INLAND

Refrigeration & Air Conditioning

Health & Welfare Trust Fund

Health and Paid Time Off Plan of Benefits
Summary Plan Description

Amended and Restated Effective July 1, 2021

Administered by:

SOUTHERN CALIFORNIA PIPE TRADES ADMINISTRATIVE CORPORATION

501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 385-2767 | www.scptac.org

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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 Eligible 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
- Paid Time Off

The Paid Time Off benefit is described in Section IV below. All of the other component benefit programs are summarized in separate material prepared by UnitedHealthcare, Delta Dental, Vision Service Plan, and the Union Labor Life Insurance Co. (ULLICare). You can obtain this material from the Fund Office.

A. Questions

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

Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund
c/o Southern California Pipe Trades Administrative Corporation
501 Shatto Place, Suite 500
Los Angeles, CA 90020
(213) 385-6161 (800) 595-7473 (213) 385-2767 (fax)
www.scptac.org/inland.html info@scptac.org

Office hours are 8:00 a.m. to 4:00 p.m. Monday, Tuesday, Wednesday, and Friday, and 8:00 a.m. to 6:00 p.m. on Thursday.

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

B. Foreign Language Assistance / Asistencia Lengua Extranjera

This booklet contains a summary in English of your plan rights and benefits under the Fund. If you have difficulty understanding any part of this booklet, contact the Fund Office either in person or by telephone.

AVISO A LOS PARTICIPANTES QUE HABLAN ESPAÑOL: Si tiene alguna pregunta tocante este folleto, o requiere alguna otra información tocante a su cobertura de salud, por favor no dude en comunicarse con la Oficina del Fondo al 800-595-7473, donde habrá varios representantes bilingües que con gusto le ayudarán.

IMPORTANT DISCLAIMER:

The benefits hereunder are provided pursuant to insurance/HMO contracts and a governing plan document or documents adopted by the Board of Trustees of the 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 documents, then the terms of the insurance/HMO contracts and the governing plan documents will control, rather than this Summary Plan Description. You should not rely on any oral description of the Plan because the written terms of the Plan will always govern.

II.
ELIGIBILITY REQUIREMENTS

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 individual benefits. Similarly, if your eligibility terminates, you (and your Eligible Dependents, if any) will lose coverage under all of the component benefit programs.

A. Participants

1. Initial Eligibility. You will become eligible for benefits as a Participant on the first day of the second month following the date on which your Reserve Account has been credited by Contributing Employers with the required contributions for at least 500 hours of work within a period of not less than three nor more than six consecutive months.

2. Continuation of Eligibility. Once you have established your initial eligibility, 100 hours will be deducted from your Reserve Account on the first day of each month that you are covered.

   After the 100 hours have been deducted, all hours worked for which the required contributions have been received for the prior month will be added to your Reserve Account. The maximum number of hours credited to your Reserve Account is capped at (may not exceed) 600. The hours in your Reserve Account are used to maintain your eligibility when you work fewer than 100 hours per month.

   If your eligibility terminates because of insufficient hours, you will again become eligible when your Reserve Account has a total of at least 100 hours, for which the required contributions have been received, within the six months 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 months will be tolled during any period in which you cannot work due to a work-related illness or injury for which you are receiving workers' compensation benefits, as determined by the Board of Trustees based on acceptable evidence.

3. Termination of Eligibility. Your eligibility will cease, and coverage will no longer be purchased on your behalf if you have fewer than 100 hours in your reserve account on the first day of any month. For example, if you have 100 hours in your Reserve Account as of January 31, 100 hours will be deducted from your Reserve Account on February 1 for coverage in February. If, on the other hand, you only have 99 hours in your Reserve Account as of January 31, you will not be eligible for benefits in February.

4. Note Regarding USERRA. Your eligibility terminates on the date you enter full-time active duty in the uniformed services of the United States. Per the Uniformed Services Employment and Reemployment Rights Act (USERRA), the hours in your Reserve Account will be automatically preserved until you can return to covered employment after the termination of your service. During that time (for up to 24 months), you may purchase coverage similar to COBRA continuation coverage for yourself and your Eligible Dependents. To do so, you must submit to the 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, you may use the hours in your Reserve Account to provide coverage for your Eligible Dependents. The months of coverage used will no longer be available to provide coverage for you upon your return to covered employment.

If you are honorably discharged from full-time active duty, coverage will be reinstated on the first day you return to, or are available for, active employment with a Contributing Employer, provided this occurs within 90 days of completing uniformed service. When your coverage is reinstated, all provisions, limitations, and exclusions of the Plan will apply to the extent that they would have applied if you had not taken uniformed services leave, and coverage had been continuous under the Plan.

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

5. Forfeiture of Hours. You will permanently lose all of the hours credited to your Reserve Account in the following situations:

   a. *Employment Outside of California*. The hours in your Reserve Account will be forfeited on the first day of the seventh month following six 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 Reserve Account on July 1.

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

   c. *Disqualifying Non-Union Employment*. Your eligibility will terminate when you perform work in the refrigeration, air conditioning, plumbing, heating, and piping industry that is not covered by a collective bargaining agreement. Any hours credited to your Reserve Account will be forfeited upon the commencement of such employment or self-employment. You may be required to prove to the Fund that you are not working in prohibited employment to prevent the forfeiture of your hours under this provision.

6. Keep Your Plan Informed of Address Changes. To protect your family's rights, you should keep the Fund Office informed of any changes in the addresses or dependent status of family members, including birth, death, or divorce. You should also keep a copy for your records of any notices you send to the Fund Office.

B. Eligible Dependents

1. Commencement of Eligibility. Your dependents will become covered as Eligible Dependents on the same day your coverage becomes effective if they meet the eligibility rules below and if you submit the required documentation of Eligible Dependent status to the Fund Office. Required documentation may include such items as marriage certificates, birth certificates, or adoption papers. Contact the Fund Office for details on what documentation you must submit to establish your dependents' eligibility. If you do not submit required documentation timely as prescribed by the Fund Office, your dependent's coverage effective date may be delayed until the first day of the month following the date the Fund Office receives the required documentation.

   Eligible Dependents may include your Spouse and Children (through the last day of the month in which the child turns age 26).

   Children include your natural child, legally adopted child, child "placed for adoption", stepchild, or any other child for whom, by a Qualified Medical Child Support Order (QMCSO) or court order of legal guardianship, you are legally responsible for 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.

2. 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 (a) you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, (b) your dependents meet the eligibility requirements described above, and (c) you provide appropriate evidence of Eligible 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 Eligible Dependent status is received, whereupon eligibility will be retroactive according to the HMO or insurance provider's rules. Therefore, you must consult with the Fund Office immediately if you encounter a delay in obtaining an official marriage or birth certificate to preserve your new Eligible Dependent's retroactive eligibility date.

If you do not request enrollment for a newly acquired Eligible Dependent 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 Fund Office receives the enrollment request and the required documentation of Eligible Dependent status.

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

IMPORTANT NOTICE REGARDING CHANGES IN DEPENDENT STATUS:

You must immediately notify the Fund Office in writing when dependent status changes occur. This includes the final dissolution of marriage, death, and any other events that would make your dependent not eligible for further coverage. The changing of your Beneficiary for death or other benefits is not a proper divorce notification. You need not notify the Fund Office when a covered child reaches age 26.

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

C. Non-Bargaining Unit Members

1. Coverage for Non-Bargaining Unit Members. A Contributing Employer bound by a collective bargaining agreement may elect to contribute to the 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.

2. Establishment of Eligibility. A non-bargaining unit employee of a Contributing Employer who regularly works 30 or more hours per week is eligible for coverage under the 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 Fund, and the employee is enrolled when the Employer elects to cover its non-bargaining unit employees, or, if later, within 90 days of the date the employee is first hired.

   An employee who was eligible to participate in the Plan, but did not enroll for coverage during this time, will not be permitted to enroll at a later date. If, however, the employee declined enrollment for him or

herself (or his or her Eligible Dependents) because of other group health insurance coverage, the employee may in the future be able to enroll him or herself (or his or her Eligible Dependents) in this Plan, provided that (a) the employee requests enrollment within 30 days after the other coverage ends, (b) the employee and his or her dependents meet the Plan's eligibility requirements, and (3) the employee completes and submits a form provided by the Fund Office which states that the reason for declining coverage under the Plan is due to other group 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 or her family will be added to the Plan provided by this Fund with no lapse in coverage.

3. Effective Date of Coverage. Coverage will be effective for the non-bargaining unit Employee and his or her Eligible Dependents on the first day of the month following the receipt of the first contribution.

4. Continuation of Coverage. The Employee and his or her Eligible Dependents will remain eligible during each month following two months after the month in which the Employee works at least 30 hours per week and for which his or her Employer makes required contributions to the Fund on his or her behalf. There are no Reserve Accounts for non-bargaining unit Employees.

   Example: If an employee works at least 30 hours per week during the month of March and his or her Employer makes required contributions, the Employee will remain eligible for the month of May.

5. Termination of Eligibility. The eligibility of the non-bargaining unit Employee will terminate on the earliest of the following dates:

   a. The last day of the month for which an Employer contribution is made;
   b. The date the Employer ceases to contribute on behalf of his/her bargaining unit employees;
   c. The date the Plan terminates; or
   d. The first day of the month in which the non-bargaining unit Employee ceases to be employed by the Employer or the non-bargaining unit Employee's average hours drop below 30 hours per week.

D. Claims and Appeals Procedures Regarding Eligibility

The Plan maintains claims and appeals rules that apply to claims and appeals regarding eligibility under the Plan or eligibility for Plan benefits. These claims and appeals rules include, among other restrictions, filing deadlines for claims, filing deadlines for appeals of denied claims, and filing deadlines for civil actions brought in court challenging a Plan denial of an appeal relating to eligibility. The Plan's claims and appeals rules are summarized beginning on page 13 of this Summary Plan Description booklet.

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 Paid Time Off benefits.

The Fund provides medical benefits through a contract with UnitedHealthcare. Dental benefits are provided through a contract with Delta Dental. Vision benefits are provided through a contract with Vision Service Plan

(VSP). Life, accidental death & dismemberment, and dependent life insurance benefits are provided through a contract with ULLICare. The Paid Time Off benefit is provided directly by the Fund.

A summary of each benefit provided under the Plan is set forth in material provided by UnitedHealthcare, Delta Dental, Vision Service Plan, and ULLICare, except for the Paid Time Off benefit described under Section IV below.

Note: To obtain services from UnitedHealthcare, Delta Dental, and Vision Service Plan, you must live in one of their service areas. If you do not reside in a designated service area, you may be unable to obtain services from these HMO/insurance companies. UnitedHealthcare does not provide for services outside of California. You may obtain information regarding coverage areas directly from the providers.

Employer contributions to the Fund will fund the cost of the benefits provided through the component benefit programs. The Fund will pay the required premiums to the various companies, except for Paid Time Off benefits. The Fund will use Employer contributions to pay Paid Time Off benefits.

IV.
PAID TIME OFF BENEFITS

A. Annual Payment of Paid Time Off Benefits

Your benefits include Paid Time Off pay. Every December 1, the Fund will pay you an amount equal to the Employer contributions for Paid Time Off benefits received on your behalf during the 12 months from November 1 through October 31, preceding the December 1 payout. The payment may also include interest if, in the discretion of the Trustees, a sufficient amount remains after payment of administrative expenses to warrant an allocation to each Participant. Each Paid Time Off payment will be accompanied by a statement of hours reported on your behalf, contributions received, and interest, if any, allocated to your Paid Time Off Account.

B. Interim Withdrawals

You may withdraw all or part of your accrued Paid Time Off Account before December 1. You may request one interim withdrawal each calendar quarter, not to exceed the balance in your Paid Time Off account at the time of withdrawal.

Interim withdrawals will reduce the amount available at the regular December 1 payout. During the period of approximately November 20th through December 5th each year, interim withdrawals are unavailable due to the preparations necessary for annual payments.

If you take an interim withdrawal from your Paid Time Off Account, you will not share in any interest income that may have been earned on the withdrawn amount during the February 1 to January 31 Plan Year prior to which the interim distribution was made. Further, the 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 Paid Time Off Account balance will be distributed to your Beneficiary. Your Beneficiary is the person or persons you name in writing on an Enrollment & Beneficiary Form provided by the Fund for that purpose. If you have not named in writing a Beneficiary, or if your Beneficiary does not survive you, the Paid Time Off Account balance will be distributed in the following order: first to 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 an Enrollment & Beneficiary form, that designation will be revoked automatically in the event of divorce. You may reinstate your ex-spouse as a Beneficiary by

completing a new Enrollment & Beneficiary form and filing it with the Fund Office after the date of divorce. For more information, contact the Fund Office.

D. Forfeiture of Paid Time Off Benefits

If you fail to claim Paid Time Off benefits in the two calendar years following the year in which the benefits were payable to you as part of the December annual payment of benefits, such benefits, together with any interest or income accrued thereon, will automatically revert to the Fund freed from obligation to you and may be used by the Board of Trustees to pay for the costs of administration of the Fund or any other lawful purpose.

E. Claims and Appeals Procedures Regarding Paid Time Off Benefits

The Plan maintains claims and appeals rules that apply to claims and appeals regarding Paid Time Off benefits under the Plan. These claims and appeals rules include, among other restrictions, filing deadlines for claims, filing deadlines for appeals of denied claims, and filing deadlines for civil actions brought in court challenging a Plan denial of an appeal. The Plan's claims and appeals rules relating to Paid Time Off benefits are summarized beginning on page 13 of this Summary Plan Description booklet.

See also "Circumstances Which May Affect Benefits" on page 10 concerning other and additional plan restrictions relating to Paid Time Off benefits.

V.
GENERAL INFORMATION ABOUT THE PLAN

A. Information Required by ERISA

Plan name: The Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund

Plan number: 501

Type of plan: This Plan is 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 Paid Time Off benefits.

Contributions and funding: Contributions. The Plan is financed by Employer contributions and, in some cases, by Participant self-payments of contributions. The amount of contributions is determined by the collective bargaining agreement.

The Fund pays the insurance premiums for your benefits. However, you may owe a co-payment or deductible for part of the covered benefits. If the Plan does not cover the services you receive, you may owe the full cost of those services.

Funding. The Plan's assets and reserves are held in trust by the Board of Trustees of the Fund. They are invested in bank savings accounts and short-term bank instruments, government and corporate bonds, and certain other investments approved by the Trustees. All of the plans' benefits are fully insured or provided by contract with an HMO, except for the Paid Time Off benefit, which is self-funded.

Group contracts between the Fund and the following companies provide for the following benefits: UnitedHealthcare (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 Fund, are responsible for (1) 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 you and your Eligible Dependents must use under their respective component benefit plans. These companies guarantee the payment of claims incurred before the group contracts terminate.

Paid Time Off benefits are provided directly by the Fund. The Fund has contracted with the Southern California Pipe Trades Administrative Corporation, a third-party administrator, to pay Paid Time Off benefit claims on behalf of the Fund.

Type of administration:

The Board of Trustees of the Fund consists of an equal number of Employer and Union representatives, following the Agreement and Declaration of Trust that governs this Plan. As the Plan Administrator and named fiduciary, the Board of Trustees is authorized to control and manage the operation and administration of the Plan.

The Fund has contracted with the Southern California Pipe Trades Administrative Corporation, a third-party administrator, to provide claims administration and other services and act as the 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 Fund has allocated to UnitedHealthcare, Delta Dental, Vision Service Plan, and ULLICare, respectively, the responsibility for administering claims (except for 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, Suite 500
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 5701 Katella Ave. Cypress, CA 90630-5082 (800) 624-8822 Policy/Contract No. 003579	Vision Service Plan 3333 Quality Dr. Rancho Cordova, CA 95670 (800) 877-7195 Policy/Contract No. 12076721
	Delta Dental 17871 Park Plaza Dr., Ste. 200 Cerritos, CA 90703 (562) 403-4000 Policy/Contract No. 8371	ULLICare, Inc. 8403 Colesville Rd. Silver Spring, MD 20910 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, Suite 500
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 on any Trustee.

Collective Bargaining Agreement: The Plan is maintained according to Collective Bargaining Agreements, copies of which may be obtained upon written request to the Fund Office and which may be examined at the Fund Office or the Local Union office.

Contributing Employer: You may inquire in writing as to whether your Employer is a Contributing Employer, and, if so, you may obtain your Employer's address from the 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 August 1, 2015.

B. 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, authorizing benefit payments, and gathering information necessary for administering the Plan.

C. Plan Interpretation

The Board of Trustees has discretionary authority to determine eligibility for benefits and to interpret the terms of the Plan except to the extent that the Board has delegated such authority to UnitedHealthcare, Delta Dental, Vision Service Plan, or 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 Plan's provisions and make the necessary factual determinations regarding eligibility for benefits or any other issue regarding the Plan.

D Workers' Compensation Not Affected

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

E. 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.

F. Circumstances Which May Affect Benefits

Coverage under the Plan for you and your Eligible Dependents will cease under certain circumstances, such as termination of eligibility (see Section II of this booklet) and termination of the Plan. For Paid Time Off benefits, if you take an interim withdrawal of your Paid Time Off benefit, you will not receive interest earnings that the Board of Trustees may have credited to your Paid Time Off Account. Other circumstances can result in the termination, reduction, or elimination of benefits.

G. Plan Amendment and Termination

According to the Trust Agreement establishing the Fund and the Plan document, the Board of Trustees of the 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 end coverage for some or all Participants and their Eligible Dependents. If the Plan is terminated, your rights are limited to the payment of eligible expenses incurred before termination. Any assets of the Fund remaining upon termination will be used to continue providing the types of benefits provided by this Fund, per the governing plan documents and applicable law.

H. No Contract of Employment

This Summary Plan Description is not intended to be, and cannot 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.

I. 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.

J. Acts of Third Parties (Subrogation and Reimbursement)

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

K. Medicare Election at Age 65

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

L. Reciprocal Contributions

This Plan is a party to the United Association Health & Welfare Fund Reciprocal Agreement, which provides for money-follows-the-Member reciprocity with all health funds that have also signed the agreement. Under this agreement, contributions are transferred to your home local health fund(s) automatically. This Fund may also enter into other similar reciprocity agreements.

- Incoming Reciprocity
  Contributions made to another health fund that has signed an applicable reciprocal agreement will generally be transferred to this Fund according to the reciprocal agreement.

- Outgoing Reciprocity
  Contributions to this Fund will be transferred to your home local health fund(s) if your home local health fund has signed an applicable reciprocal agreement, according to the reciprocal agreement.

Contributions are reciprocated based on your home local in the United Association's records.

See also "Forfeiture of Hours" on page 3 of this Summary Plan Description regarding out-of-area work. Contact the Fund Office or your Local Union if you have additional questions.

VI.
CLAIMS AND APPEALS PROCEDURES

You will file most claims and appeals with the particular insurer that provides the benefit at issue. For example, if your claim involves medical treatment, hospitalization, or prescription drugs, you will file your claim and any subsequent appeal with UnitedHealthcare. If your claim involves dental services, you will file your claim and any subsequent appeal with Delta Dental. If your claim involves vision care, you will file your claim and any subsequent appeal with VSP. If your claim involves the payment of a death, accidental death, or dismemberment claim, you will file your claim and any subsequent appeal with ULLICO.

If your claim or appeal involves any other Plan rule or any disagreement in how the Plan is being administered, including eligibility to participate in the Plan, Paid Time Off benefits, or any decision rendered by the Fund Office or the Board of Trustees, you will file a claim with the Fund Office and an appeal with the Fund's Board of Trustees.

IMPORTANT	**All applications or claims for benefits should be made directly to the benefits provider or insurer. In the rare instance that your claim or application needs to be presented to the Fund Office or the Board of Trustees, this section describes the procedures for filing such a claim or application for benefits.**

A. Processing Claims with the Fund Office

The time limits in which the Fund Office will respond to your claim depends on the type of claim filed.

1. Urgent Care Claim

An urgent care claim is a claim that involves emergency medical care needed immediately to avoid serious jeopardy to your life, health, or ability to regain maximum function or which a physician with knowledge of your medical condition thinks would subject you to severe pain if your claim were not dealt with in the "urgent care" time frame, which is as follows. The Fund Office will notify you whether your urgent care claim is approved or denied as soon as possible but not later than 72 hours after it receives your claim unless your claim is incomplete. The Fund Office will notify you as soon as possible if your claim is incomplete but not more than 24 hours after receiving your claim. The Fund Office may notify you orally unless you request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional information, the Fund Office will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information, or the end of the period within which you must provide the information.

2. **Pre-Service Claim**
   A pre-service claim is a claim that conditions receipt of a benefit, in whole or part, on the pre-approval of the benefit. Hospital admission pre-certification is an example of a pre-service claim. The Fund Office will notify you whether your claim is approved or denied within a reasonable time, but no later than 15 days after receipt of your claim. This period may be extended by one 15-day period if special circumstances beyond the control of the Fund Office require that additional time is needed to process your claim. If an extension is needed, the Fund Office will notify you before the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Fund Office expects to reach a decision. If the Fund Office needs an extension because you have submitted an incomplete claim, the Fund Office will notify you of this within five days of receipt of your claim. The notice will describe the information needed to make a decision. If the Fund Office needs more information from you, the time for making a decision on your claim will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

3. **Post-Service Claim**
   A post-service claim is a claim submitted after the service or procedure has occurred. Most claims will fall under this category. The Fund Office will notify you of its determination within a reasonable time but no later than 30 days after receiving your claim. This period may be extended by one 15-day period if special circumstances beyond the control of the Fund Office require that additional time is needed to process your claim. If an extension is needed, the Fund Office will notify you before the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Fund Office expects to reach a decision. If the Fund Office needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have until 45 days after receiving this notice to provide the specified information. If the Fund Office needs more information from you, the time for making a decision on your claim will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

4. **Concurrent Care Claim**
   A concurrent care claim is any claim to extend the course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided over a period of time or number of treatments. A concurrent care claim can be an urgent care claim, a pre-service claim, or a post-service claim. If the Fund Office has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Fund Office will notify you of its determination within 24 hours after receiving your claim, provided that the Fund receives your claim at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided in the appropriate time frame, depending on whether it is a pre-service or post-service claim.

5. **Disability Claim**
   A disability claim will be handled like post-service medical claims. However, some special time periods apply to processing a disability claim. The Fund Office will notify you of its determination within a reasonable time, but no later than 45 days after receipt of your claim. This period may be extended for up to two additional 30-day periods for circumstances beyond the control of the Fund Office if the Fund Office notifies you of the extensions before the expirations of the initial 45 days and the first 30-day extension period, respectively. Any notice of extension will identify the circumstances requiring an extension, the date by which the Fund Office expects to reach a decision, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and additional information needed, if any, to resolve those issues. If the Fund Office needs more information from you,

the time for making a decision on your claim will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

You will be provided, free of charge and before an adverse benefit determination is issued, with (a) any new or additional evidence considered, generated, or used by the Plan concerning the claim, and (b) any new or additional rationale on which the adverse benefit determination will be based. The new or additional evidence or rationale must be provided as soon as possible and sufficiently before an adverse benefit determination is due to give you a reasonable opportunity to respond to the new information before the adverse benefit determination is issued.

B. Notice of Denial of Claim

If a claim for benefits is denied, in whole or in part or if there has been a rescission of your coverage, the Fund Office will provide you a written notice that (1) states the specific reason(s) for the denial, (2) refers to the specific Plan provisions on which the denial or rescission is based, (3) describes any additional material or information that might help the claim, (4) explains why that information is necessary, and (5) describes the Fund's review procedures and applicable time limits, including a right to bring a civil action under Section 502(a) of ERISA.

If an internal rule, guideline, protocol, or similar criterion was relied on in making the adverse determination, then (1) the specific rule, guideline, protocol, or similar criterion will be provided to you, or (2) you will receive a statement that such a rule, guideline, protocol, or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol, or other criterion will be provided upon request.

If your claim relates to a disability benefit and it is denied, the Fund Office will provide you, if applicable, with (1) any specific internal criteria, including any internal rules or guidelines used in making the determination and (2) an explanation of any disagreement with any determination from a health care/vocational professional who treated or evaluated you, a medical/vocational expert whose advice was obtained by the Fund, or a SSA disability determination.

If the adverse determination is based on a medical judgment, you will be provided with an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be given free of charge upon request.

C. Appeals Procedure

This Plan includes an appeal procedure that must be followed before a lawsuit involving the Plan, the Board of Trustees, or the Fund may be brought. The purpose of the appeals procedure is to make it possible for claims and disputes to be resolved fairly and efficiently without costly litigation.

IMPORTANT	**Most appeals should be made directly to the benefits provider or insurer. In the rare instance that your appeal needs to be presented to the Fund's Board of Trustees, this section describes the procedures for presenting such an appeal.**

1. Appealing a Benefit Denial

If your claim for benefits is denied, in whole or in part, or if there has been a rescission of your coverage, you may request that the Board of Trustees review the benefit denial or rescission of coverage. The Board of Trustees may delegate the responsibility to decide appeals to a subcommittee. Throughout this section, any reference to the Trustees also refers to a subcommittee thereof. All appeals, except for urgent care appeals, must be in writing. An urgent care appeal may be oral or written and may be made by telephone,

facsimile, or other available means. All appeals must be received by the Fund within 180 calendar days after you receive the notice of the denial or rescission of coverage from the Fund Office. Failure to file a timely written appeal will constitute a complete waiver of the right to appeal. The decision of the Fund will be final and binding.

In presenting your appeal, you have the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits or objection to rescission of coverage. You are also 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 for benefits or rescission of coverage. Personal appearances on appeals are at the discretion of the Trustees.

Your appeal should state the specific reasons why you believe the denial of your claim was in error. You should also submit any documents or records that support your claim. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, your appeal should state clearly why you believe you are entitled to the benefits or other relief you are claiming. The Trustees can best consider your position if they clearly understand your claims, reasons, or objections.

The Trustees' review will take into account all comments, documents, records, and other information that you submit, without regard to whether such information was submitted to or considered by the Fund Office in its determination. The Trustees will also not afford deference to the initial decision by the Fund Office.

The Fund Office maintains records of determinations on appeal and Plan interpretations so that those determinations and interpretations may be referred to in future cases with similar circumstances.

In deciding an appeal of a Fund Office determination that was based, in whole or in part, on a medical judgment, the Trustees will, when appropriate, consult with a health care professional who has appropriate training and expertise in the particular field of medicine, and who was not consulted by the Fund Office in connection with its determination. You will also be provided with the identity of any medical or vocational experts whose advice was obtained at any level of the claims and appeals process without regard to whether that advice was relied on.

2. Timing of Appeal Decisions

The Board of Trustees, or a subset thereof, if so authorized, will decide all appeals.

Post-Service Claims Appeals. Most claims will be post-service claims appeals. The Trustees will meet at least once each quarter to review pending appeals. The decision of the Trustees will be made by the meeting immediately following the date the appeal is received by the Fund Office. If the appeal is received during the 30 days preceding the meeting, the decision will not be made until the second meeting following receipt of the appeal. The time for processing an appeal may be extended in special circumstances by written notice to you before the beginning of the extension. Such an extension may only last until the third meeting following receipt of the appeal.

3. Notice of Decision on Appeal

Written notice of the decision of the Trustees will be sent within five days from the date of the meeting at which the appeal was reviewed.

Urgent Care Claims Appeals. An urgent care claim appeal will be decided as soon as possible but not later than 72 hours after it is received by the Fund Office.

Pre-Service Claims Appeals. A pre-service claims appeal will be decided within a reasonable period of time, but not later than 15 days after it is received by the Fund Office.

Concurrent Claims Appeals. A concurrent claim appeal will be decided either in the time period of a post-service claim appeal or a pre-service claim appeal depending on the type of claim.

Disability Claims Appeals. If your claim pertains to disability benefits, it will be decided in the time period of a post-service claim appeal.

If your appeal is denied, in whole or in part, you will receive a written decision that will include: (1) the specific reason(s) for the denial; (2) the specific Plan provisions on which the denial is based; (3) 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 (4) a statement of your right to bring a lawsuit under Section 502(a) of ERISA.

If an internal rule, guideline, protocol, or similar criterion was relied on in making the adverse determination, you will be provided with the specific rule, guideline, protocol, or similar criterion, or will receive a statement that such a rule, guideline, protocol, or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol, or other criterion will be provided to you upon request.

If the decision is based on a medical judgment, you will be provided with an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the medical circumstances or a statement that such explanation will be provided free of charge upon request.

If your appeal relates to a disability benefit and it is denied, you will be provided, if applicable, with (1) any specific internal criteria, including any internal rules or guidelines used in making the determination and (2) an explanation of any disagreement with any determination from a health care/vocational professional who treated or evaluated you, a medical/vocational expert whose advice was obtained by the Fund, or an SSA disability determination.

If, in reviewing your appeal for a disability benefit, the Trustees consider, rely upon, or generate any new or additional evidence, or if the Trustees are considering denying your appeal based on new or additional rationale, you will be provided with this information, free of charge, and offered a reasonable opportunity to respond before an adverse decision is made.

4. Decisions on Appeal are Final and Binding

The Trustees' decision is final and binding on all parties, including anyone claiming a benefit on your behalf.

Once a final decision is rendered, there is no right to re-file the same appeal or request reconsideration. If such an appeal or request for reconsideration is filed, the Trustees may refuse to consider it.

The Trustees have full discretion and authority to determine all matters relating to the benefits provided under this Plan, including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. The Trustees also have full discretion and authority over the standard of proof required for any inquiry, claim, or appeal and over the application and interpretation of the Plan.

If the Trustees deny the appeal and you decide to seek judicial review, the Trustees' decision will be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. Generally, no lawsuit may be brought without first exhausting the above claims and appeals procedures. Nor may any evidence be used in court unless it was first submitted to the Trustees before the decision on appeal. No legal action may be commenced against the Trust, the Plan, or the Trustees more than two years after the claim has been denied on appeal.

5. Deadline for Filing Suit Following Denial of Appeal (or Denial of Claim if no Appeal)
Any civil action brought under Section 502(a) of ERISA, challenging a denial of eligibility for benefits under this Plan, in whole or in part, must be filed within two years of the date of the Plan's denial of your appeal relating thereto. If no appeal was filed, even though appeals are required as a condition of filing a suit, then the suit must be brought within two years of the date of the Plan's denial of your claim.

IMPORTANT	**No legal action may be commenced against the Fund or the Trustees more than two years after the claim has been denied on appeal.**

6. Right to Authorized Representative
In making a claim or appeal, you may be represented by an authorized representative. If your representative is not an attorney or court-appointed guardian, you must designate the representative by a signed written statement. A parent of a minor child is assumed to be the authorized representative of the child for purposes of filing a claim for benefits or appealing a denial of a claim. However, neither you nor your representative has a right to an in-person hearing or appearance before the Trustees.

7. Other Appeals
If you receive any written correspondence from the Fund Office that could be interpreted as adversely affecting your interest, you may appeal to the Trustees for a determination or review of that correspondence. Such a request for review must be in writing and must be made within 180 calendar days of receipt of the correspondence from the Fund Office. Such appeals will be processed in the same manner as appeals for claims for benefits.

VII.
RIGHTS UNDER FEDERAL LAW

A. 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 these procedures from the Fund Office.

B. Maternity Coverage
Maternity care for female Participants and Eligible Dependent Spouses only: Per the Newborns' and Mothers' Health Protection Act, 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 over 48 hours (or 96 hours).

C. Mastectomy Coverage
Per 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:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prosthesis; and
4. Treatment of physical complications of 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.

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

Your Employer, not the Fund, must continue to pay for health coverage during any approved leave under the federal Family and Medical Leave Act (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

1. The Employer has at least 50 Employees working within a 75 mile radius; and
2. You worked for the Employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and
3. Your leave is required for one of the following reasons:
   a. Birth or placement of a child for adoption or foster care;
   b. To care for your child, Spouse, or parent with a serious health condition; or
   c. Your own serious health condition; or
   d. A "qualifying exigency" as defined in applicable regulations arising out of the fact that a covered family member is on active duty or called to active duty status in the National Guard or Reserves in Support of a federal contingency operation. In addition, the FMLA provides that an eligible Employee who is a qualifying family member or next of kin of a covered military service member can take up to 26 work weeks of leave in a single 12-month period to care for the covered service member with a serious illness or injury incurred in the line of duty.

Details concerning FMLA leave are available from your Employer. Requests for FMLA leave must be directed to your Employer; the Fund cannot determine whether or not you qualify. If a dispute arises between you and your Employer concerning eligibility for FMLA leave, health coverage may continue by making COBRA self-payments. If the dispute is resolved in your favor, the Plan will obtain the FMLA-required contributions from your Employer and will refund the corresponding COBRA payments to you. If your Employer continues coverage during an FMLA leave and you fail to return to work, you may be required to repay your Employer for all contributions paid to the Plan for coverage during your leave.

The California Family Rights Act ("CFRA") provides much of the same protections as the FMLA. If you are on leave granted under the CFRA, your Employer may be obligated to continue to pay contributions on your behalf to provide you with uninterrupted coverage under this Fund during your leave, similar to the requirements imposed on employers by the FMLA. You should contact your Employer if you believe you are entitled to leave under the CFRA.

E. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

1. Protected Health Information

The U.S. Department of Health & Human Services issued the Standards for the Privacy of Individually Identifiable Health Information. Under HIPAA, these rules give you greater control over who may have access to the information in your medical records. Health plans, such as this Plan, cannot share Protected Health Information ("PHI") under many circumstances without written authorization.

2. Use or Disclosure of PHI

The Fund may use or disclose your PHI for treatment, payment, or health care operations without your written authorization.

a. Payment generally means the activities of a Fund to collect premiums, to fulfill its coverage responsibilities, provide benefits under the Plan, and obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to, the following: determining coverage and benefits under the Plan, paying for or obtaining reimbursement for health care, adjudicating subrogation of health care claims or coordination of benefits, billing, and collection, making claims for stop-loss insurance, determining medical necessity and performing utilization review. For example, the Fund will disclose the minimum necessary PHI to medical service providers for the purposes of payment.
b. Health Care Operations are certain administrative, financial, legal, and quality improvement activities of the Fund that are necessary to run the Fund and support the core functions of treatment and payment. For example, the Fund may disclose the minimum necessary PHI to the Fund's attorney, auditor, actuary, and consultant(s) when these professionals perform services for the Fund that requires them to use PHI. Persons who perform services for the Fund are called "business associates". Federal law requires the Fund to have written contracts with its business associates before sharing PHI with them. The disclosure of your PHI must be consistent with the Fund's contract with them. Other examples of business associates are a Fund's stop-loss insurance carrier, claims repricing services, utilization review companies, prescription benefit managers, PPOs, and HMOs.
c. Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. The Fund is not typically involved in treatment activities.

The Fund is permitted or required to use or disclose your PHI without your written authorization for the following purposes and in the following circumstances, as limited by law:

a. The Fund will use or disclose your PHI to the extent it must do so by law.
b. The Fund may disclose your PHI to a public health authority for certain public health activities, such as (1) reporting of a disease or injury, or births and deaths, (2) conducting public health surveillance, investigations, or interventions; (3) reporting known or suspected child abuse or neglect; (4) ensuring the quality, safety or effectiveness of an FDA-regulated product or activity; (5) notifying a person who is at risk of contracting or spreading a disease; and (6) notifying an Employer about a member of its workforce, for workplace medical surveillance or the evaluation of work-related illness and injuries, but only to the extent the Employer needs that information to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA), or State law requirements having a similar purpose.
c. The Fund may disclose your PHI to the appropriate government authority if the Fund reasonably believes that you are a victim of abuse, neglect, or domestic violence.
d. The Fund may disclose your PHI to a health oversight agency for oversight activities authorized by law, including (1) audits; (2) civil, administrative, or criminal investigations; (3) inspections; (4) licensure or disciplinary actions; (5) civil, administrative, or criminal proceedings or actions; and (6) other activities.
e. The Fund may disclose your PHI in the course of any judicial or administrative proceeding in response to an order by a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process.
f. The Fund may disclose your PHI for a law enforcement purpose to law enforcement officials. Such purposes include disclosures required by law or in compliance with a court order or subpoena, grand jury subpoena, or administrative request.
g. The Fund may disclose your PHI in response to a law enforcement official's request to identify or locate a suspect, fugitive, material witness, or missing person.
h. The Fund may disclose your PHI if you are the victim of a crime and you agree to the disclosure or, if the Fund is unable to obtain your consent because of incapacity or emergency, and law enforcement

demonstrates a need for the disclosure and/or the Fund determines in its professional judgment that such disclosure is in your best interest.

i. The Fund may disclose your PHI to law enforcement officials to inform them of your death if the Fund believes your death may have resulted from criminal conduct.
j. The Fund may disclose PHI to law enforcement officials that it believes is evidence that a crime occurred on the Fund's premises.
k. The Fund may disclose your PHI to a coroner or medical examiner for identification purposes. The Fund may disclose your PHI to a funeral director to carry out his/her duties upon your death or before and in reasonable anticipation of your death.
l. The Fund may disclose your PHI to organ procurement organizations for cadaveric organ, eye, or tissue donation purposes.
m. The Fund may use or disclose your PHI for research purposes if the Fund obtains one of the following: (1) documented institutional review board or privacy board approval; (2) representations from the researcher that the use or disclosure is being used solely for preparatory research purposes; (3) representations from the researcher that the use or disclosure is solely for research on the PHI of decedents; or (4) an agreement to exclude specific information identifying the individual.
n. The Fund may use or disclose your PHI to avoid a serious threat to the health or safety of you or others.
o. The Fund may disclose your PHI if you are in Uniformed Service and your PHI is needed by military command authorities. The Fund may also disclose your PHI for the conduct of national security and intelligence activities.
p. The Fund may disclose your PHI to a correctional institution where you are being held.
q. The Fund may disclose your PHI in emergencies or after you provide verbal consent under certain circumstances.
r. The Fund may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

The Fund may use or disclose your PHI to you, to your personal representative, to a third party (such as your Spouse or Domestic Partner) according to an Authorization Form, and to the Board of Trustees of the Fund but only for the purposes and to the extent specified in the Plan:

a. The Fund will provide you with access to your PHI. The Fund will generally require you to complete and execute a "Request for Protected Health Information Form" and will provide you with access to PHI consistent with the request form or as otherwise required by law.
b. The Fund may provide your personal representative or attorney with access to your PHI in the same manner as it would provide you with access, but only upon receipt of documentation demonstrating that your personal representative or attorney has authority under applicable law to act on your behalf.
c. Unless otherwise permitted by law, the Fund will not use or disclose your PHI to someone other than you unless you sign and execute an authorization form. You can revoke an authorization form at any time by submitting a cancellation of authorization form to the Fund. The cancellation of authorization form revokes the authorization form on the date it is received by the Fund.
d. The Fund will disclose your PHI to the Fund's Board of Trustees only per the Fund's Privacy Policy and the Plan's provisions.

3. Individual Rights

You have certain important rights concerning your PHI. You should contact the Fund's Privacy Officer to exercise these rights.

a. You have a right to request that the Fund restrict the use or disclosure of your PHI to carry out payment or health care operations. The Fund is not required to agree to a requested restriction.
b. You have a right to receive confidential communications about your PHI from the Fund by alternative means or at alternative locations if you submit a written request to the Fund in which you clearly state that the disclosure of all or part of that information could endanger you.

c. You have a right to inspect and copy your PHI that the Fund maintains in a "designated record set". A "designated record set" consists of records or other information containing your PHI that is maintained, collected, used, or disseminated by or for the Fund in connection with: (1) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Fund, or (2) decisions that the Fund makes about you.
d. You have a right to amend your PHI that was created by the Fund and that is maintained by the Fund in a designated record set if you submit a written request to the Fund in which you provide reasons for the amendment.
e. You have a right to receive an accounting of disclosures of your PHI, with certain exceptions if you submit a written request to the Fund. The Fund need not account for disclosures that were made more than six years before the date on which you submit your request or any disclosures that were made for treatment, payment, or health care operations.

4. Duties of the Fund

The Fund has the following obligations:

a. The Fund by law must maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices concerning PHI. To obtain a copy of the Fund's entire Privacy Policy, you should contact the Fund's Privacy Officer.
b. The Fund is required to abide by the terms of the notice currently in effect.
c. The Fund will provide a paper copy of the notice currently in effect to you upon request.
d. If a breach of your PHI is discovered, the Fund has certain obligations to provide a notice to you.

5. Changes to Notice

The Fund reserves the right to change the terms of this notice and make the new notice provisions effective for all PHI it maintains, regardless of whether the PHI was created or received by the Fund before issuing the revised notice.

Whenever there is a material change to the Fund's uses and disclosures of PHI, individual rights, the Fund's duties, or other privacy practices stated in this notice, the Fund will promptly revise and distribute the new notice to Participants and Beneficiaries.

Copies of the Fund's privacy notices, including its Notice of Privacy Practices, are available at no charge from the Fund Office and may be accessed online at www.scptac.org/Inland/Privacy.html.

6. Contacts and Complaints

If you believe your privacy rights have been violated, you may file a written complaint with the Fund's Privacy Officer at the following address:

Inland Refrigeration & Air Conditioning Health and Welfare Fund Attention: Privacy Officer 501 Shatto Place, Suite 500 Los Angeles, CA 90020	(800) 595-7473 (213) 385-6161 www.scptac.org info@scptac.org

You may also file a complaint with the U.S. Secretary of Health and Human Services in Washington, DC. The Fund will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person for filing a complaint.

7. For More Information About Privacy

If you want more information about the Fund's policies and procedures regarding the privacy of your medical and other personal information, contact the Fund's Privacy Officer.

VII.
IMPORTANT NOTICES

A. No Assignment of Benefits

No one, including, but not limited to, a Participant or an Eligible Dependent, is permitted to assign any benefits, rights, or claims for benefits to any third party including, but not limited to, a provider or a facility, without the express written consent of the Board of Trustees. Accordingly, unless written consent is provided, the Plan will not recognize or accept any assignment of benefits, rights, or claims for benefits, or any appeal of a denied claim for benefits. "Benefits, rights or claims for benefits" includes, but is not limited to: (i) a claim, or an appeal of a denied claim, for payment of a benefit under the terms of the Summary Plan Description or other Plan document or communication; (ii) a claim for benefits or other relief under Section 502(a) of ERISA; (iii) a breach of fiduciary duty claim under ERISA or common law; (iv) a claim brought under state law; or (v) a claim for penalties assessable under any law or regulation.

A Participant or an Eligible Dependent may direct that benefits payable from this Plan to him or her be paid to a provider or a facility that delivered the related medical care to the Participant or Eligible Dependent. However, the Plan is not obligated to accept such direction, and no payment made by the Plan to the provider, nor any communication about benefits or payments between representatives of the Plan and a provider or a facility, shall be considered an assignment of the benefit, an assignment of a claim or an appeal, waiver of this no assignment provision, or a contract with the provider or the facility to pay benefits.

B. Erroneous Payments

Every effort will be made to ensure accuracy in the payment of your benefits. If an error is discovered, regardless of how long ago it occurred, and it is determined that the Fund has paid any benefits that you are not entitled to, you must reimburse the Fund for the erroneous payments, including attorney's fees, interest, and reasonable collection costs. The Trustees have the right to seek repayment from you through any legal means, including the right to reduce future benefit payments for you or your Eligible Dependents by the amount of the erroneous payment.

C. Misrepresentation or Fraud

If you receive benefits because of false information or a misleading or fraudulent representation, you must repay all erroneous amounts paid by the Fund, and you will be liable for all costs of collection, including attorneys' fees. The Trustees reserve the right to reduce future benefit payments by the amount of the payment made because of fraud or misrepresentation.

D. No Fund Liability

Whether designated by the Fund or otherwise, the use of the services of any hospital, physician, or other provider of health care is your voluntary act. Nothing in this SPD is meant to be a recommendation or instruction to use any provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Plan. Providers are independent contractors, not employees or subcontractors of the Plan. The Trustees make no representation regarding the quality of service or treatment of any provider. They are not responsible for any acts of commission or omission of any provider in connection with Fund coverage. The provider is solely responsible for the services and treatments rendered.

The Plan, the Board of Trustees, or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care, or lack thereof, or over any health care services provided or delivered to anyone by any health care provider. Neither the Plan, the Board of Trustees, nor any of their designees, have any liability whatsoever for any loss or injury caused to anyone by any health care provider because of negligence, by failure to provide care or treatment, or otherwise.

IX.
COBRA AND OTHER CONTINUATION COVERAGE RIGHTS

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 Eligible Dependent(s) must pay for COBRA coverage if you want it.** This section of the booklet includes a summary of your rights and obligations regarding COBRA coverage. For more information about COBRA, contact the Fund Office.

A. What Benefits Can Be Continued Under COBRA?

Under COBRA, you may only continue the benefits you have at the time of a Qualifying Event (discussed below in section B). However, you may not continue your life insurance, accidental death and dismemberment, dependent life insurance, or Paid Time Off benefits under COBRA.

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

B. What are COBRA Qualifying Events?

1. 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:

    a. Your hours of employment are reduced;
    b. Your employment ends for any reason other than your gross misconduct; or
    c. Your eligibility terminates due to your 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 Eligible Dependents will have a separate right to elect COBRA coverage. Therefore, it is important that you and all of your Eligible Dependents read this section.

2. Spouse. If you are the Eligible 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:

    a. Your Spouse's hours of employment are reduced;
    b. Your Spouse's employment ends for any reason other than his or her gross misconduct;
    c. Your eligibility terminates due to entrance into active duty in the uniformed services of the United States;
    d. Divorce or legal separation from your Spouse;
    e. Death of your Spouse; or
    f. Your Spouse becomes enrolled in Medicare (Part A, Part B, or Part C).

3. Eligible Dependent Children. An Eligible 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:

    a. The Participant's hours of employment are reduced;
    b. The Participant's employment ends for any reason other than his or her gross misconduct;
    c. The Participant becomes enrolled in Medicare (Part A, Part B, or Part C);

d. The parents' divorce or legal separation;
e. The child stops being eligible for coverage under the Plan as an Eligible Dependent; or
f. Death of the Participant.

C. When Does COBRA Coverage Begin?

Generally, COBRA coverage for you and your Eligible 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.

1. If the Qualifying Event is termination of employment, reduction in hours, or death. You and your Eligible 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 Eligible 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 Eligible Dependents Plan coverage for an additional six 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 Eligible Dependents will lose Plan coverage on the first day of July. This is because the 600 hours in your Reserve Account will give your Eligible Dependents Plan coverage for an additional six 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 Eligible 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 Eligible Dependents any additional Plan coverage. COBRA coverage, if elected, will begin on January 1.

2. If the Qualifying Event is divorce/legal separation, enrollment in Medicare, or cessation of eligibility as an Eligible Dependent child. Your Eligible 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 Eligible Dependent child turns 26 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 the Participant is 18 months. The maximum COBRA coverage period for your Eligible Dependents is 36 months unless you lose coverage under the Plan because of employment termination or a reduction in hours. In these instances, the maximum COBRA coverage period for your Eligible Dependents is 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 Eligible Dependent must notify the Fund Office in writing of the Social Security Administration's determination within 60 days of the date you receive 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: (a) the end of the 29-month period; (b) 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 Fund Office within 30 days after its date of issuance by Social Security); (c) the date the disabled individual becomes entitled to Medicare; or (d) according 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, 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 Fund Office 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 Eligible Dependents for COBRA coverage. Three months after your COBRA coverage begins, your child turns 26 years old and loses Eligible Dependent coverage eligibility under the Plan. Your Eligible Dependent 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 Fund Office in writing within 60 days of your child's 26th birthday.

   This extended period of COBRA coverage is **not** available to an individual who became your Spouse after the termination of employment or reduction in hours. However, this extended period of COBRA coverage is open 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.

3. Termination of Employment or Reduction in Hours After Medicare Entitlement - Special Rule. If you become 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 (a) 18 months from the date they lost Plan coverage due to your termination of employment or reduction of hours; or (b) 36 months from the date you became entitled to Medicare.

4. Special Extension of COBRA coverage under California law (Cal-COBRA).You and your Eligible 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 (called Cal-COBRA) only applies to your UnitedHealthcare coverage. Please contact UnitedHealthcare with any questions you may have about this special extension of HMO coverage under California law. This coverage is not provided by the 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 Eligible Dependent for COBRA coverage, you must notify the Fund Office in writing **within 30 days** of acquiring the new dependent. There may be a change in your COBRA premium amount to cover the new Eligible Dependent.

2. Loss of Other Group Health Plan Coverage. If, while you are enrolled in COBRA coverage, your Eligible Dependent loses coverage under another group health plan, you may enroll that Eligible Dependent for coverage for the balance of your COBRA coverage period, provided that:

   a. The Eligible 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 (i) COBRA coverage that was exhausted or (ii) 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 timely or termination of coverage for cause.)

   You must enroll the Eligible Dependent within 30 days after the termination of the other coverage. Adding an Eligible 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 Eligible Dependent (Spouse or child) must have been eligible for COBRA coverage as of the date of the initial Qualifying Event but must have not enrolled. The Participant must enroll the Eligible Dependent within 60 days after the date Medicaid or CHIP coverage is lost or the date the Eligible 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 Eligible Dependents only after the Fund Office has determined that a Qualifying Event has occurred. The Fund Office cannot make this determination unless it is properly notified.

When You Must Notify the Plan of a Qualifying Event:

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 (1) that event; or (2) the date that Plan coverage ends as a result of that event. That notice should be sent to the 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, Suite 500
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 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 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 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 Fund Office promptly and in writing** if any such event occurs 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 Fund Office.

G. Deadline to Elect COBRA Coverage

Once the 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 60 days from the date your coverage ends or, if later, 60 days from the date the Fund Office sends you the COBRA election form to make your decision.

If you and/or any of your Eligible 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 Eligible Dependents must pay for COBRA coverage as follows:

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 fully negotiable check, cashier's check, or money order.

3. The initial COBRA coverage payment should be received by the Fund Office no later than the first day your COBRA coverage begins 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 February, payment should be received by February 1st. Failure to make a monthly payment within 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 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 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 disqualifying employment as defined in Section II.

J. If You Have Questions about COBRA

If you have questions about your COBRA coverage, you should contact the 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). The addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at http://www.dol.gov/ebsa.

K. Keep Your Plan Informed of Address Changes

To protect your family's rights, you should keep the Fund Office 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 Fund Office.

L. Options for Coverage Other Than COBRA

1. Conversion to Individual Coverage Option (available for HMO Participants only). Under certain circumstances, Participants and eligible family members whose coverage through an HMO ends can 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. Your conversion coverage must be through the same HMO plan. For more information, please contact UnitedHealthcare.

2. Special Enrollment in Another Group Health Plan. Whether or not you become eligible for COBRA continuation coverage, you may have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of a Qualifying Event. You will also have the same special enrollment rights at the end of COBRA continuation coverage if you elect COBRA continuation coverage and continue the coverage for the maximum time available to you.

3. Federal or State Marketplace or Exchange Coverage. You may also be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away. You can see what your premium, deductibles, and out-of-pocket costs will be before you decide to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. You can access California's Marketplace at http://www.coveredca.com.

X.
STATEMENT OF ERISA RIGHTS

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

A. Receive Information About Your Plan and Benefits.

- Examine, without charge, at the Plan Administrator's office and 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 Benefits Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the plan's operation, 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.

B. Continue Group Health Plan Coverage.

Continue health care coverage for yourself or your Eligible Dependents if there is a loss of coverage under the plan due to a Qualifying Event. You or your Eligible Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

C. Prudent Actions by Plan Fiduciaries.

In addition to creating rights for plan participants, ERISA imposes duties upon the people 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.

D. 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 frames.

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 denied or ignored, in whole or in part, you may file suit in a state or Federal court. Also, 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 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.

E. 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, 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, Delta Dental, Vision Service Plan, or ULLICare.

XI.
DEFINITIONS

Beneficiary
Beneficiary means the person entitled to receive death benefits from this Plan according to the Participant's designation on a Enrollment & Beneficiary Form or according to the Plan's terms.

Board of Trustees
All of the Trustees established as one body according to the Trust Agreement.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985 that may provide for continuation coverage when a Participant or Eligible Dependent loses coverage under the Plan.

Collective Bargaining Agreement
Any and all negotiated labor agreements between a Contributing Employer, or employer association acting on behalf of Employers, and Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association"), or any local Union affiliate of the District Council that requires contributions to the Inland Refrigeration & Air Conditioning Health and Welfare Fund. It also refers to an agreement, to which the United Association is a party, requiring contributions to the Fund.

Contributing Employer
An Employer signed to a Collective Bargaining Agreement or Participation Agreement, or an Employer that assigns its bargaining rights to an employer association signed to a Collective Bargaining Agreement, that requires contributions to the Fund.

Covered Employment
Work by an Employee under a Collective Bargaining Agreement.

Eligible Dependent
The Participant's Spouse, if timely enrolled, and children through age 25, who satisfy requirements of the Plan.

Employee
An Employee is anyone employed by a Contributing Employer in a position for which the Employer makes contributions to the Fund under a Collective Bargaining Agreement. Employees may also include an Employer or someone employed by an organization signatory to a Participation Agreement.

Employer
See Contributing Employer.

ERISA
Employee Retirement Income Security Act of 1974, as amended.

Fund
The Inland Refrigeration & Air Conditioning Health and Welfare Fund created by the Trust Agreement establishing that Fund.

Fund Office
Inland Refrigeration & Air Conditioning Health and Welfare Fund
c/o Southern California Pipe Trades Administrative Corporation
501 Shatto Place, Suite 500
Los Angeles, CA 90020

(800) 595-7473
(213) 385-6161
www.scptac.org/inland.html
info@scptac.org

Medicare
Medicare means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended.

Participant
An Employee who has satisfied the rules to become eligible for benefits under the terms of the Plan.

Participation Agreement
An agreement approved by the Board of Trustees permitting a Contributing Employer or a related organization, whose participation in the Fund has been approved by the Board of Trustees, to pay contributions to the Plan for Employees who are not covered by a Collective Bargaining Agreement.

Plan
The benefits, rules, and other provisions described in this SPD.

Plan Year
February 1 through January 31.

Qualified Medical Child Support Order (QMCSO)
An order issued by a court or authorized state or other governmental agency providing for coverage to an alternate recipient. The order must meet all of the requirements of ERISA, including approval as a qualified order by the Fund.

Qualifying Event
A circumstance that permits a Participant, Spouse, or child to elect COBRA coverage. Qualifying Events may include, but are not limited to, the loss of coverage due to a reduction in hours of employment, divorce from the Participant, death of the Participant, or an eligible child turning age 26.

Reserve Account
The Reserve Account is established by hours reported and paid for by Contributing Employers on an Employee's behalf. Eligibility is determined by the hours credited and debited to and from the Reserve Account as outlined in Section II, page 2.

SPD
Summary Plan Description. This document. A description of the provisions of and benefits available under the Inland Refrigeration & Air Conditioning Health and Welfare Fund.

Spouse
Any person to whom a Participant is legally married under the laws within the jurisdiction in which the marriage took place.

Trust Agreement
The written document titled "Restated Agreement and Declaration of Trust for the Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund" according to which the Fund has been established and maintained, and to which this Plan has been adopted, and any amendments thereto.

Trustees
Employer and Union representatives who oversee the Fund.

Union(s)
Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, AFL-CIO ("United Association"), and its affiliated local Unions, and such other unions which have or may in the future become parties to and agree to be bound by the Trust Agreement.

XII.
TRUSTEES

The following is a list of the Trustees as of the publication date of this SPD. The members of the Board of Trustees may change from time to time. If you want a current listing of the Trustees, contact the Fund Office.

Union Trustees

Mr. Al Powers
U.A. Local 364
223 S. Rancho Ave.
Colton, CA 92324
(909) 825-0359

Mr. Joseph Raymond
U.A. Local 364
223 S. Rancho Ave.
Colton, CA 92324
(909) 825-0356

Mr. David Hanson
U.A. Local 398
8590 Utica Ave., Suite 200
Rancho Cucamonga, CA 91730
(909) 945-5557

Mr. Jerry Trevino
U.A. District Council No. 16
501 Shatto Place, Suite 400
Los Angeles, CA 90020
(213) 487-4262

Management Trustees

Ms. Cheryl James
ARCA/MCA
3602 Inland Empire Blvd., #B-206
Ontario, CA 91764
(909) 477-4515

Mr. Ron Hickey
EMCOR Service/Mesa Energy
2 Cromwell
Irvine, CA 92618-1816
(949) 460-0460

Mr. Michael Reed
Stater Bros. Markets
301 S. Tippecanoe Ave.
San Bernardino, CA 92408
(909) 733-5002

Mr. Joe Wisdom
South Coast Facility Services
800 East Orangethorpe Ave.
Anaheim, CA 92801
(877) 738-6644