WESTERN STATES INSULATORS AND ALLIED WORKERS' HEALTH PLAN
(Revised January 2025)

Amendment 1

Pursuant to the authority set forth in Article VII, Section 7.2(t) of the Western States Insulators and Allied Workers Health and Welfare Fund Agreement and Declaration of Trust, the Board of Trustees hereby amend the Summary Plan Description as follows:

1. Effective September 1, 2025, amend Section titled "Appeals" in its entirety to state as follows:

APPEALS

The Board of Trustees or a committee appointed by the Board of Trustees, hereafter referred to as the Appeals Committee, have full discretionary authority to determine eligibility and interpret all Plan documents and to make all factual determinations concerning any claim or right asserted under or against the Plan. A participant whose claim is denied in whole or in part may request a review of the claim by filing a written application with the Board or Appeals Committee within 180 days after the denial. As part of the appeal procedure the participant or the participant's representative will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. Relevant information includes identification of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit decision, any statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The Board or Appeals Committee will not afford any deference to the initial benefit determination. If the adverse benefit determination is based in whole or in part on a medical judgment, the Board or Appeals Committee shall consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such consultant shall be different from any individual consulted in connection with the initial determination or the subordinate of any such person. Additionally, the Board or Appeals Committee will review written comments, documents, records, and any other information relating to the claim for benefits submitted by the participant, so long as this information is provided to the Board or Appeals Committee before a final decision is rendered on the written application for review of the denial.

Any notice of adverse determination will include (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records,

and other information relevant to claimant's claim; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures; (5) a statement of the claimant's right to bring an action under ERISA Section 502(a) within two (2) years after a claim has been denied; (6) the specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination; and (7) an explanation of the scientific or clinical judgment for the termination if the denial was based on medical necessity or other similar exclusion or limit.

In the case where a participant's claim is denied in whole or in part is based on the eligibility application filed before the services are rendered, the participant shall be notified of the decision of the Board or Appeals Committee in writing, within a reasonable amount of time, but not later than 30 days following receipt of the request for review.

In the case where a participant's claim is denied in whole or in part after the medical services have been rendered, the participant shall be notified within 5 days from the date of the scheduled Appeals Committee meeting. The Appeals Committee meets quarterly, and decisions on requests for review of the claim shall be made at the next succeeding regular Appeals Committee meeting following the receipt of the request for review, except that a request for review received within 30 days preceding the date of such meeting. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be made no later than the third meeting following the receipt of the petition for review. Notification of the extension shall be sent to the Claimant prior to the commencement of the extension describing the special circumstances and the date as of which the benefit determination will be made.

The decision on review shall be in writing and shall include a specific reason for the decision with specific reference to the pertinent provisions of the Plan on which the decision is based. You will also receive, upon request and free of charge, reasonable access to and copies of all information relevant to your claim for benefits, the specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination and an explanation of the scientific or clinical judgment for the termination if the denial was based on medical necessity or other similar exclusion or limit, if any. The notice will also state your right to bring an action under ERISA Section 502(a) within two (2) years after a claim has been denied.

The decision of the Board or Appeals Committee shall be final and binding upon the participant and all persons claiming through the participant. The Board and Appeals Committee have full discretionary authority to interpret all Plan documents and to make all factual determinations concerning any claim or right asserted under or against the Plan or Trust. Determinations of the Board or Appeals Committee shall be subject to judicial review only for abuse of discretion. No legal action may be commenced or maintained against the Trust Fund or Plan more than two (2) years after a claim has been denied.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on October 21, 2025 the Chair and Co-Chair have been granted authority to execute this Amendment.

Executed on Oct 21, 2025 at Hermosa Beach, CA.

Chair

Co-Chair