24 months), you may purchase COBRA coverage for you and your dependents, in accordance with the COBRA rules of the Plan. To do so, you must submit to the Trust Fund Office within 60 days of entering the uniformed services full-time a written election to continue coverage. However, you may elect to waive your rights under USERRA. In that case, the hours in your account may be applied to provide coverage for your Dependents. The months of coverage applied will no longer be available to provide coverage for you upon your return to covered employment.

Coverage will be reinstated for participants who are honorably discharged from full-time active duty on the first day the participant returns to, or is available for, active employment with a contributing employer, provided this occurs within 90 days of completing uniformed service.

When coverage is reinstated, all provisions, limitations and exclusions of the Plan will apply to the extent that they would have applied if the participant had not taken uniformed services leave and coverage had been continuous under the Plan.

For more information about your rights under USERRA, contact the Trust Fund Office.

- Forfeiture of Hours. You will permanently lose all of the hours credited to your account in the following situations:

Employment Outside of California: The hours in your account will be forfeited on the first day of the seventh month following six (6) consecutive months of any employment outside of California. For example, if you leave California to work in another state, and you work continuously in that state from January 1 through June 30, you will forfeit the hours in your account on July 1.

Moving Out of the Service Area: If you move outside of the Southern California service areas established by UnitedHealthcare/PacifiCare, Delta Dental or Vision Service Plan, the hours in your account will be forfeited on the first day of the seventh month following the date of your move.

Non-Union Employment: Your eligibility will terminate on the date you perform work in the refrigeration, air conditioning, plumbing, heating and piping industry which is not covered by a collective bargaining agreement. Any hours credited to your account will be forfeited upon the commencement of such employment or self-employment. You may be required to provide proof to the Trust Fund that you are not working in prohibited employment not covered by a collective bargaining agreement in order to prevent the forfeiture of your hours under this provision.

- Delinquent Employer Contributions. If your employer has been delinquent in making contributions for two (2) or more consecutive months, the Plan Administrator will notify you of such delinquency and your hours will not be credited to your account unless: (1) your employer cures the delinquency before the due date for the following month's contributions, or (2) you make self-payments within thirty (30) days of the date the Plan Administrator gives you written notice stating the amount of the self-payment required to continue eligibility. Self-payments may be made for a maximum of six (6) months from the first full month that follows the date of the notice. To the extent that contributions are subsequently collected from your employer, you will be reimbursed as appropriate for your self-payments. Self-payments are due no later than the first day of the month for which coverage is sought.
- Keep Your Plan Informed of Address Changes. In order to protect your family's rights, you should keep the Trust Fund Office informed of any changes in the addresses or dependent status of family members, including births, deaths, or divorces. You should also keep a copy, for your records, of any notices you send to the Trust Fund Office.

B. Dependents

Commencement of Eligibility. Your dependents will become covered on the same day your coverage becomes effective, if they meet the eligibility rules below and the required documentation of dependent status is submitted to the Trust Fund Office. Required documentation may include such items as marriage certificates, birth certificates or adoption papers. Contact the Trust Fund Office for details on what documentation must be submitted in order to establish eligibility for your dependents. If required documentation is not submitted within the time prescribed by the Trust Fund Office, the dependent's coverage effective date may be delayed until the first day of the month following the date the Trust Fund Office received the required documentation.

"Eligible Dependents" or "Dependents" include the participant's:

1. lawful spouse;

2. unmarried children through the last day of the month in which the child turns age 19 if they are dependent upon the participant for more than half of their support;
3. unmarried children who are age 19 through the last day of the month in which the child turns age 23, if they are enrolled as full time students in an accredited institution of learning and dependent upon the participant for more than half of their support. An unmarried child 19 through 22 years of age who was in school the last month of a semester prior to summer break and who is enrolled for the following semester will be covered during the summer break if you submit a Full-Time Student Inter-Term Break Certification Form (available from the Trust Fund Office). In order for a student 19 through 22 years of age to maintain coverage during school terms, you must submit a student certification from the school registrar to the Trust Fund Office for each enrollment period.

If a child eligible under this student provision takes a medically necessary leave of absence from school (or changes to part time status due to medical necessity), his or her eligibility may continue for up to 12 months while on such medical leave (or part time status). In order for a student 19 through 22 years of age to maintain coverage while on medical leave (or part time status), you must submit to the Trust Fund Office a written certification from a physician that the child is suffering from a serious illness or injury and that a leave of absence from school (or reduced hours) is medically necessary. The certification must be submitted to the Trust Fund Office within 30 days following the date the leave of absence begins. This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or part time status) and ends on the date that is the **earlier** of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan;

4. unmarried dependent children 19 years of age or older if the child is **solely** dependent upon the participant for support and is totally prevented from earning a living because of a mental or physical handicap. The disabled child must have been handicapped while covered under the Plan prior to reaching the limiting age of 19, or 23 if a full-time student. Written evidence of such incapacity must be furnished to the HMO/insurance companies with respect to any such child within thirty-one (31) days after the attainment of such limiting age. Proof of the continued existence of such incapability must also be furnished from time to time at the request of the HMO/insurance companies.

Unmarried children include the participant's natural child, legally-adopted child, child "placed for adoption" if under 18 years old, step child or any other child for whom, by a Qualified Medical Child Support Order (QMCSO) or court order of legal guardianship, the participant is legally responsible for the child's health care expenses. A child is "placed for adoption" with you on the date you first became legally obligated to provide full or partial support of the child whom you plan to adopt. If the participant is the legal guardian of a child who is not a "relative," as listed in Internal Revenue Code Section 152(d)(2)(A) through (G), the child must, for the entire year, have the same principal place of abode as the participant and be a member of the participant's household.

Additional Requirements for Children. To qualify as an eligible dependent, an unmarried child cannot be a "qualifying child" of any person other than the participant, except for the child's other parent in certain cases of divorce/separation (see special rule below). The term "qualifying child" is defined in Internal Revenue Code § 152(c). A child will not be treated as the qualifying child of another person if that other person is not required by federal law to file an income tax return and that person either does not file an income tax return or files one solely to obtain a refund of withheld income taxes.

There is a special rule in certain cases of divorce/separation. If the participant does not provide over half of the child's support, the child will be an eligible dependent provided that: the participant and

the child's other parent are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or live apart at all times during at least six months of the calendar year; the participant and the child's other parent provide over half of the child's support; the child is in the custody of one or both of his or her parents for more than half of the year (note that under applicable Internal Revenue Service rules, once a child becomes emancipated (typically at age 18), the IRS no longer considers the child to be in the custody of either parent for purposes of this special rule); the child is either the participant's or the other parent's "qualifying child" or "qualifying relative" under Internal Revenue Code §§ 152(c) and (d); and the child meets all other required eligibility criteria.

Newly Acquired Dependents. If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption after your coverage becomes effective, you may enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, that your dependents meet the eligibility requirements described above, and that you provide appropriate evidence of dependent status within 90 days of the marriage, birth, adoption, or placement for adoption, such as a certified copy of the official, government-issued birth or marriage certificate, or a copy of the document placing the child for adoption. No eligibility will be provided until appropriate evidence of dependent status is received, whereupon eligibility will be retroactive according to the rules of the HMO or insurance provider. It is therefore essential that, if you encounter a delay in obtaining an official marriage or birth certificate, you consult with the Fund Office immediately in order to preserve your new dependent's retroactive eligibility date.

If enrollment for a newly acquired eligible dependent is not requested within 30 days from the date dependency status is met, the dependent's coverage effective date may be delayed until the first day of the month following the date the Trust Fund Office received the request for enrollment and required documentation of dependent status.

Termination of Eligibility. Your Eligible Dependent's coverage will terminate on the same day your coverage terminates, with the following exception: if your coverage terminates due to your death, coverage for your Eligible Dependents will be continued for the period of time that you would have been covered had you lived based on the number of hours in your account, or on the last day of the month in which the dependent no longer meets the qualifications of a dependent, whichever occurs earlier.

IMPORTANT NOTICE REGARDING CHANGES IN DEPENDENT STATUS

You must IMMEDIATELY notify the Trust Fund Office in writing when dependent status changes occur. This includes final dissolution of marriage, death, a former full-time student over 19 not taking enough units at school, marriage of a child, and any other events which would make your dependent not eligible for further coverage. The changing of a participant's beneficiary for death or other benefits is not acceptable notification of divorce.

If you do not immediately notify the Trust Fund Office and claims and/or premiums are paid on behalf of an ineligible dependent, the participant and/or the dependent are responsible for reimbursing the Trust for such claims and/or premiums, including attorney's fees, interest and reasonable collection costs. The Trust Fund may recover these amounts through legal action or otherwise as determined in the sole and absolute discretion of the Board of Trustees. The participant and/or dependent may also be required to reimburse the Trust Fund and/or HMO for the value of any HMO benefits provided to the ineligible dependent.

C. Non-Bargaining Unit Members

- Coverage for Non-Bargaining Unit Members. Effective February 1, 1990, a contributing employer who is bound by a collective bargaining agreement may elect to contribute to the Trust Fund for all of its full-time employees and their Eligible Dependents who are not engaged in work covered by the collective bargaining agreement or any other labor agreement.
- Establishment of Eligibility. A non-bargaining unit employee of a contributing employer who regularly works thirty (30) or more hours per week is eligible for coverage under the Trust Fund if his or her employer has signed a participation agreement acceptable to the Board of Trustees, timely payments for coverage are made to the Trust Fund, and the employee is enrolled within ninety (90) days of the date he or she is first hired.

An employee who was eligible to participate in the Plan, but had not enrolled for coverage during this time period, will not be permitted to enroll at a later date. If, however, the employee declined enrollment for him or herself (or his or her dependents) because of other health insurance coverage, the employee may in the future be able to enroll him or herself (or his or her dependents) in this Plan, provided that: (i) the employee requests enrollment within 30 days after the other coverage ends, (ii) the employee and his or her dependents meet the Plan's eligibility requirements, and (iii) the employee completes and submits a form provided by the Plan Administrator which states that the reason for declining coverage under the Plan is due to other health insurance coverage.

An employer may exclude from coverage any non-bargaining unit employee who is covered as a dependent under his or her spouse's employment-based plan of hospital/surgical/medical insurance for which said employer pays the majority of the premium, provided the employee signs a statement acknowledging the exclusion, and the employer agrees that when the spouse's eligibility terminates, the excluded employee and his/her family will be added to the Plan provided by this Trust Fund with no lapse in coverage.

- Effective Date of Coverage. Coverage will be effective for the employee and his or her Eligible Dependents on the first day of the month following the receipt of the first contribution.
- Continuation of Coverage. The employee will remain eligible during each month his/her employer makes a contribution to the Trust Fund on his/her behalf.
- Termination of Eligibility. The eligibility of the non-bargaining unit employee will terminate on the earliest of the following dates:
 - The last day of the month for which an employer contribution is made;
 - The date the employer ceases to contribute on behalf of his/her bargaining unit employees;
 - The date the Plan terminates; or
 - The date the non-bargaining unit employee ceases to be employed by the employer or the non-bargaining unit employee's hours drop below thirty (30) hours per week.

III.

SUMMARY OF PLAN BENEFITS

This Plan provides you and your Eligible Dependents with medical (including hospital and prescription drug benefits), dental, vision, life insurance, accidental death & dismemberment, dependent life insurance, and vacation benefits.

Medical benefits are provided through a contract between the Trust Fund and UnitedHealthcare/PacifiCare, dental benefits are provided through a contract between the Trust Fund and Delta Dental, and vision benefits are provided through a contract between the Trust Fund and Vision Service Plan. The life insurance, accidental death & dismemberment, and dependent life insurance benefits are provided through a contract between the Trust Fund and ULLICare. The vacation benefit is provided directly by the Trust Fund.

A summary of each benefit provided under the Plan is set forth in material provided by UnitedHealthcare/PacifiCare, Delta Dental, Vision Service Plan and ULLICare, with the exception of the vacation benefit, which is described under Section IV, below.

PLEASE NOTE: In order to obtain services from UnitedHealthcare/PacifiCare, Delta Dental, and Vision Service Plan, you must live in one of their service areas located in Southern California. If you do not reside in a designated service area in Southern California, you will not be able to obtain services from these HMO/insurance companies. Information regarding coverage areas may be obtained directly from the providers.

The cost of the benefits provided through the component benefit programs will be funded by employer contributions to the Trust Fund. The Trust Fund will pay the required premiums to the various companies, with the exception of the vacation benefit, in which case the Trust Fund will use employer contributions to pay benefits directly to you or your beneficiary.

IV.

VACATION BENEFITS

A. Annual Payment of Vacation Benefits

Your benefits include vacation pay. Every December 1, the Trust Fund will send out a check to you in an amount equal to the employer contributions received on your behalf during the twelve (12) months ending October 31 preceding the December 1 payout. The checks may also include interest if, in the discretion of the Trustees, there is a sufficient amount remaining after payment of administrative expenses to warrant an allocation to each participant. Each vacation payment shall be accompanied by a statement of hours reported on your behalf, contributions received, and interest, if any, allocated to your account.

B. Interim Withdrawals

You may withdraw all or part of your accrued vacation pay before December 1. You may request an interim withdrawal only once during each calendar year. The maximum amount of an interim withdrawal is \$1,000.00 or the balance held on your behalf on the first day of the calendar month prior to the month in which you requested the withdrawal, whichever is less.

Interim withdrawals will reduce the amount available at the regular December 1 payout. No interim withdrawals will be allowed during the months of November and December due to the proximity of these months to the normal December 1 payout.

If you take an interim withdrawal of vacation monies, you will not share in any interest income that may have been earned on the withdrawn amount during the fiscal period prior to which the interim distribution was made. Further, the Trust Fund may assess a reasonable charge to you for administrative expenses incurred in processing your request for an interim withdrawal.

C. Beneficiary

Upon your death, any unpaid vacation monies shall be distributed to your designated beneficiary. If you have not designated a beneficiary, or if your beneficiary does not survive you, the vacation monies will be distributed in the following order: surviving spouse; if none, then to surviving children in equal shares; if none, then to your estate.

If you designate your spouse as your beneficiary on a beneficiary designation form setting forth this rule, that designation will be revoked automatically in the event of divorce. A participant may reinstate the beneficiary designation of an ex-spouse by completing a new beneficiary designation form and filing it with the Trust Fund Office after the date of divorce. For more information contact the Trust Fund Office.

D. Forfeiture of Vacation Benefits

If a participant fails to claim vacation benefits during either of the two calendar years following the year in which such benefits were payable to the participant as part of the December annual payment of benefits, such benefits, together with any interest or income accrued thereon, shall revert to the Trust Fund freed from obligation to the participant and may be used by the Board of Trustees to pay for the costs of administration of the Trust Fund or for any other lawful purpose.

V.

GENERAL INFORMATION ABOUT THE PLAN

Plan name:	The Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund
Plan number:	501
Type of plan:	An ERISA welfare benefit plan that provides medical (including hospital and prescription drug benefits), dental, vision, life insurance, accidental death & dismemberment, dependent life insurance, and vacation benefits.
Contributions and funding:	<p>Contributions. The Plan is financed by employer contributions, and in some cases by participant self-payments of contributions, and the amount of the contributions is determined by the collective bargaining agreement.</p> <p>The insurance premiums for your benefits are paid by the Trust Fund, although you may owe a co-payment or deductible for part of the covered benefits. If the services you receive are not covered by the Plan, you may owe the full cost of those services.</p> <p>Funding. The Plan's assets and reserves are held in trust by the Board of</p>

Trustees of the Trust Fund, and are invested in various bank savings accounts and short-term bank instruments, government and corporate bonds and certain other investments approved by the Trustees. All of the benefits under the Plan are fully insured or provided by contract with an HMO, with the exception of the vacation benefit, which is self-funded.

Group contracts between the Trust Fund and the following companies provide for the following benefits: UnitedHealthcare/ PacifiCare (for medical benefits); Delta Dental (for dental benefits); Vision Service Plan (for vision benefits); and ULLICare (for life insurance, accidental death & dismemberment, and dependent life insurance benefits). These companies, and not the Trust Fund, are responsible for (i) determining the amount of any benefits payable under their respective component benefit plans, and (2) prescribing claims procedures to be followed and the claims forms to be used by participants and their dependents under their respective component benefit plans. These companies guarantee the payment of claims incurred before the group contracts terminate.

The vacation benefit is provided directly by the Trust Fund. The Trust Fund has contracted with the Southern California Pipe Trades Administrative Corporation, a third party administrator, to pay vacation benefit claims on behalf of the Trust Fund.

Type of administration:

The Board of Trustees of the Trust Fund consists of an equal number of employer and union representatives, in accordance with the Agreement and Declaration of Trust which relates to this Plan. The Board of Trustees, as the Plan Administrator and named fiduciary, is authorized to control and manage the operation and administration of the Plan.

The Trust Fund has contracted with the Southern California Pipe Trades Administrative Corporation, a third party administrator, to provide claims administration and other services, and to act as the Trust Fund Office. The Southern California Pipe Trades Administrative Corporation does not insure the benefits.

For medical, dental, vision, life insurance, accidental death & dismemberment, and dependent life insurance benefits, the Trust Fund has allocated to UnitedHealthcare/PacifiCare, Delta Dental, Vision Service Plan and ULLICare, respectively, the responsibility for administering claims (with the exception of determining eligibility questions on appeal) and for exercising other fiduciary functions.

Plan year:

February 1 to January 31

Plan Administrator/ Plan Sponsor/ Named Fiduciary:

Board of Trustees of the Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund

c/o Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, California 90020
(213) 385-6161 (800) 595-7473 (213) 385-2767 (fax)

Plan Sponsor's Employer Identification Number:

95-6115404

HMO/Insurance Companies:

UnitedHealthcare/PacifiCare
5701 Katella Ave.
Cypress, CA 90630-5082
(800) 624-8822
Policy/Contract No. 003579

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195
Policy/Contract No. 12076721

Delta Dental
P.O. Box 3370
Cerritos, CA 90703
(562) 403-4000
Policy/Contract No. 8371

ULLICare, Inc.
11 Massachusetts Ave., N.W.
Washington, DC 20001
Policy/Contract Nos. C-1578 and C-2649

Agent for service of legal process:

Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund

501 Shatto Place, 5th Floor
Los Angeles, California 90020
(213) 385-6161 (800) 595-7473 (213) 385-2767 (fax)

Service of legal process may also be made on the Plan Administrator in care of Southern California Pipe Trades Administrative Corporation or any Trustee.

Trustees:

Union Trustees

Mr. Richard Edwards
U.A. Local 364

Mr. Frank Trainor
U.A. Local 364

Mr. John Sherman
U.A. Local 398

Mr. Don Tanaka
U.A. District Council #16

Management Trustees

Mr. Richard J. Sawhill
ARCA/MCA

Mr. Todd Shaw
Desert Air Conditioning

Mr. Scott Limbacher
Stater Bros.

Mr. Dee Kennedy
Couts Heating & Cooling

c/o Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, CA 90020

Collective Bargaining Agreement:

The Plan is maintained pursuant to a collective bargaining agreement, a copy of which can be obtained upon written request to the Trust Fund Office and can be examined at the Trust Fund Office or at the local union office.

Contributing Employer:

You can inquire in writing as to whether your employer is a contributing employer, and if so, you may obtain your employer's address from the Trust Fund Office.

Effective Date:

May 15, 1965. The Plan has been amended several times since its original effective date. Unless otherwise stated this Plan is effective February 1, 2010.

A. Plan Administration

The administration of the Plan is under the supervision of the Board of Trustees. The administrative duties of the Board of Trustees include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan.

B. Plan Interpretation

The Board of Trustees has the discretionary authority to determine eligibility for benefits and to interpret the terms of the Plan except to the extent the Board has delegated such authority to UnitedHealthcare/PacifiCare, Delta Dental, Vision Service Plan and ULLICare. Using its discretionary authority, the Board of Trustees may correct defects, make findings of fact, rectify any omission, or reconcile any inconsistency or ambiguity in the Plan. Any interpretation or determination made under the Board's discretionary authority will be given full force and effect. The Board of Trustees retains the sole and absolute discretion to interpret the provisions of the Plan and to make the necessary factual determinations regarding eligibility for benefits or any other issue regarding the Plan.

C. Worker's Compensation Not Affected

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by worker's compensation insurance laws or similar legislation.

D. Trust Agreement

The provisions contained in this Summary Plan Description are subject to and controlled by the provisions of the Trust Agreement, and, in the event of any conflict between the provisions contained in this booklet and booklet inserts and the provisions contained in the Trust Agreement, the provisions of the Trust Agreement shall prevail.

E. Circumstances Which May Affect Benefits

Coverage under the Plan for you and your covered dependents will cease under certain circumstances, such as termination of eligibility (see Section II of this booklet) and termination of the Plan. With respect to the vacation benefit, if you take an interim distribution of your vacation benefit, you will not receive interest earnings that the Board of Trustees may have credited to your account. Other circumstances can result in the termination, reduction or elimination of benefits.

F. Plan Amendment and Termination

Pursuant to the Trust Agreement establishing the Trust Fund and the Plan document, the Board of Trustees of the Trust Fund, in the exercise of its sole and absolute discretion, can amend, replace, or terminate the group contracts through which benefits are provided under the Plan at any time. The Board also can amend or terminate the Plan itself at any time. Plan amendments include amendments to terminate coverage for some or all participants and their dependents. If the Plan is terminated, the rights of a participant covered under the Plan are limited to the payment of eligible expenses incurred prior to termination. Any assets of the Trust Fund remaining upon termination will be used to continue providing the types of benefits provided by this Trust Fund, in accordance with the governing plan documents and applicable law.

G. No Contract of Employment

This summary plan description is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and your employer to the effect that you will be employed for any specific period of time.

H. Coordination of Benefits

If you or your Eligible Dependent(s) are covered by other insurance, you may be subject to “coordination of benefits” for your medical, dental and vision benefits, as described in the provider material. Coordination of benefits occurs when two or more separate plans cover the same claim by sharing its cost. In no event will the aggregate of benefits payable exceed 100% of the actual eligible charges incurred. Please consult the provider material for details regarding coordination of benefits.

I. Acts of Third Parties (Subrogation)

If someone else is legally responsible or agrees to compensate you for an illness or injury suffered by you or your dependent(s) that is covered by this Plan, you may be subject to a “subrogation” provision requiring you to reimburse the company (such as UnitedHealthcare/PacifiCare) that paid benefits on your behalf relating to that illness or injury. Please consult the provider material for details regarding subrogation.

J. Medicare Election at Age 65.

Please consult the material provided by UnitedHealthcare/PacifiCare for details regarding your right to elect Medicare at Age 65.

K. Reciprocity with Other Pipe Trades Plans

The Trust Fund is party to the U.A. National Reciprocity Agreement. If you work for a union employer who contributes on your behalf to any trust fund bound to this reciprocity agreement, you may direct that contributions paid on your behalf be transferred to this Trust Fund, your “home” Trust Fund. Upon receipt of the contributions, your “hours” account will be credited based upon the hours reported as worked. Since the reciprocity agreements are subject to change and the identities of the participating trust funds also change, please contact the Trust Fund Office to determine if a reciprocity agreement covers your work location. See also Section II(A) “Forfeiture of Hours” regarding out-of-area work. Contact the Trust Fund Office or your Local Union if you have additional questions or need any forms.

VI.

CLAIMS AND APPEALS PROCEDURES

A. Applicability

These claims procedures apply only to claims for vacation benefits. These claims procedures **do not** apply to claims for medical, dental, vision, life insurance, accidental death & dismemberment, and dependent life insurance benefits. For these benefits, the respective insurer or HMO is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or HMO contract. Please refer to the provider material for the procedures applicable to claims for benefits under those programs (including any requirement to submit claim forms), which are incorporated herein by reference.

These appeals procedures apply only to appeals of claims that were denied based on eligibility. For example, if UnitedHealthcare/PacifiCare claims that you are no longer an eligible participant, these procedures govern such an “eligibility” denial. If, on the other hand, UnitedHealthcare/PacifiCare claims that you have exhausted a certain benefit, such as the number of counseling sessions, these procedures do not govern, and you must use UnitedHealthcare/PacifiCare’s claim procedures. For

questions concerning these claims and appeals procedures, please contact the appropriate insurer or HMO or the Trust Fund Office.

B. Claims

- **Filing a Claim.** You must file a claim with the Trust Fund Office using the claim forms provided by the Plan. Your claim will be considered “filed” when it is received by the Trust Fund Office. Claims must be submitted to the Trust Fund Office within 180 days from the date of service. Late claims may be rejected as untimely.
- **Time Period for Claims Review.** The Plan will make a decision within 90 days after you file your claim, unless the Plan needs an extension of time for processing. If an extension is necessary, the Plan will send you a written notice containing the reason for the extension and the date by which the Plan expects to decide your claim, which will not be more than 180 days from the date you filed your claim.
- **Claim Denial Notice.** If the Plan denies your claim, in whole or in part, it will send you a written denial notice containing: (i) the specific reason(s) for the denial; (ii) reference to the specific Plan provision(s) on which the denial is based; (iii) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; (iv) a description of the Plan’s review procedures and the time limits applicable to such procedures; and (v) a statement of your right to bring a civil action under ERISA Section 502(a) following the denial of your claim on appeal.

C. Appeals

- **Type of Appeal.** The Plan’s procedure for processing your appeal varies depending on the underlying claim that was denied. Your appeal will fall into either Health or Non-Health:

Health. Your appeal will be considered a Health Appeal if you are appealing a claim for medical, dental, or vision benefits that was denied based on ineligibility. There are two kinds of Health Appeals:

Post-Service. Your appeal is “Post-Service” if your underlying claim was a request for payment for care you already received.

Pre-Service. Your appeal is “Pre-Service” if your underlying claim was a request for approval of a benefit before you receive it, as required by the Plan (e.g., pre-approval for certain medical benefits), or a request for an extension of an ongoing course of treatment that the Plan has already approved, such as increasing the number of treatments previously authorized.

Urgent Care. Your appeal is considered “Urgent Care” if it is a “Pre-Service” appeal and applying the time frames allowed for consideration and approval of the underlying claim could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Non-Health. Your appeal will be considered a Non-Health Appeal if you are appealing a claim for vacation benefits that was denied, or if you are appealing a claim for life insurance, accidental death & dismemberment, or dependent life insurance benefits that was denied based on ineligibility.

- **Filing an Appeal.** If you disagree with the decision made on your claim, in whole or in part, you may ask the Board of Trustees to review the decision by filing a written appeal with the Trust Fund Office. You must file a Health Appeal within 180 days and a Non-Health Appeal within 60

days after you receive the written denial notice. Your appeal will be considered “filed” when it is received by the Trust Fund Office. Your appeal must clearly state why you are disputing the denial and may be accompanied by any supporting documentary material you wish to be reviewed.

For Urgent Care Health Appeals, you may request an expedited appeal orally or in writing, and all necessary information may be exchanged by telephone, fax, email or other expeditious method.

As part of the appeals procedure, the Plan will provide you, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. Furthermore, you may submit written comments, documents, records, and other information relating to your claim. In some cases, you may be able to present your case before the Board of Trustees.

- Time Period for Reviewing Appeals. If you file a Pre-Service Health Appeal, the Plan will notify you of its decision within 30 days of receipt of the appeal by the Trust Fund Office. For Urgent Care Health Appeals, you will be sent a notice of decision on review within 72 hours of receipt of the appeal by the Trust Fund Office.

For all other appeals, the Board will decide your appeal at the first quarterly board meeting which occurs at least 30 days after your written appeal is received, unless special circumstances require an extension of time for review. If an extension is required, the Plan will send you a written notice containing the reason for the extension and the date by which the Board expects to decide your appeal, which will be no later than the third board meeting after you file your appeal. If, however, the reason for the extension is your failure to submit information necessary to decide your appeal, the extension notice will describe the required information, and you will be given at least 45 days for Post-Service Health Appeals (90 days for Non-Health Appeals) from receipt of the notice to provide such information. The time period for making the decision will be suspended during this time. The Plan will notify you within 5 days after the Board makes its decision.

- Appeal Denial Notice. If the Plan denies your appeal, in whole or in part, it will send you a written denial notice containing: (i) the specific reason(s) for the denial of your appeal; (ii) reference to the specific Plan provision(s) on which the denial on appeal is based; (iii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and (iv) a statement of your right to bring a civil action under ERISA Section 502(a).
- Remedies Following Denial of Appeal. If you are not satisfied with the decision made on your appeal, you may file a lawsuit in federal court against the Plan. However, no legal or equitable action for benefits under this Plan may be brought unless and until you have submitted a claim for benefits, been notified that the claim is denied (or the claim is deemed denied), filed a written appeal for review (or oral appeal of an Urgent Care Health Appeal), and been notified in writing that the denial of the claim has been confirmed (or the claim is deemed denied on review). “Deemed denied” means that you filed a claim or an appeal and had not received any response by the expiration of the response time allowed for the type of claim or appeal.

D. Use of an Authorized Representative

You may have an authorized representative file a claim or appeal a denied claim on your behalf. You may be required to furnish documentation to the Plan showing that you have authorized the person to be your representative.

E. Other Important Information about Your Rights

Your failure to timely file a claim or an appeal within the appropriate time periods shall constitute a waiver of your right to file a claim or appeal a denied claim, as the case may be.

If the Plan fails to follow these claims and appeals procedures, and it does not correct the error without prejudice to you, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedies under ERISA Section 502(a).

The denial of a claim which is not timely appealed, or the decision of the Board of Trustees with respect to an appeal, is final and binding upon all parties, subject only to judicial review as provided under ERISA.

You may not bring an action for benefits provided by the Plan, or enforce any right under the Plan, until after you have exhausted the administrative remedies available under the Plan, and thereafter, the only action that you may bring is one to dispute the decision of the Board.

VII.

RIGHTS UNDER FEDERAL LAW

A. Certificates of Creditable Coverage

If your coverage under this Plan stops, you and your covered dependents will receive a “certificate of creditable coverage” that shows your period of coverage under the Plan. You may need to furnish the certificate if you become eligible under another group health plan if it excludes coverage for certain medical conditions that you have before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your dependents may also request a certificate within 24 months of losing coverage under this Plan. If you need another copy of your Certificate of Coverage, you may request one from the Trust Fund Office.

B. Qualified Medical Child Support Orders.

The Plan will provide medical, dental, and vision benefits as required by any qualified medical child support court order (QMCSO), as defined in ERISA Section 609(a), issued in a domestic relations proceeding (e.g., a divorce or legal separation proceeding) requiring you to cover a child who is not in your custody.

The Plan has written procedures for determining whether an order qualifies as a QMCSO. You and your beneficiaries can obtain, upon request, a free copy of such procedures from the Trust Fund Office.

C. Maternity Coverage.

Maternity care for female participants and Dependent spouses only: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the doctor from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

D. Mastectomy Coverage.

In accordance with the Women's Health and Cancer Rights Act of 1998, a covered individual who is receiving benefits under the Plan in connection with a mastectomy on one or both breasts will be provided coverage in a manner determined in consultation between the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

This coverage is subject to the same annual deductibles and coinsurance/co-payment provisions applicable to other medical and surgical benefits provided under the Plan.

E. Leave under Family and Medical Leave Act (FMLA).

If you take a leave under the Family and Medical Leave Act (FMLA), you may continue your medical, dental, and vision benefits for yourself and your Eligible Dependents subject to the terms of the law.

The Plan will maintain your and your Eligible Dependent's eligibility until the end of the leave, provided your employer properly grants the leave under the FMLA and makes payment of the required contributions to the Trust Fund. Contact your employer to determine whether you are eligible for FMLA leave.

Whether or not you keep your coverage while you are on FMLA leave, if you return to work promptly at the end of that leave, your medical, dental, and vision coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. This is also true for any of your Eligible Dependents who were covered by the Plan at the time you took your leave.

Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your Eligible Dependents in the same way they apply to all other participants and their Eligible Dependents. To find out more about the terms on which you may be entitled to coverage while on FMLA leave, contact the Trust Fund Office.

F. Privacy of Health Information

The Trust Fund complies with rules included in the Health Insurance Portability and Accountability Act (HIPAA) regarding how your health information may be used and disclosed and how you can get access to it. Copies of the Trust Fund's Privacy Notices are available at no charge from the Trust Fund Office.

It may be necessary for you to complete and submit to the Trust Fund Office a HIPAA authorization form if you want the Trust Fund Office to release information about you to someone else such as your Union representative, spouse or adult children. Likewise, if your spouse or child 18 years of age or older wants the Trust Fund Office to release information about himself or herself to someone else such as you, it may be necessary for them to complete and submit a HIPAA authorization form. The authorization forms can be obtained from the Trust Fund Office.

VIII.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

A federal law known as “COBRA” (the Consolidated Omnibus Budget Reconciliation Act of 1985) gives you and your covered family members the right to temporarily extend your health coverage under the Plan (called “COBRA coverage”) following certain life events (called “qualifying events”) that would normally end your Plan coverage. **You or your Dependent(s) must pay for COBRA coverage.** This section of the booklet is a summary of your rights and obligations regarding COBRA coverage. For more information about COBRA, contact the Trust Fund Office.

A. What Benefits Can Be Continued Under COBRA?

Under COBRA, you may only continue the benefits that you have at the time of a qualifying event (discussed below in section B). You may not, however, continue your life insurance, accidental death and dismemberment, dependent life insurance, or vacation benefits under COBRA.

If you elect COBRA coverage, you will be entitled to the same coverage that is provided to other participants and their Dependents under the Trust. You do not have to show that you are insurable to obtain COBRA coverage.

B. What are COBRA Qualifying Events?

Participants. If you are a participant covered by the Plan, you have the right to choose COBRA coverage for yourself if you lose your group health coverage under the Plan for any of the following reasons:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.
3. Your eligibility terminates due to entrance into active duty in the uniformed services of the United States.

Even if you do not elect COBRA coverage for yourself, each of your covered Dependents will have a separate right to elect it. THEREFORE, IT IS IMPORTANT THAT YOU AND ALL OF YOUR DEPENDENTS READ THIS SECTION.

Spouse. If you are the Dependent spouse of a covered participant, you have the right to choose COBRA coverage for yourself if you lose your health coverage under the Plan for any of the following reasons:

1. Your spouse’s hours of employment are reduced;
2. Your spouse’s employment ends for any reason other than his or her gross misconduct;
3. Your Dependent eligibility terminates due to entrance into active duty in the uniformed services of the United States.
4. Divorce or legal separation from your spouse;
5. The death of your spouse;
6. Your spouse becomes enrolled in Medicare (Part A, Part B, or both).

Dependent Children. A Dependent child of a covered participant has the right to choose COBRA coverage for him or herself if he or she loses health coverage under the Plan for any of the following reasons:

1. The participant’s hours of employment are reduced;
2. The participant’s employment ends for any reason other than his or her gross misconduct;

3. The participant becomes enrolled in Medicare (Part A, Part B, or both);
4. The parents' divorce or legal separation;
5. The child stops being eligible for coverage under the Plan as an "Eligible Dependent"; or
6. The death of the participant.

C. When Does COBRA Coverage Begin?

Generally, COBRA coverage for you and your Dependents will begin on the date that Plan coverage is lost due to a qualifying event. This date depends on the type of qualifying event involved, as explained below.

If the qualifying event is termination of employment, reduction in hours, or death: You and your Dependents will lose Plan coverage on the first day of the month in which you have less than 100 hours left in your reserve account.

Example 1: If you lose your job in January with 600 hours left in your reserve account, you and your Dependents will lose Plan coverage on the first day of July. This is because the 600 hours in your reserve account will give you and your Dependents Plan coverage for an additional six (6) months, from January through June. COBRA coverage, if elected, will begin on July 1.

Example 2: If you die in January with 600 hours left in your reserve account, your Dependents will lose Plan coverage on the first day of July. This is because the 600 hours in your reserve account will give your Dependents Plan coverage for an additional six (6) months, from January through June. COBRA coverage, if elected, will begin on July 1.

Example 3: If you lose your job in January with 75 hours left in your reserve account, you and your Dependents will lose Plan coverage on the first day of that month. This is because the 75 hours in your reserve account is not enough to give you and your Dependents any additional Plan coverage. COBRA coverage, if elected, will begin on January 1.

If the qualifying event is divorce/legal separation, enrollment in Medicare, or the cessation of eligibility as a "Dependent Child": Your Dependents will lose Plan coverage on the last day of the month in which the qualifying event occurs. In these instances, it does not matter how many hours you have in your reserve account.

Example: If your Dependent child turns 19 years of age on January 15, your child will lose Plan coverage on January 31, and COBRA coverage (if elected) will begin on February 1.

D. How Long Does COBRA Coverage Last?

The maximum COBRA coverage period for you is 18 months. The maximum COBRA coverage period for your Dependents is 36 months, unless coverage under the Plan is lost because of a termination of employment or a reduction in hours. In these instances, the maximum COBRA coverage period for your Dependents is eighteen (18) months. There are, however, three ways to extend an 18-month period of COBRA coverage, which are described in detail below.

1. Disability Extension

If you or your family member elects COBRA coverage, and then is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage or earlier, you and your entire family may be entitled to receive up to an additional 11 months of COBRA coverage (at increased rates), for a total maximum of 29 months.

To be eligible for this extension, you or your Dependent must notify the Plan Administrator in writing of the Social Security Administration's determination within 60 days of the date you received the determination, but before the end of the initial 18-month period of COBRA coverage.

This extended period of COBRA coverage for disability will end on the earliest of the following: (i) the end of the 29-month period; (ii) 30 days after the last day of the month in which Social Security determines the disabled person is no longer disabled (this must be reported to the Plan Administrator within 30 days after its date of issuance by Social Security); (iii) the date the disabled individual becomes entitled to Medicare; or (iv) pursuant to the applicable termination provisions of this section specifying when COBRA coverage ends.

2. Second Qualifying Event

If, during the initial 18-month COBRA coverage period, the former participant dies, becomes divorced or legally separated, or becomes entitled to Medicare (Part A, Part B, or both), or if a covered child ceases to be an “Eligible Dependent” under the Plan, **the maximum COBRA coverage period for the affected spouse and/or child may be extended to 36 months from the date Plan coverage was lost due to termination of employment or reduction in hours. In all of these cases, you or your family member must notify the Plan Administrator of the second qualifying event within 60 days of such event.**

Example: You lose your job (the first qualifying event), and you enroll yourself and your Dependents for COBRA coverage. Three months after your COBRA coverage begins, your child turns 19 years old and is no longer eligible for Plan coverage. Your child can continue COBRA coverage for another 33 months, for a total of 36 months of COBRA coverage, provided you or another family member notifies the Plan Administrator in writing within 60 days of your child’s 19th birthday.

This extended period of COBRA coverage is **not** available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the participant) during the initial 18-month period of COBRA coverage.

Termination of Employment or Reduction in Hours After Medicare Entitlement - Special Rule. If you became entitled to Medicare before the occurrence of a qualifying event that is your termination of employment or reduction in hours, then your affected spouse and/or children can elect COBRA coverage for up to the longer of: (1) 18 months from the date they lost Plan coverage due to your termination of employment or reduction of hours; or (2) 36 months from the date you became entitled to Medicare.

3. Special Extension of COBRA coverage under California law

You and/or your Dependents may be entitled to an 18-month extension of COBRA coverage under California law, up to a total of 36 months coverage from the date Plan coverage was lost due to your termination of employment or reduction of hours. The premium payments for such extended coverage (months 19 through 36) will be higher than the payments for standard COBRA coverage. This extended coverage under California law only applies to your UnitedHealthcare/PacifiCare coverage. Please contact UnitedHealthcare/PacifiCare with any questions you may have about this special extension of HMO coverage under California law. This coverage is not provided by the Trust Fund.

E. Adding Dependents to Your COBRA Coverage

1. New Spouses and Children

If, while you are enrolled in COBRA coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of your COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for those five months of COBRA coverage. To enroll your new Dependent for COBRA coverage, you must notify the Plan

Administrator in writing **within 30 days** of acquiring the new Dependent. There may be a change in your COBRA premium amount in order to cover the new Dependent.

2. Loss of Other Group Health Plan Coverage

If, while you are enrolled in COBRA coverage, your Dependent loses coverage under another group health plan, you may enroll that Dependent for coverage for the balance of your COBRA coverage period, provided that

- a. The Dependent was previously offered enrollment in the Plan but declined Plan coverage due to coverage under another group health plan; and
- b. The other coverage was (a) COBRA coverage that was exhausted or (b) other health plan coverage that was lost due to loss of eligibility or termination of employer contributions, reaching the lifetime maximum, or moving out of an HMO service area if HMO coverage terminated for that reason. (Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.)

You must enroll the Dependent **within 30 days** after the termination of the other coverage. Adding a Dependent may cause an increase in the amount you must pay for COBRA coverage.

3. Medicaid and CHIP Events

If, while a participant is enrolled in COBRA continuation coverage under the Plan, his or her eligible dependent who is not enrolled for coverage under the Plan loses coverage through Medicaid or a State children's health insurance program (CHIP) or becomes eligible for a premium assistance program through Medicaid or CHIP, the participant may enroll the eligible dependent for COBRA coverage under the Plan for the balance of the period of COBRA continuation coverage. The spouse or dependent must have been eligible for COBRA coverage as of the date of the initial Qualifying Event, but have not enrolled. The participant must enroll the spouse or dependent within 60 days after the date Medicaid or CHIP coverage is lost or the date the spouse or dependent is determined to be eligible for premium assistance.

F. Your Responsibility to Notify the Plan

The Plan will offer COBRA coverage to you and your family members only after the Plan Administrator has determined that a qualifying event has occurred. The Plan Administrator cannot make this determination unless it is properly notified.

When You Must Notify the Plan of a Qualifying Event (Very Important Information): **In order to elect COBRA coverage after a divorce, legal separation, or a child ceasing to be an "Eligible Dependent" under the Plan, you and/or a family member must inform the Plan in writing of that event within 60 days of the later of: (i) that event; or (ii) the date that Plan coverage ends as a result of that event. That notice should be sent to the Trust Fund Office at the following address:**

**Inland Refrigeration and Air Conditioning
Health and Welfare Trust Fund**
c/o Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, CA 90020
(213) 385-6161 (800) 595-7473 (213) 385-2767 (fax)

NOTE: If the qualifying event is divorce or legal separation, you must provide the Trust Fund Office with a copy of the legal document within 60 days of the date of the decree.

IF SUCH A NOTICE IS NOT RECEIVED BY THE TRUST FUND OFFICE WITHIN THE 60-DAY PERIOD, YOUR FAMILY MEMBER(S) WILL NOT BE ENTITLED TO CHOOSE COBRA COVERAGE.

Your Employer is responsible for notifying the Trust Fund Office of your death, termination of employment, reduction in hours, or enrollment in Medicare. However, **you or your family member should also notify the Trust Fund Office promptly and in writing** if any such event occurs, in order to avoid confusion over the status of your health care coverage in the event there is a delay or oversight in the Employer's transmittal of information to the Plan Administrator Office.

G. Deadline to Elect COBRA Coverage

Once the Trust Fund Office has determined that a qualifying event has occurred, you and/or your family members will be sent a COBRA election form, as well as other information regarding COBRA coverage. You will have at least sixty (60) days from the date your coverage ends or, if later, sixty (60) days from the date the Trust Fund Office sends you the COBRA election form, to make your decision.

IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT ELECT COBRA COVERAGE WITHIN THIS 60-DAY PERIOD, YOU AND/OR THEY WILL HAVE NO GROUP HEALTH COVERAGE FROM THIS PLAN AFTER THE DATE COVERAGE ENDS.

H. Paying for COBRA Coverage

You and/or your Dependents must pay for COBRA coverage on the following basis:

1. Any person with COBRA coverage must pay a monthly premium for such coverage. The amount of such premium will be established by the Board of Trustees from time to time and furnished to the eligible person with the COBRA election form.
2. All payments must be made by check, cashiers check, or money order.
3. The initial COBRA coverage payment should be received by the Trust Fund Office no later than the first day your COBRA coverage begins, in order to avoid possible delays in claim payments and eligibility problems. However, this initial payment will be accepted up to 45 days from the date you elect COBRA coverage. The first payment must cover the number of months from the date COBRA coverage began, including the month in which the first payment is made.
4. After the first COBRA coverage payment is made, additional payments must be made every month to keep coverage. Monthly payments must be received by the first of the month to avoid possible delays in claim payments and eligibility problems. For example, if you want COBRA coverage for the month of February, payment should be received by February 1st. Failure to make a monthly payment within thirty (30) days of the beginning of the payment coverage month will result in termination of COBRA coverage as of the end of the period for which payment has been made.

The Trust Fund Office will not send you monthly bills or warning notices. It is your responsibility to submit payments when due.

I. Termination of COBRA Coverage

Your COBRA coverage will end on the earliest of the following dates:

1. The date the maximum COBRA coverage period has been reached as described previously;
2. The date that the Trust Fund ceases to provide health care coverage to any participant;
3. The date you fail to make a timely premium payment for your COBRA coverage;
4. The date you become entitled to receive Medicare, unless entitlement to Medicare is for a reason other than age;

5. The date you become eligible as a participant, spouse or dependent of a participant for another group's health and welfare benefits, unless that plan of benefits would exclude you due to pre-existing conditions. In this case COBRA coverage will not end until the date the condition is covered under the new plan or the maximum time allowed under COBRA coverage is reached, whichever happens first; or
6. In the case of total disability, at the end of the month after the month in which Social Security determines that the disability no longer exists.
7. The date you begin working in Non-Union Employment as defined in Section II.

J. Certification of Coverage when Coverage Ends

When your COBRA coverage ends, the Trust Fund Office will automatically provide you and/or your covered dependents (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under the Plan ends, and you and/or your covered dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered dependents, a health insurance policy, you may need this certificate to prove that you did not have a break in coverage of 63 consecutive days or more, in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered dependents in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under the Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered dependents) by first class mail shortly after your (or their) coverage under the Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any covered dependent upon receipt of a written request for such a certificate if that request is received by the Trust Fund Office within two years after the later of the date your coverage under the Plan ended or the date COBRA coverage ended.

K. Conversion to Individual Coverage Option (applicable only to HMO participants)

Under certain circumstances, participants and eligible family members whose coverage through an HMO ends, are allowed to purchase individual conversion coverage through their HMO without evidence of insurability. Individuals must apply for conversion coverage and pay the premium within 31 days of the loss of their coverage. To take advantage of this provision, your individual coverage must be through the same HMO plan. For more information, please contact UnitedHealthcare/PacifiCare.

L. If You Have Questions about COBRA

If you have questions about your COBRA coverage, you should contact the Trust Fund Office or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

M. Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

IX.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan 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 benefit or exercising your rights under ERISA.

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

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

If you have a claim for benefits which 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 medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your 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 (formerly known as the Pension and Welfare Benefits 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Nothing in the foregoing Statement of ERISA Rights is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Board of Trustees reserves the right to amend, modify or discontinue all or part of this Plan at any time and for any reason, in its sole and absolute discretion in accordance with procedures specified in the Agreement and Declaration of Trust under which the Plan is established and maintained. The provisions of the Plan cannot be modified or amended in any way by any statement or promise made by any other person, including employees of the union or any employer. The Board of Trustees has full discretion and authority to determine questions concerning the interpretation or administration of the Plan including, without limitation, all questions relating to eligibility for Plan benefits, and the determination of the Board shall be conclusive and binding as to all persons and for all purposes, except to the extent the Board has delegated specific discretionary authority to UnitedHealthcare/PacifiCare, Delta Dental, Vision Service Plan, or ULLICare.

This booklet contains a summary in English of your Plan rights and benefits under the Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund. If you have difficulty understanding any part of this booklet, contact:

Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund
c/o Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, CA 90020
(213) 385-6161 (800) 595-7473 (213) 385-2767 (fax)