AMENDMENT EIGHT TO THE

U.A. LOCAL 467 HEALTH AND WELFARE PLAN

Recitals

WHEREAS, it has always been the intent of the Board of Trustees of the U.A. Local 467 Health and Welfare Plan ("Plan"), to comply with the Mental Health Parity and Addiction Equity Act, Women's Health & Cancer Rights Act, and Patient Protection and Affordable Care Act and adopts this amendment to comply with these Acts pursuant to the Guidance (FAQ Implementation Part 31, April 20, 2016) jointly released by the Departments of Labor, Health and Human Services and the Treasury; and

THEREFORE, the Board of Trustees amends the Plan to make the following clarifications:

Amendment

The Board of Trustees of the Plan has amended **Article II (Plan Benefits)** of the Plan by replacing Section "H" (Women's Health & Cancer Rights Act of 1998") with below, and adding new Sections "N" (Mental Health Parity & Addiction Equity Act) and "O" (Patient Protection and Affordable Care Act) as follows:

H. Women's Health & Cancer Rights Act of 1998

Under a federal law called the Women's Health and Cancer Rights Act of 1998, group health Plans, insurers and HMOs (such as Kaiser) that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive breast surgery. For a Participant or beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending physician and the patient for (a) all stages of reconstruction of the breast on which the mastectomy was performed, including coverage for nipple and areola reconstruction, and repigmentation to restore the physical appearance of the breast, (b) surgery and reconstruction on the other breast to produce a symmetrical appearance, and (c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas. This coverage is subject to the Plan's annual deductibles and coinsurance provisions.

N. The Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that prevents large group health plans (such as this Plan) and health insurers that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations), treatment limitations (e.g., number of visits or days of coverage), and non-quantitative treatment limitations (e.g., preauthorization requirement, exclusion based on medical necessity) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits. Pursuant to the Final MHPAEA rules (effective January 1, 2015 for this Plan), the Plan or Health Insurer will provide any current participants or potential participants, or contracting providers, upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits will also be provided upon request.

It is the intention of the Board of Trustees and the contracted insurers (ex. Kaiser Permanente) that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa/mentalhealthparity/*. Please also refer to the Evidence of coverage booklet provided to you by Kaiser for a complete description of the mental health/substance use benefits available to you, if you are enrolled in the Kaiser HMO option.

O. Patient Protection and Affordable Care Act

1. **GRANDFATHERED PLAN.** The Board of Trustees believes this Plan is a "Grandfathered health plan" under the federal law known as the Patient Protection and Affordable Care Act of 2010 ("ACA"). As permitted by the ACA, a Grandfathered health plan can preserve certain basic health coverage that was already in effect when the ACA was enacted. Being a Grandfathered health plan means that the Plan is not required to include certain consumer protections of the ACA that apply to other plans, for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the ACA, such as the elimination of annual and lifetime limits on the Plan's Essential Health Benefits. (For a definition of what constitutes as Essential Health Benefits please visit ***www. Healthcare.gov/glossary/essential-health-benefits)***.

   Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Manager. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 or ***www.dol.gov/ebsa/healthreform***. This website has a table summarizing which protections do and do not apply to grandfathered health plans. Implementation of the ACA's provisions began with the July 1, 2011, Plan Year.

2. **NO PRE-EXISTING CONDITION EXCLUSIONS FOR ANY INDIVIDUAL.** The ACA prohibits insurance plans in the individual and group markets from imposing pre-existing condition exclusions on any individual for Plan Years beginning after January 1, 2014. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for an individual with cancer because the individual had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the individual because of the individual' s pre-existing medical condition). This Plan does not impose any pre-existing condition exclusions.

3. **DEPENDENT CHILD COVERAGE THROUGH AGE 25.** In accordance with the ACA, the Plan will permit a Participant's eligible Child(ren) to be enrolled and maintained as a Dependent through the end of the month in which the Child(ren) attains age 26, regardless of whether the Child(ren) are eligible for coverage through his or her own employer-sponsored group health plan (or his or her Spouse's plan) and regardless of the Child(ren)'s marital status, student status, financial dependency, residency, or employment status.

4. **INDIVIDUAL MANDATE & MINIMUM ESSENTIAL COVERAGE.** With certain exceptions, the ACA requires you and your Dependents to have health coverage that qualifies as minimum essential coverage or pay a penalty for noncompliance. Minimum essential coverage includes jointly-sponsored coverage such as this Plan. The ACA also establishes a minimum value standard of benefits for health plans. Minimum value means coverage under a health plan (such as this Plan) meets the minimum value standard if the plan's share of the total allowed costs of benefits provided is 60% or greater. If you are covered under the Plan, you meet the individual mandate. Unless exempt, individuals will have to report their health coverage when filing their income tax returns. Beginning in January 2016, the Plan and/or Insurers (such as

Kaiser) will be required to send covered individuals a Statement (known as a Form 1095-B) about such coverage, in order for you to meet your Individual mandate requirement. The Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.

5. **AVAILIABILITY OF SUMMARY OF BENEFITS & COVERAGE.** The ACA requires group health plans and health insurers to provide a Summary of Benefits and Coverage, also known as the "SBC", to Participants and their Dependents. The SBC is a standard format, written in easy-to-understand language, summary of what the Plan covers and what it costs. It is intended to help you understand and compare the different benefits and coverage options available to you under the Plan. Under the ACA, you also have a right to request and receive within 7 business days a copy of the Plan's SBC in paper form, at any time and free of charge. If you want a copy of the Kaiser HMO Plan SBC, please contact Kaiser Permanente at 800-464-4000. For a copy of the Plan's Self-funded PPO SBC, please contact the Trust Fund Office at 408-288-4400.

6. **ELIMINATION OF LIFETIME & ANNUAL LIMITS ON ESSENTIAL HEALTH BENEFITS.** The ACA prohibits both grandfathered and non-grandfathered health plans from imposing lifetime and annual dollar limits on Essential Health Benefits. In accordance with the requirements of the ACA, this Plan does not impose any lifetime and annual dollar limits on its Essential Health Benefits. However, the Plan is permitted to impose annual limits on certain non-Essential Health Benefits consistent with the ACA and lawful regulations issued thereunder. Non-Essential Health Benefits means benefits that are not Essential Health Benefits as determined by the Plan and Claims Administrator in its sole discretion.

7. **CERTIFICATES OF CREDITABLE COVERAGE NO LONGER REQUIRED.** Effective December 31, 2014, Insurers and Group Health Plans are no longer required to provide a Certificate of Creditable Coverage upon termination of your health coverage.

8. **PROHIBITION ON RESCISSIONS.** Under the ACA, group health plans and insurers must not rescind coverage (meaning cancel or discontinue coverage retroactively) unless a covered individual commits fraud or makes an intentional misrepresentation of material fact. However, a retroactive cancellation or discontinuance of coverage is not a rescission if it: has only prospective effect; is initiated by the covered individual; due to delay in administrative record-keeping; termination of coverage retroactive to the divorce if a plan does not cover former spouses; or attributed to a failure to timely pay required premiums or contributions toward the cost of coverage. In accordance with the ACA, this Plan will not rescind coverage unless permitted by the ACA or your and/or your eligible dependent commits fraud or makes an intentional misrepresentation of material fact.

Approved: June 7, 2016

Union Trustee

Mark Burri, Chair

Employer Trustee

Ron Mitchell, Co-Chair

AMENDMENT NINE TO THE

U.A. LOCAL 467 HEALTH AND WELFARE PLAN

Recitals

WHEREAS, the Board of Trustees of the U.A. Local 467 Health and Welfare Plan (the "Plan") adopts this amendment to comply with the requirements under the Patient Protection and Affordable Care Act ("Act") Section 1557 Non-discrimination rules, which prevents covered entities from discriminating against or refusing to treat an individual on the basis of race, color, national origin, sex (including gender identity, pregnancy, sex stereotyping), age or disability;

WHEREAS, the Board of Trustees desires to amend the Plan to cover pregnancies for eligible dependent children up to age 26 and medically necessary gender transition services for eligible participants and dependents effective 1/1/2017; and

THEREFORE, the Board of Trustees amends the Plan as follows:

Amendment

Effective January 1, 2017, Article III. (FORMAL RULES FOR PAYMENT OF MEDICAL BENEFITS OF THE SELF-FUNDED PPO PLAN), Subsection "11." of Section J. (SPECIFIC COVERAGE RULES) is amended to allow coverage of pregnancies for eligible dependent children and new Subsection "17." is added to allow coverage of medically necessary transgender services, as follows:

J. Specific Coverage Rules

11. Pregnancy. Effective January 1, 2017, charges incurred as a result of pregnancy and related conditions for Employees, legal eligible spouses, and eligible dependent children up to age 26 will be paid on the same basis as any other disability or sickness.

17. Transgender Services. Effective January 1, 2017, procedures or treatments for transgender services determined to be medically necessary by a licensed physician will be covered under the Plan.

Effective January 1, 2017, Article III (FORMAL RULES FOR PAYMENT OF MEDICAL BENEFITS OF THE SELF-FUNDED PPO PLAN), Subsections "7." and "10." of Section K. (EXCLUSIONS) are amended to allow coverage of pregnancies for eligible dependent children up to age 26 and medically necessary gender transition services, as follows:

K. Charges Not Covered (EXCLUSIONS)

7. Miscellaneous Procedures. Charges associated with the following procedures or services…

- Gender alteration procedures unless determined to be medically necessary by a licensed physician (effective January 1, 2017).

10. Pregnancy of Dependent Children. This subection is eliminated effective January 1, 2017 and charges for pregnancy and related conditions for eligible dependent children will be covered under the Plan.

Approved: September 19, 2016

Union Trustee

Mark Burri, Chair

Employer Trustee

Ron Mitchell, Co-Chair

AMENDMENT TEN TO THE

U.A. LOCAL 467 HEALTH AND WELFARE PLAN

Recitals

WHEREAS, the Board of Trustees of the U.A. Local 467 Health and Welfare Plan (the "Plan") determined that it would be in the best interest of the Plan Participants to allow out of state retirees under age 65 to be on the Blue Cross PPO Plan given that Blue Cross has networks throughout the country;

WHEREAS, permitting out-of-state retirees under age 65 to participate would result in such retirees having benefits similar to the benefits provided to in-state retirees at no or little additional cost;

WHEREAS, adopting this Amendment is a change to Amendment Four that was adopted on December 13, 2011;

THEREFORE, the Board of Trustees amends the Plan as follows:

Amendment

Effective as of September 1, 2015, Article II, Section A on page 19 of the Plan document is amended as follows:

> Out-of-state retirees of the U.A. Local 467 Health and Welfare Plan who are under age 65 are permitted to participate in the Blue Cross Preferred Provider Option in the same manner as in-state Participants have such right. As a result, the Plan will no longer provide for a direct reimbursement to such retirees for obtaining their own coverage outside the Plan.

Approved: September 9, 2015

Union Trustee

Mark Burri, Chair

Employer Trustee

Ron Mitchell, Co-Chair

AMENDMENT ELEVEN TO THE

U.A. LOCAL 467 HEALTH AND WELFARE PLAN

Recitals

WHEREAS, the Board of Trustees of the U.A. Local 467 Health and Welfare Plan (the "Plan") determined that in the situation of a Participant incurring a permanent disability prior to reaching retirement age under the U.A. Local 467 Defined Benefit Pension Plan, the Participant will be eligible for the Medicare Retiree Plan if he has at least 25 Benefit Credits under the U.A. Local 467 Defined Benefit Pension Plan and has not worked for a non-signatory employer;

THEREFORE, the Board of Trustees amends the Plan as follows:

Amendment

Effective as of June 1, 2017, Article I, Section D of the U.A. Local 467 Health and Welfare Plan document is amended by adding the following language to Number 3.

> If the Participant is permanently and totally disabled prior to age 65 entitling him to a disability pension benefit under the U.A. Local 467 Defined Benefit Pension Plan, he must have at least 25 Benefit Credits under the U.A. Local 467 Defined Benefit Pension Plan and not have performed any work for a non-signatory employer in the Plumbing and Pipefitting Industry (also known as the "Pipe Trades Industry").

Approved: June 13, 2017

Union Trustee

Mark Burri, Chair

Employer Trustee

Ron Mitchell, Co-Chair

AMENDMENT ~~TWO~~ 12
to the
U.A. LOCAL 467 HEALTH AND WELFARE PLAN

Recitals

WHEREAS, the Board of Trustees of the U.A. Local 467 Health and Welfare Plan ("Plan") has determined that it is in the best interest of the Plan and the Plan Participants to comply with the San Francisco Equal Benefits Ordinance;

THEREFORE, the Board of Trustees amends the Restated Plan to include provisions for registered Domestic Partners as follows:

Amendment

Section 9 is added to Article I, Section A. of the U.A. Local 467 Health and Welfare Plan as follows:

> Section 9 Domestic Partner. The primary intent of this section is to comply with the San Francisco Equal Benefits Ordinance. Where the term spouse is used in this Plan, the term shall also mean a registered Domestic Partner of a Participant provided that the Plan has received timely written notice of such registered Domestic Partnership. The intent of the Board of Trustees is that a Domestic Partner be a registered Domestic Partner, including both same-sex and opposite-sex partners, registered with any state or local government agency authorized to perform such registration. There are no requirements for proof of relationship or waiting periods that are not also applied to married couples except as provided in the registration requirements. COBRA-like continuation coverage is available to domestic partners and their children to the same degree and in the same manner as continuation coverage is available to spouses and step-children. This section will be interpreted in such a way as to comply with the Equal Benefits Ordinance.
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> To be entitled to benefits as a registered Domestic Partner, a Participant and his Domestic Partner must provide the Plan with proof that the Domestic Partnership has been registered with the City and County of San Francisco and/or the State of California or other appropriate government agency. To the extent required, the Plan shall comply with applicable IRS requirements relating to providing benefits to Domestic Partners, including imputed income tax for the value of the benefits if the Domestic Partner does not qualify as a dependent under IRS rules. The Participant and the Domestic Partner agree to provide immediate written notice to the Plan Office of the termination of the Domestic Partnership.

Effective: January 1, 2017

Mark Burri, Chair

Ron Mitchell, Co-Chair