U.A. LOCAL NO. 393
DEPENDENT CARE ASSISTANCE
FLEXIBLE SPENDING ACCOUNT PLAN

(Effective January 1, 2019)

Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan. No individual trustee, employer, union representative or other person has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board.

The Board has authorized BeneSys Administrators to respond in writing to your written questions. If you have a question about your benefits, you should write to the BeneSys for a definitive answer. To obtain an accurate answer, you will need to provide complete and accurate information about your situation.

As a courtesy to you, the members' advocate or BeneSys Administrators may also respond informally to oral questions. Oral information and answers are not binding upon the Board and cannot be relied on in any dispute concerning your benefits.

You are obligated to cooperate with the Board of Trustees and to provide any information to assist with eligibility verification when requested within 30 days of the request. If you fail to cooperate with requests for information from the Board of Trustees, they have the authority not to pay benefits under the Plan.

BeneSys Administrators
P.O. Box 2460
San Jose, CA 95109
Telephone (408) 588-3751

Members' Advocate
Nancy Ferguson
Telephone (408) 464-3738
Email 393@MemberAdvocate.org

INTRODUCTION

This Dependent Care Assistance Flexible Spending Account Plan allows you to pay for eligible dependent care expenses with pretax dollars. The Plan allows employees who enroll to contribute some of their hourly wage, before withholding for federal income, Social Security (FICA) and most state taxes, to a Dependent Care Assistance Flexible Spending Account that can be used to pay for eligible dependent care expenses, such as day care, preschool, or after-school care (Qualified Expenses are defined below).

The Plan is intended to qualify as a Dependent Care Flexible Spending Account under Sections 106, 125, and 129 of the Internal Revenue Code ("the Code"), as amended and the Treasury Regulations thereunder.

1. SUMMARY OF HOW THE PLAN WORKS

- You must enroll by filing an Enrollment Contribution Change form with U.A. Local 393 that specifies how much you would like contributed to your Dependent Care Assistance Flexible Spending Account, subject to the IRS limits.
- You pay your dependent care expenses as usual. You will need to keep receipts and other documentation of expense.
- After the dependent care has been provided, you submit a claim form with receipts to the Administrative Office. All claims for the Plan Year must be submitted by April 15th of the following year.
- The Administrative Office will process your reimbursement claim and mail you a check for the amount of the claim or, if less, the amount remaining in your Dependent Care Assistance Flexible Spending Account.
- The IRS requires that all money contributed to your Dependent Care Assistance Flexible Spending Account in a Plan Year (January 1st – December 31st) be used in that Plan Year or the Grace Period (through March 15th of the following year). Any money remaining in your Dependent Care Assistance Flexible Spending Account will be forfeited. It is very important when you enroll, you make your contribution decision based on a careful estimate of the dependent care expenses you will incur during the Plan Year.
- If a claim reimbursement request is denied, you can appeal to the Board of Trustees by submitting a written appeal within 180 days of receiving the denial notice. Once the Board hears your appeal, their determination will be sent to you no later than 5 days after the decision is made. If your appeal is denied, you have a right to bring a civil action under ERISA § 502(a). No legal action may be commenced or maintained against the Trust or Plan more than two (2) years after an appeal for benefits is denied. In any such action, the determinations of the Board of Trustees are subject to judicial review only for abuse of discretion.

2. HOW TO ENROLL

You are eligible to enroll in the U.A. Local No. 393 Dependent Care Assistance Flexible Spending Account Plan if you are not a 1% or more owner of an employer and you meet the criteria of either (1) or (2) below:

(1) (a) you are working for an employer who makes contributions to the U.A. Local 393 Health and Welfare Plan pursuant to the U.A. Local 393 Master Labor Agreement **and** (b) you are eligible for coverage under the U.A. Local No. 393 Health and Welfare Plan; or

(2) (a) You are an officer or an employee of U.A. Local No. 393 or an employee of the Lloyd E. Williams Pipe Trades Training Center and (b) you previously worked under the U.A. Local 393 Master Labor Agreement or another collective bargaining agreement benefitting pipefitters and related classifications.

Before the beginning of each Plan Year (January 1st – December 31st) there will be an open enrollment period during which an employee may submit an Enrollment Contribution Change form with U.A. Local 393 that specifies hourly amount to be deferred to the employee's Dependent Care Assistance Flexible Spending Account. This form must be completed annually.

The Board of Trustees, at their discretion, may establish special enrollment periods during the Plan Year where you can revoke or change your contribution election. However, your contribution election cannot be revoked or changed during the Plan Year unless during the Plan Year you have one of the following events which affects your eligibility for benefits under this Plan:

(1) a change in your marital status because of marriage, death of spouse, divorce or legal separation, or annulment;
(2) a change in the number of your qualifying dependents because of birth, death, adoption or placement for adoption;
(3) a change in your or your spouse's employment status because of termination or commencement of employment, strike or lockout, a commencement or return from an unpaid leave of absence;
(4) your dependent either satisfies or ceases to meet the definition of Qualified Dependent under Section 4 of this Plan.

or you may also change or revoke your election during the Plan Year if

(1) you demonstrate, to the satisfaction of the Trustees a significant increase or decrease in the cost of dependent care imposed by a provider who is not your relative;

(2) you change your child care provider during the Plan Year; or
(3) there is a change in the number of hours of care provided by your child care provider.

If you first become eligible under the U.A. Local No. 393 Health and Welfare Plan after open enrollment for the Plan Year and otherwise meet the requirements for enrollment, you may still enroll by submitting the Enrollment Contribution Change form to U.A. Local 393 within sixty (60) days of your initial eligibility under the U.A. Local No. 393 Health and Welfare Plan. Contributions will be deducted for hours worked starting in the month following when the form is submitted to U.A. Local 393.

The hourly amount specified on the Enrollment Contribution Change form will be deducted from your wages and sent to the Plan on a pretax basis (before federal, state, and Social Security (FICA) taxes). The specified hourly contribution will be deducted until the IRS maximum contribution limit is reached.

It is very important when you enroll, you make your contribution decision based on a careful estimate of the dependent care expenses you will incur during the Plan Year because you will forfeit amounts contributed to the Plan that are unused at the end of the Plan Year or the Grace Period. For more information about what dependent care expenses can be reimbursed by the Plan see Sections 4 and 5.

3. CONTRIBUTION LIMITS

There is no minimum contribution limit.

The maximum contribution limit is determined by the IRS, and subject to change. The maximum that can be contributed is the lesser of:

- $5,000 per Plan Year (January 1st – December 31st), this is reduced to $2,500 if you are married but file separate tax returns
- Your total earned income
- Your spouse's total earned income

In general, the maximum contribution limits are the same regardless of the number of dependents you have, and whether you are single or married. If your spouse is also eligible to participate in a dependent care flexible spending account, your combined contributions should not exceed the maximum contribution limit.

If your spouse is incapable of self-care or is a full-time student and you claim one dependent, his or her earned income is considered to be $250 per month ($3,000 per year). If your spouse is incapable of self-care or a full-time student and you claim two or more dependents, your spouse's earned income is considered to be $500 per month ($6,000 per year).

4. QUALIFIED DEPENDENTS

The Plan can only reimburse eligible dependent care expenses for Qualified Dependents as defined under Section 129 of the Code. A Qualified Dependent includes:

- Your child under age 13 in your custody, whom you claim as a dependent on your tax return;
- Your legal spouse who is physically or mentally incapable of self-care and who lives with you at least half the year; and
- Your dependent age 13 or older who lives with you, is physically or mentally incapable of self-care, and whom you claim as a dependent on your tax return.

If care is provided outside of your home for your legal spouse or dependent age 13 or older, the spouse or dependent must live in your home at least eight (8) hours each day.

Divorced Individuals: If you are divorced and you are the custodial parent, your child is a Qualifying Dependent even if you do not claim the child as a tax dependent. A divorced, non-custodial parent cannot be reimbursed under this Plan, even if the divorced non-custodial parent claims the child as a tax dependent.

5. ELIGIBLE DEPENDENT CARE EXPENSES

Eligible Dependent Care Expenses, as defined by Section 129 of the Code, can be reimbursed by the Plan. Eligible Expenses must meet the following requirements:

- The expense must be for a Qualifying Dependent, see Section 4 of this Plan, and be necessary so that you (and your spouse, if married) can work or look for work (you must have income during the year). Or, if your spouse is not working or seeking work, he or she must be a full-time student or incapable of self-care.
- If care is provided by a day care center, the center must charge a fee. If the center cares for six or more dependents who don't reside there, it must comply with all state and local licensing laws and applicable regulations.
- The Eligible Dependent Care Expense must be incurred during the Plan Year (January 1st – December 31st) or the Grace Period (through March 15th of the following year). You incur expenses when the care is provided, not when you are billed or when you pay for the care.

Examples of Eligible Dependent Care Expenses for Qualifying Dependents:

- Before and after school care

- Preschool and nursery school expenses
- Extended day programs
- Au pair and nanny services (the amount paid for the care of the dependent)
- Babysitting expenses (in and outside your home)
- Summer day camp
- Elder day care expenses

Examples of ineligible dependent care expenses:

- Overnight camp
- Expenses attributable to a disabled spouse or tax dependent living outside your household
- Tuition for Kindergarten or above
- Food expenses, unless inseparable from care
- Incidental expenses, such as extra charges for events or activities, unless inseparable from care
- Educational expenses
- Amounts paid to your spouse, your child under age 19, a parent of your child who is not your spouse, or a person for whom you or your spouse is entitled to claim as a dependent on your tax return

6. SUBMITTING A CLAIM

To submit a claim, you must send a claim form and receipts to the Administration Office as follows:

U.A. Local 393 Dependent Care Assistance Flexible Spending Account
c/o BeneSys Administrators
P.O. Box 2460
San Jose CA 95109.

If the expense is an Eligible Dependent Care Expense for a Qualified Dependent, the Administration Office will send you reimbursement for the amount of the claim or, if less, the amount remaining in your Dependent Care Assistance Flexible Spending Account. If your expenses are not clearly Eligible Dependent Care Expenses, the Administration Office may ask you for additional information to determine whether reimbursement is allowed.

All claims for the Plan Year must be submitted by April 15th of the following year.

For a copy of the claim form, contact the Administrative Office at: (408) 588-3751.

7. UNUSED MONIES AT THE END OF THE PLAN YEAR

The IRS requires that all money contributed to your Dependent Care Assistance Flexible Spending Account in a Plan Year (January 1st – December 31st) be used in that Plan Year or the Grace Period (through March 15th of the following year). Any monies remaining in your Dependent Care Assistance Flexible Spending Account at the end of the Grace Period are forfeited to the Plan.

8. ANNUAL STATEMENT

Annually, on or before January 31st, the Plan will send each enrolled employee a written statement showing the employee's contributions to the Plan and the Eligible Dependent Care Expenses reimbursed by the Plan in the previous Plan Year.

INFORMATION ABOUT THE PLAN

Plan Name: U.A. Local No. 393 Dependent Care Assistance Flexible Spending Account Plan

Plan Administrator: The Plan is administered by a joint Board of Trustees consisting of Employee Trustees appointed by U.A. Local No. 393 and Employer Trustees appointed by the participating Employer Associations. The Board of Trustees is assisted in the administration of the Plan by BeneSys Administrators, a contract Administrator.

Address of Plan Administrator: The address and telephone of the Board of Trustees and the Trust Fund Office are:

U.A. Local No. 393 Dependent Care Assistance Flexible Spending Account Plan
c/o BeneSys Administrators
P.O. Box 2460
San Jose, CA 95109
Telephone (408) 588-3751

Plan Sponsor: The Plan is sponsored by the Board of Trustees of the U.A. Local No. 393 Dependent Care Assistance Flexible Spending Account Plan.

Board of Trustees: The U.A. Local No. 393 Dependent Care Assistance Flexible Spending Account Plan Board of Trustees consists of representatives of employees from U.A. Local No. 393 and representatives of employers and the signatory employer associations. The current members of the Board are:

Employee Trustees
Steve Flores
U.A. Local 393
6150 Cottle Road
San Jose, Ca 95123

Employer Trustees
Alex Hall
Northern California Mechanical
Contractors Association
P.O. Box 159
Benicia, CA 94510

Greg Gonzales
U.A. Local No. 393
6150 Cottle Road
San Jose, CA 95123

Leroy Ginn
Acco Engineered Systems
1133 Aladdin Avenue
San Leandro, CA 94577

Gary Glenn
U.A. Local No. 393
6150 Cottle Road
San Jose, CA 95123

Dave McLaughlin
Dave McLaughlin Plumbing
508 Anita Lane
Millbrae, CA 94030

Wayd LaPearle
U.A. Local No. 393
6150 Cottle Road
San Jose, CA 95123

Michael Vlaming
Industrial Contractors, UMIC, Inc.
447 Georgia Street
Vallejo, CA 94590

Ed Nichols
U.A. Local No. 393
6150 Cottle Road
San Jose, Ca 95123

Larry Gates
Santa Clara Valley Contractors' Association
400 Reed Street
Santa Clara, CA 95052

Alternate Trustee:
Robert Dills
Western Allied Mechanical, Inc.
1180 O'Brien Drive
Menlo Park, CA 94025

Plan Year: January 1st through December 31st

Agent for Service of Legal Process:
George M. Kraw
Katherine McDonough
Patricia McCormick
KRAW LAW GROUP, A PROFESSIONAL CORPORATION
605 Ellis Street, Suite 200
Mountain View, CA 94043
(650) 314-7800

Legal process may also be served on any Trustee at his or her regular place of business or on the Administration Office.

The Trustees also employ the following firm as special legal counsel for collections:

WYLIE, MCBRIDE, PLATTEN & RENNER
c/o Bob Jesinger
2125 Canoas Garden Avenue, Suite 120
San Jose, CA 95125

Plan Consultant and Actuary:
Sidney T. Kaufmann
Kaufmann & Goble Associates
160 West Santa Clara Street, Suite 1550
San Jose, CA 95113

Plan Auditor:
Alex Miller
Vavrinek, Trine, Day & Company
Certified Public Accountants
1900 S. Norfolk St., Suite 225
San Mateo, CA 94403

Investment Consultant:
Don Grijalva
Wells Fargo Advisors
550 South Winchester Blvd, Suite 601
San Jose, CA 95128

Employer Identification: 94-6401544

Plan Funding & Collective Bargaining Agreement: The Plan is funded by elective deferrals by employees working for an employer signatory to a collective bargaining agreement with U.A. Local No. 393.

U.A. Local No. 393 currently has collective bargaining agreements with the following employer associations:

Industrial Contractors-UMIC, Inc.
447 Georgia Street
Vallejo, CA 94590
(707) 552-6040

Northern California Mechanical
Contractors Association
P.O. Box 159
Benicia, CA 94510
(800) 640-5152

Plumbing, Heating, and Cooling
Contractors Association of the
Greater Bay Area
1047 Whipple Avenue
Redwood City, CA 94062
(650) 364-7717

Santa Clara Valley
Contractors Association
400 Reed Street
Box 58032
Santa Clara, CA 95052
(408) 727-5887

A complete list of employers and employee organizations sponsoring the U.A. Local No. 393 Dependent Care Assistance Flexible Spending Account Plan may be obtained by participants and beneficiaries upon written request, and is available for examination by participants and beneficiaries.

The reserve assets of the fund are held in trust by a qualified bank.

Obtaining Copies Of Plan Documents: The following documents are available for examination or copying:

- Collective bargaining agreement calling for contributions to the Plan
- Detailed schedule of benefits of the Plan
- Any other document defining the benefits payable under the Plan

There may be a charge for copies of any document, except for the detailed schedule of benefits, which is available for no charge. All requests for copies of documents must be in writing. Examination of documents will be allowed only upon reasonable notice, and only during normal business hours.

APPENDIX A: CLAIMS AND APPEALS PROCEDURE

1. Claims and Appeals Procedure for Dependent Care Expense Claims and Other Matters Within the Discretion of the Board of Trustees.

The following claims and appeals procedures shall apply to matters within the discretion of the Board of Trustees of the U.A. Local No. 393 Dependent Care Assistance Flexible Spending Account Plan. Such matters include, but are not limited to, claims and appeals regarding eligibility under the U.A. Local No. 393 Dependent Care Assistance Flexible Spending Account Plan for reimbursement of dependent care expenses.

The procedures specified in this Appendix, plus supplementary procedures adopted by the Trustees, shall be the sole and exclusive procedures available to any individual who is adversely affected by any action of the Trustees, the Administration Office or any other Plan fiduciary or agent. The Board of Trustees reserves full discretionary authority to interpret Plan language and to decide all claims or disputes regarding right, type, amount or duration of benefits, or claim to any payment from this Trust. The Administration Office shall apply the written provision of the Plan to claims, but does not have any discretionary authority to interpret Plan language. The decision of the Board of Trustees on any matter within its discretion shall be final and binding on all parties.

(a) FILING A CLAIM: Participants/claimants may initiate a claim for benefits by contacting the Administration Office and following the instructions given to access the benefit. An authorized representative may submit a claim on behalf of a claimant.

(b) NOTIFICATION OF FAILURE TO FOLLOW PLAN PROCEDURES: If the claimant fails to follow the Plan's procedures for filing a claim for benefits, the Administration Office will notify the claimant as soon as possible, but within 5 days following the failure. This notification may be oral, unless the claimant or authorized representative requests it in writing.

(c) NOTIFICATION OF CLAIM DECISION:

(1) Time Limits and Requests for Additional Information. The Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 30 days after the Administration Office received the claim.

The 30-day time period may be extended for one additional 15-day period, but only due to matters beyond the Administration Office's control. If the Administration Office needs a 15-day extension, it will, before the end of the first 30 day period, notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

(2) CONTENTS OF CLAIM DENIAL NOTICE: The Administration Office will provide the claimant with written notice if his or her claim for benefits is denied. The notice will include the following information:

(A) A statement of the specific reason(s) for the denial;

(B) Reference to the specific Plan provision(s) on which the denial was based;

(C) If the Administration Office's decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;

(D) A description of any additional information or documents that the claimant will need to submit if he or she wants the claim to be reconsidered, and an explanation of why that information is necessary;

(E) A description of the Plan's appeal procedures; and

(F) A statement of the claimant's right to bring a civil action under ERISA § 502(a), if the appeal is unsuccessful.

(d) APPEAL PROCEDURES:

(1) The claimant may appeal any adverse action within the discretion of the Board of Trustees to the Board of Trustees.

(2) SUBMISSION OF APPEAL: Appeals must be in writing, and state in detail the matter or matters involved. To submit an appeal, the claimant must send a letter with any documents and information that he or she wants the Board to consider to the Administration Office.

(3) TIME LIMITS: The deadline for submission of any appeal to the Board of Trustees is 180 days of receiving the denial of the original claim by the Administration Office. Failure to file an appeal within the 180-day period shall constitute a waiver of the claimant's right to the review of, and of the claimant's objections to, the denial of his/her claim, whether or not the Plan is prejudiced by the failure.

(4) STANDARD FOR REVIEW: The Board of Trustees has full discretionary authority to decide upon Plan benefits, to interpret the Plan language conclusively, and to make a final determination of the rights of any participant or other person with respect to Plan benefits. The Board of Trustees will take into account everything that the claimant submitted, including material that was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial determination.

Neither a person who made the initial determination nor such a person's subordinate shall have a vote in the decision on appeal.

(5) NOTIFICATION:

(A) TIME LIMITS FOR NOTIFICATION:

The Board of Trustees will render a decision on the appeal at the regularly scheduled meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal.

If special circumstances (such as a need for a further hearing) require further extension, the decision will be made no later than the third meeting following the filing of the appeal. In such cases, the Administration Office will notify the claimant in writing of the extension, describing the special circumstances and the date the determination will be made, before the extension begins.

The Board may authorize a hearing if the Board determines that a hearing would be of assistance in its deliberation. If the Board authorizes a hearing, the claimant will be notified of the date, time and place of the hearing. The claimant may appear personally and/or may be represented by an attorney or any other representative of his or her choosing, at his or her own expense.

The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but no later than 5 days after the decision is made. The Board of Trustees' response period will be extended by any additional time it takes for the claimant to provide requested information.

(B) CONTENTS OF NOTICE:

The Administration Office will send the claimant written notice of the Board of Trustees' decision on appeal. If the appeal has been denied, the notice will include the following information:

(i) The specific reason(s) for the denial;

(ii) Reference to the specific Plan provision(s) on which the denial is based;

(iii) If the decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific

rule was relied upon and that a copy of such rule will be provided free of charge upon request;

(iv) A statement that the claimant may view and receive copies of documents, records or other information relevant to the claim, upon request and free of charge; and

(v) The claimant's right to bring a civil action under ERISA § 502(a).

(6) TIME LIMIT FOR BRINGING A LAWSUIT:

No legal action may be commenced or maintained against the Trust or the Plan more than two (2) years after an appeal for benefits has been denied. In any such lawsuit, the determinations of the Board of Trustees are subject to judicial review only for abuse of discretion.

APPENDIX B: YOUR RIGHTS UNDER ERISA

As a participant in the U.A. Local No. 393 Dependent Care Assistance Flexible Spending Account Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or

any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare or vacation benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court, although your right to sue may be limited if you have not used the Plan's appeal procedures. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administration Office. 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, which is the San Francisco Regional Office, 90 7th Street, Suite 11300, San Francisco, CA 94103 (415) 625-2481, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.