NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

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JUNE 2017

TO: ACTIVE AND RETIRED PARTICIPANTS

RE: SUMMARY OF MATERIAL MODIFICATIONS TO THE NORTHERN CALIFORNIA PIPE TRADES HEALTH AND WELFARE PLAN

The Board of Trustees of the Northern California Pipe Trades Health and Welfare Trust Fund ("Plan") is pleased to provide you with the following summary of changes in the Plan, called a Summary of Material Modification ("SMM"). Please review the important changes below.

A. SUMMARY OF AGREEMENTS AND BENEFITS – Plan Amendment
ACTIVE Participants
Article II of the Restated Plan – Effective July 1, 2017

Effective July 1, 2017, the Plan's Summary of Agreements and Benefits Chart has been amended as follows:

II. SUMMARY OF AGREEMENTS AND BENEFITS

Classification	Initial Eligibility Requirement	Hours Required for Monthly Eligibility	Reserve Hour Bank	Jury Duty	Active Subsidized Self-Payment
ACTIVE (MLA + Others)	300 hours in consecutive 6-mos.	125	6-mos. Max (750 hours)	**YES**	12-mos. Max & overall 18-mos. Max in rolling 36 month period
HELPER (MLA+ Others) (*Effective 9-1-2015 KAISER ONLY)*	125 hours in consecutive 6-mos.	125	2-mos. Max (250 hours)	NO	4-mos. Max & overall 6-mos. Max in rolling 36 month period
SHORTLINE *(Effective 9-1-2015 Helpers are allowed KAISER ONLY)*	300 hours in consecutive 6-mos.	125	6-mos. Max (750 hours)	**YES**	12-mos. Max & overall 18-mos. Max in rolling 36 month period
RESIDENTIAL *(KAISER ONLY)*	120 hours in consecutive 6-mos.	120	1 mo max **-OR-** 3-mos. Max (360 hours) if worked 1200 hours in each of the preceding 2 calendar years	NO	4-mos. Max & overall 6-mos. Max in rolling 36 month period
TRADESMAN *(KAISER ONLY)*	300 hours in consecutive 6-mos.	125	2-mos. Max (250 hours)	NO	4-mos. Max & overall 6-mos. Max in rolling 36 month period
RESIDENTIAL LIGHT COMMERCIAL (RLC) *(KAISER ONLY)*	120 hours in consecutive 6-mos.	120	1 mo max **-OR-** 3-mos. Max (360 hours) if worked 1200 hours in each of the preceding 2 calendar years	NO	4-mos. Max & overall 6-mos. Max in rolling 36 month period
SERVICEMAN (Other Applicable Agreements) *(KAISER ONLY)*	300 hours in consecutive 6-mos.	125	6-mos. Max (750 hours)	NO	4-mos. Max & overall 6-mos. Max in rolling 36 month period
NON-BARGAINING	1 HW Flat Rate Contribution	1 HW Flat Rate	NONE	NO	NO
UA NATIONAL DISTRIBUTION AGREEMENT (*Effective 9-1-2015 KAISER ONLY)*	300 hours in consecutive 6-mos.	125	6-mos. Max (750 hours)	NO	12-mos. Max & overall 18-mos. Max in rolling 36 month period

B. ELIGIBILITY RULES – Plan Amendment
RESERVE HOUR BANK FOR NEW TRADESMAN AND SERVICEMAN WORKING UNDER THE REFRIGERATION AND AIR CONDITIONING AGREEMENT AND FOOD STORE ADDENDUM AND OTHER APPLICABLE HEATING & AIR CONDITIONING AGREEMENTS
ACTIVE Participants
Article III, Section A(2)(d)3 of the Restated Plan – Effective July 1, 2017

Effective with May 2017 hours for July 1, 2017, eligibility, the Plan has been amended to eliminate granting of a one month hour bank after initially working 800 hours and an additional one month after working 1600 hours and, instead, allow a two (2) month Reserve Hour Bank for New Tradesman and Serviceman working under the Refrigeration and Air Conditioning Agreement and Food Store Addendum, and Other Applicable Heating and Air Conditioning Agreements.

d. Tradesman and Serviceman Working Under the Refrigeration and Air Conditioning Agreement and Food Store Addendum and Other Applicable Heating & Air Conditioning Agreements.

The following provision(s) apply to New Tradesman and/or Serviceman hired on or after January 1, 2014, working under the Refrigeration and Air Conditioning Agreement and Food Store Addendum:

3. Effective with May 2017 hours (July 2017 eligibility), New Tradesman and Other Applicable Employees, who have not already been granted the two (2) month Reserve Hour Bank, will have any hours reported in excess of 125 hours in a month banked in the Participant's Reserve Hour Bank. A Participant may accumulate excess hours up to a maximum of 250 hours or two (2) months in his/her Reserve Hour Bank. Existing Tradesman and Existing Other Applicable Employees are entitled to keep their existing hour banks; however, once an Existing Tradesman or Existing Other Applicable Employee has used and reduced his/her Reserve Hour Bank to two (2) months, the new two (2) month maximum will apply.

C. RETIREE HEALTH AND WELFARE PLAN – Plan Amendment
SURVIVING SPOUSE/DEPENDENT COVERAGE
RETIRED Participants
Article XIII, Section A.7. of the Restated Plan – Effective June 1, 2017

Effective June 1, 2017, the Plan's Surviving Spouse and Dependent Coverage rules have been amended to eliminate reference to one additional month being allowed at the Retiree rate and to require a one (1) year marriage requirement in order for a Spouse to qualify for Surviving Dependent Coverage.

7. Surviving Spouse/Dependent Coverage: When a Retiree (who meets all the Retiree Health and Welfare eligibility requirements) passes away and the Surviving Spouse/Dependent is eligible for and elects Surviving Dependent Health and Welfare Benefits (which are the same as Retiree Health and Welfare Benefits), the Plan provides for continued coverage for eligible Dependents at the Surviving Dependent Coverage monthly premium rate effective the month after the Retired Participant passes away.

EXAMPLE: A Retiree passes away on June 5, 2017. The Surviving Dependent of the Retiree chooses to elect Surviving Dependent Coverage. Effective July 1, 2017, the Surviving Dependent will pay the Surviving Dependent monthly premium rate. Monthly premiums are subject to increase at any time at the discretion of the Board of Trustees without a formal Plan Amendment.

Effective June 1, 2017, in addition to other eligibility requirements in this section, a Surviving Dependent Spouse must be married to the Participant for at least one (1) year prior to the Retiree's death in order to continue Surviving Spouse Coverage under the Plan.

If the Retired Participant's Surviving Spouse (who was married to the Participant for at least one year prior to the Participant's death) and/or Surviving Dependent Child(ren) were eligible and enrolled as Dependents under the Participant's Retiree Health and Welfare Plan at the time of the Participant's death, the Surviving Spouse and/or Surviving Dependent Child(ren) may continue coverage offered at rates determined by the Board or Trustees. Surviving Spouses who remarry lose coverage immediately (effective the date of the marriage). The new Spouse and/or any

newborn child(ren) and/or stepchild(ren) from the new marriage are also excluded from Retiree Health and Welfare Benefits. In addition, any Surviving Dependent Child(ren) would only be eligible to continue coverage providing that they continue to meet all other Plan requirements for Dependent Child(ren) including age requirements. Please refer to Article VII, Sections D, E, F and G. **Please be aware that for Surviving Dependent Child(ren), when reviewing the Eligibility Requirements Section, the term "Participant" should be substituted with either "Surviving Natural Parent" or "Legal Guardian", whichever is applicable.**

Surviving Spouse and/or Dependent Child(ren) Continuation of Coverage as described above is provided in lieu of COBRA continuation coverage. **Refer to Article XI COBRA Continuation Coverage**. As a result, please be aware that if a Surviving Spouse and/or Dependent Child(ren) no longer qualify for this Continuation of Coverage and have been covered for 36 or more months, COBRA benefits would not be available. However, if a Surviving Spouse and/or Dependent Child(ren) lose eligibility but have been covered for less than 36 months, the Surviving Spouse and/or Dependent Child(ren) would be eligible to continue coverage under COBRA for a total period not to exceed 36 months (including months of coverage purchased under Surviving Spouse/Dependent coverage).

If the Surviving Spouse and/or Dependent Child(ren) have alternate coverage at the time he/she is eligible for the Continuation of Coverage, he/she may choose to delay the Retiree Health and Welfare coverage until termination of the alternate coverage, provided that he/she notifies the Trust Fund Office in writing within a reasonable time prior to the other coverage's termination date and subject to proof of such termination of other coverage.

If the Participant's Surviving Spouse and/or Dependent Child(ren) owes any amount to the Plan as a result of the Participant having enrolled and/or maintained an ineligible Dependent in the Plan and fails to repay such amount irrespective of whether such amount was discharged in U.S. Bankruptcy Court or any other Court, then the Surviving Spouse and/or Dependent Child(ren) do not qualify for Surviving Spouse/Dependent Health and Welfare Benefits.

A Surviving Spouse and/or Surviving Dependent Child(ren) of a deceased Active Participant may be offered Surviving Dependent Continuation Coverage under the Retiree Health and Welfare Plan providing the deceased Participant met <u>ALL</u> of the following requirements:

1. The Surviving Dependent Spouse and/or Surviving Dependent Child(ren) were eligible for Pre-Retirement Death Benefits under the Pension Plan at the time of the Active Participant's death; **and**
2. If the Surviving Dependent is a Dependent Spouse, the Spouse was married to the Participant for at least one (1) year prior to the Active Participant's death; **and**
3. The Surviving Dependent Spouse and/or Surviving Dependent Child(ren) were eligible and enrolled as Dependents under the Participant's Active Health and Welfare Plan at the time of the Participant's death; **and**
4. The Surviving Dependent(s) meets the Plan definition of an eligible Dependent(s) under the Retiree Health and Welfare Plan (Article VII); however, no Domestic Partner coverage is available; **and**
5. At the time of the Participant's death he/she had accrued a minimum of at least ten (10) years of Benefit Credits and ten (10) years of Vesting Credits, exclusive of Pro Rata Reciprocal Credits, without a Permanent Break in Service under the Northern California Pipe Trades Pension Plan; **and**
6. The Participant had Active eligibility through hours worked, Reserve Hour Bank, or Active Subsidized Self-Payments (excluding COBRA payments) under the Northern California Pipe Trades Health and Welfare Active Plan for at least 12 of the last 18 consecutive months immediately preceding his/her month of death in a classification requiring contributions to the Retiree Health and Welfare Plan; **and**
7. The Participant worked at least 1000 hours in Covered Employment during the 36 months immediately preceding the Participant's month of death; **and**
8. The Participant was a member in good standing with UA Local 342 at the time of his/her death.

D. GENERAL PROVISIONS – Plan Amendment
SUBROGATION RIGHTS/THIRD PARTY LIABILITY
ACTIVE and RETIRED Participants
Article XXI, Section K of the Restated Plan – Effective January 1, 2016

<u>Effective January 1, 2016, the Plan's Third Party Liability/Subrogation Rules have been amended to clarify that it has always been the Board of Trustees intent that the Plan has the first right of subrogation and the Plan's right to subrogation, reimbursement, and restitution are in no way limited or affected by any doctrines limiting its rights</u>.

K. SUBROGATION RIGHTS/THIRD PARTY LIABILITY

The subrogation Third Party Liability Provision in the applicable Evidence of Coverage booklet for Kaiser or Blue Shield will apply to claims covered by such PPO or HMO. This provision applies to any other benefits provided under this Plan.

This Plan does not cover any illness, injury, disease or other condition for which a third party is or may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

Charges incurred by a Participant or Dependent for which a Third Party is liable or responsible are not covered charges under any benefits provided in this Plan; however, payments on otherwise eligible expenses might be advanced to an otherwise eligible Participant or Beneficiary, if the conditions of this section are met.

In requesting any advances from the Plan on account of an illness, injury, or other condition for which a third party (or their respective insurers) may be liable or legally responsible, you and your Dependent must agree that as a condition precedent to being advanced any Plan benefits, you and your Dependent will notify the Trust Fund Office within 30 days if any claims incurred under the Plan are the result of an accident, injury, disease or other condition for which a third party is or MAY BE liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party. You must furnish any information or assistance and execute any documents that the Board of Trustees or the Board's delegate may require or request to facilitate enforcement of their rights under this Section and take no action that may prejudice or interfere with the Plan's rights under this Section.

Participants are required to reimburse the Plan immediately for any proceeds received by way of a court judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance) arising out of any claims for damages by the individual or his heirs, parents, or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. Any Participant and/or a Dependent who accepts payments from the Plan agrees that by doing so he/she is making a present assignment of his or her rights against such third party to the extent of the payments made by the Plan. These rules are automatic, but the Plan may require that any Participant sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require.

Any Participant and/or Dependent who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any Participant and/or Dependent who receives benefits and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the Participant has failed to reimburse, including reasonable interest in such unpaid funds.

The Plan is entitled to a first priority recover for the full amount of Covered Charges it has paid or may pay for the injury or illness of a Covered Person that are related to the Third Party Claim. As a condition of receiving benefits under the Plan, the Covered Person grants specific and first rights of subrogation, reimbursement and restitution to the Plan. Such rights shall come first and are not adversely impacted in any way by: (a) the extent to which the Covered Person recovers his/her full damages and/or attorneys' fees; or (b) how such recovery may be itemized, structured, allocated, denominated, or characterized; e.g., without regard to any characterization as a recovery for such matters as lost wages, damages, attorneys' fees, etc. rather than for medical expenses, the type of property or the source of the recovery, including any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on the Covered Person, no-fault insurance, or uninsured and/or underinsured motorist coverage).

Such reimbursement, restitution and subrogation rights shall extend to any property (including money) that is directly or indirectly in any way related to the Plan benefits. Without in any way limiting the preceding, the Covered Person agrees to subrogate the Plan to any and all claims, causes of action, or rights that the Covered Person has or that may arise against any person, corporation, and/or other entity who has or who may have caused, contributed to and/or aggravated the injury or condition for which the Covered Person claims an entitlement to benefits under the Plan, and to any claims, causes of action, or rights the Covered Person may have against any other no-fault coverage, uninsured and/or underinsured motorist coverage, or any other insurance coverage or fund.

The Plan's right to subrogation, reimbursement, restitution, to a lien, and as a beneficiary of a constructive trust shall in no way be affected, reduced, compromised, or eliminated by any doctrines limiting its right (equitable or otherwise, whether established at common law or statute) such as the make-whole doctrine, collateral source, contributory or comparative negligence, the common fund doctrine, or any other defense.

By accepting payments from the Plan, any Participant and/or Dependent agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the Participant's own carrier for uninsured motorists' coverage. By accepting payments from the Plan, the Participant and/or Dependent agrees that a lien shall exist in favor of the Plan upon all sums of money recovered by the Participant and/or Dependent against the third party. The lien may be filed with the third party, the third party's agents, or the court. The Participant and/or Dependent shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent. The Plan's claim shall be a

lien on said recovery and attach to the recovery or any tangible property that the recovery may be transmuted to. The Covered Person also agrees that until such lien is completely satisfied, the holder of any such property (whether the Covered Person, his/her attorney, an account or trust set up for the Covered Person's benefit, an insurer, or any other holder) shall hold such property as the Plan's constructive trustee. As such, the constructive trustee agrees to immediately pay over such property to or on behalf of the Plan pursuant to its direction to the extent necessary to satisfy the equitable lien.

If the Participant and/or Dependent settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the Participant and/or Dependent shall receive no further benefits from the Trust in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise in writing, as one which is not unreasonable from the standpoint of the Trust.

E. CLAIMS AND APPEAL PROCEDURE – Plan Amendment
ACTIVE and RETIRED Participants
Article XXIV, Section B.2.e.; Section B.2.g.; and Section B.3.f. of the Restated Plan – Effective January 1, 2018

Effective January 1, 2018, the Plan's Claims and Appeal Procedure for Disability Claims has been updated to comply with recent Department of Labor regulations.

e. **Disability Claim.** A Disability Claim must be submitted to the Trust Fund Office within 90 days after the date of the onset of the disability. The Plan will make a decision on the Disability Claim and notify the Participant of the decision within 45 days after receipt of the Claim by the Trust Fund Office. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Trust Fund Office will notify Participant of the reason for the delay and the date by which the Plan expects to render a decision. This notification will occur before the expiration of the initial 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

A decision will be made within 30 days of the time the Plan notifies the Participant of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan notifies the Participant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from the Participant, the extension notice will specify the information needed. If the information is not provided within the 45-day period, the Claim will be denied. During the 45-day period in which the Participant is allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from the date of the notification; or (2) the date the Participant responds to the request. Once the Participant responds to the Plan's request for the information, the Participant will be notified of the Plan's decision on the Claim within 30 days.

For Disability Claims, the Plan reserves the right to have a Physician examine the claimant (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

Effective January 1, 2018, a retroactive rescission (meaning cancellation or discontinuance) of your disability benefit coverage will be considered an adverse benefit determination that would trigger the Plan's appeal procedures. However, if the retroactive rescission was due to a failure to timely pay required premiums or contributions toward the cost of coverage that would not be considered an adverse benefit determination.

If the Plan has failed to comply with the Claims and Appeal procedure requirements for disability claims, you will not be prohibited from filing suit or seeking court review of a claim denial based on a failure to exhaust the administrative remedies under the Plan unless the violation was the result of a minor error or considered "de minimis." This would mean: (a) non-prejudicial, (b) attributable to good cause or matters beyond the Plan's control, (c) in the context of an ongoing good-faith exchange of information, (d) and not reflective of a pattern or practice of non-compliance by the Plan.

g. **Notice of Initial Benefit Determination.** The Participant will be provided with written notice of the initial benefit determination. If the determination is an Adverse Benefit Determination, the notice will include:

(1) The specific reason(s) for the determination;
(2) Reference to the specific Plan provision(s) on which the determination is based;
(3) A description of any additional material or information necessary to perfect the Claim and an explanation of why the material or information is necessary;
(4) A description of the appeal procedures and applicable time limits and a statement of the Participant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;
(5) If an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon request at no charge;
(6) If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge; and
(7) For Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).

Effective January 1, 2018, for **Denial of Disability claims,** in addition to the information set forth above, your denial notice will also include the following:

(1) Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
(2) Statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records and other information to your claim for benefits;
(3) Statement of your right to present evidence and testimony in support of your claim during the appeal/review process;
(4) Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;
(5) Statement that on appeal, you will have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with any new or additional evidence considered, as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances requires a further extension of time); and
(6) If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

3. Appeal Procedures:

f. **Content of Appeal Determination Notices.** The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

(1) The specific reason(s) for the determination;
(2) Reference to the specific Plan provision(s) on which the determination is based;

(3) A statement that the Participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;
(4) A statement of the Participant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal and any Plan imposed limitation to sue;
(5) If an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and
(6) If the determination was based on Medical, Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

Effective January 1, 2018, for **Appeals of Disability Claims**, in addition to the information set forth above, your Appeal Denial Notice will also include:

(1) Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
(2) Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;
(3) Any Plan imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the expiration date for bringing suit; and
(4) If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

IN ACCORDANCE WITH THE REQUIREMENTS OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED ("ERISA"), THIS DOCUMENT SERVES AS A SUMMARY OF MATERIAL MODIFICATIONS ("SMM") TO THE PLAN AND SUPPLEMENTS THE RESTATED SUMMARY PLAN DESCRIPTION THAT HAS BEEN SEPARATELY PROVIDED TO YOU. YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE RESTATED SUMMARY PLAN DESCRIPTION.

If you have any questions, please contact the Trust Fund Office at 800/780-8984 ext. 246.

Respectfully submitted,
Fund Manager
On Behalf of the Board of Trustees