WESTERN STATES INSULATORS AND ALLIED WORKERS' PENSION PLAN
(As Amended and Restated Effective January 1, 2023)

Amendment 13

Pursuant to the authority set forth in Article VII, Section 7.1(f) of the Western States Asbestos Workers' Pension Fund Agreement and Declaration of Trust, the Board of Trustees hereby amends the Plan as follows:

1. Effective September 1, 2025, amend Article VIII, Section 8.9 in its entirety to state as follows:

Section 8.9. Determination of Disputes.

a) ***Board of Trustees or Appeals Committee to Resolve Benefit Disputes***. No employee, annuitant, beneficiary or other person ("Claimant") shall have any right or claim to benefits under this Plan other than as specified herein. Any dispute as to eligibility, type, amount or duration of benefits or any right or claim to payments from the Plan shall be resolved by the Board of Trustees or a committee appointed by the Board of Trustees, hereafter referred to as the Appeals Committee, under and pursuant to this Plan, and their decision on the dispute, right or claim, shall be final and binding upon all parties thereto. The Board of Trustees and Appeals Committee has 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.

b) ***Application for Benefits***. Any person whose application for benefits under the Plan has been denied in whole or in part, or whose claim to benefits is otherwise denied, shall be notified in writing of such decision within a reasonable period of time, but not later than ninety (90) days after receipt of such application or claim by the Plan. An extension of time for processing not exceeding ninety (90) days may be required by special circumstances, in which case written notice of such extension shall be furnished to the Claimant prior to the expiration of the initial ninety (90) day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render a benefit determination. The initial benefit determination will be made by the Administrative Office, or such other agent as may be appointed by the Board of Trustees.

The notice of denial shall set forth (1) the specific reason or reasons for the denial; (2) specific reference to pertinent plan provisions on which the denial is based; (3) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; (4) appropriate information as to the steps to be taken if the Claimant wishes to submit his or her claim; and (5) a statement of the

Claimant's right to bring a civil action under ERISA Section 502(a) within two (2) years following an adverse benefit determination.

c) ***Right to Appeal.*** If the application for benefits or a claim is denied, the Claimant may petition the Board of Trustees or Appeals Committee for review of the decision. The petition for review shall be in writing, shall state in clear and concise terms the reason or reasons for disagreement with the decision, shall be accompanied by any relevant documentary material relating to the claim not already furnished to the Plan, and shall be filed by the Claimant or the Claimant's duly authorized representative with the Administrative Office within sixty (60) days after receiving the notification of the adverse benefit determination. As part of the review process the Claimant or the Claimant's duly authorized 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.

Upon receipt of a petition for review, the Board of Trustees or Appeals Committee shall proceed to review the administrative file, including the petition for review and its contents. The Board of Trustees or Appeals Committee shall have the authority to determine eligibility under the Plan and to construe and interpret the terms of the Plan. All comments, documents, records and other information submitted by the participant relating to the claim will be taken into account without regard to whether such information was submitted or considered in the initial benefit determination. A decision by the Board of Trustees or the Appeals Committee shall be made at the next succeeding regular Trustees' meeting or Appeals Committee meeting following the request for review, unless the request for review is received within thirty (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 Claimant shall be notified of the decision of the Board of Trustees or the Appeals Committee in writing no later than five (5) days from the date the determination is made. 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; and (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.

In the event that the Claimant desires additional time to present evidence in support of his or her appeal, the Claimant may request such additional time in writing. The Board of Trustees or Appeals Committee shall grant the Claimant's written request for additional time necessary to perfect an appeal, provided the written request is received before the Board of Trustees or Appeals Committee issues its decision. Requests for additional time and requests to submit additional information received after the Board of Trustees' or Appeals Committee's decision has been rendered shall be denied, unless the Board of Trustees or Appeals Committee in its sole discretion determines that the information is material to the appeal and could not have been provided earlier.

The failure to file a petition for review within such sixty (60) day period shall constitute a waiver of the Claimant's right to review, and the initial decision shall be final and binding.

d) ***Disability Claims and Appeals***. If a claim pertains to disability benefits the rules and rights set forth in this subsection shall apply in addition to those set forth above. All claims and appeals under this subsection shall be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the determination. Decisions covered by the authority of the Plan regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) making determinations with respect to disability benefits of the Plan will not be made based upon the likelihood that the individual will support the denial of benefits. Any person whose application for disability benefits is denied shall be notified of such denial within a reasonable period of time, but not later than forty-five (45) days after receipt of such application or claim. An extension of time not exceeding thirty (30) days may be necessary due to matters beyond the control of the Plan, in which case notice will be sent to the Claimant prior to the expiration of the forty-five (45) day period. If a decision cannot be rendered due to matters beyond the control of the Plan prior to the expiration of the thirty (30) day extension, the period for making a determination may be extended for up to an additional thirty (30) days, in which case notice will be sent to the Claimant prior to the expiration of the first thirty (30) day extension. The notice of extension shall include in addition to the information set forth in subsection (b) above, 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. The Claimant shall be afforded at least forty-five (45) days to provide the specified information, if any. The deadline for the Board of Trustees or Appeals Committee to render its decision is

tolled from the date on which the notification of the extension is sent to the Claimant until the date a response from the Claimant is received.

Any notice of an adverse benefit determination shall include, in addition to the information set forth in subsection (b) above (1) the internal rule, guideline, protocol, standard, or other similar criterion, applied in making the determination, including the basis for disagreeing with the view of health care professionals, vocational professionals, or with the disability determinations by the Social Security Administration (if no such criterion was used, then an affirmative statement to that effect must be provided); (2) an explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation; and (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.

If the application for benefits or a claim is denied, the Claimant or the Claimant's duly authorized representative may petition the Board of Trustees or Appeals Committee for review of the decision. The petition for review shall be filed by the Claimant or the Claimant's duly authorized representative with the Administrative Office within one hundred and eighty (180) days of receipt of the notification of adverse benefit determination. The Claimant shall have access to relevant documents, records and other information as set forth in subsection (c) above, including 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 Administrative Office shall automatically provide to the Claimant, free of charge, any new evidence or rationales (if any) as soon as possible and sufficiently in advance of the date on which the appeal determination is to be made in order to give the Claimant a reasonable opportunity to address the new evidence or rational prior to the appeal date. The Claimant or the Claimant's duly authorized representative shall have the right to review and respond to new evidence or rationales considered, relied upon or generated by the Plan in connection with the Claimant's claim during the review process. The Board of Trustees 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 of Trustees 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 and shall not be the subordinate of any such person.

A decision by the Board of Trustees or the Appeals Committee shall be made at the next succeeding regular Trustees' meeting or Appeals Committee meeting following the request for review, unless the request for review is received within thirty (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 Claimant shall be notified of the decision of the Board of Trustees or the Appeals Committee in writing no later than five (5) days from the date the determination is made. The notice of denial shall include, in addition to the information set forth in subsection (c) above (1) the internal rule, guideline, protocol, standard, or other similar criterion, applied in making the determination, including the basis for disagreeing with the view of health care professionals, vocational professionals, or with the disability determinations by the Social Security Administration (if no such criterion was used, then an affirmative statement to that effect must be provided); and (2) an explanation of the scientific or clinical judgment for the determination if the denial was based on medical necessity or other similar exclusion or limit.

All notices and disclosures under this subsection shall be provided in a culturally and linguistically appropriate manner. The Administrative Office will also provide customer service with oral language services in the non-English language and provide written notices in the non- English language upon request.

e) ***Finality of Decision on Claims.***

(1) The denial of an application or claim under subsection (c) and (d) after the right to review has been waived or the decision of the Board of Trustees or Appeals Committee on petition for review has been issued shall be final and binding upon all parties, including the Claimant. No lawsuit may be filed without first exhausting the above appeals procedure. In any such lawsuit, the determinations of the Board of Trustees or Appeals Committee are subject to judicial review only for abuse of discretion. No legal action may be commenced or maintained against the Plan more than two (2) years after a claim has been denied.

(2) The denial of an application or claim under subsection (f) after the right to review has been waived or the decision of the Board of Trustees or Appeals Committee on petition for review has been issued shall be final and binding upon all parties, including the Claimant. No lawsuit may be filed without first exhausting the above appeals procedure or a showing that the Plan was not compliant with the above procedures (unless the Plan's actions qualify as (i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the Plan's control; (iv) in context of an ongoing good-faith exchange of information; and (v) not reflective of a pattern or practice of non-compliance). In any such lawsuit, the determinations of the Board of Trustees or Appeals Committee are

subject to judicial review only for abuse of discretion. No legal action may be commenced or maintained against the Plan more than two (2) years after a claim has been denied.

f) ***Claims and Appeals Regarding Permanent Break in Service Pursuant to Article V, Section 5.2***. If a claim pertains to the ability to avoid a permanent break in service pursuant to Article V, Section 5.2, the rules and rights set forth in this subsection shall apply in addition to those set forth above. All claims and appeals under this subsection shall be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the determination. Decisions covered by the authority of the Plan regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) making determinations with respect to disability benefits of the Plan will not be made based upon the likelihood that the individual will support the denial of benefits. Any person whose application for disability benefits is denied shall be notified of such denial within a reasonable period of time, but not later than forty-five (45) days after receipt of such application or claim. An extension of time not exceeding thirty (30) days may be necessary due to matters beyond the control of the Plan, in which case notice will be sent to the Claimant prior to the expiration of the forty-five (45) day period. If a decision cannot be rendered due to matters beyond the control of the Plan prior to the expiration of the thirty (30) day extension, the period for making a determination may be extended for up to an additional thirty (30) days, in which case notice will be sent to the Claimant prior to the expiration of the first thirty (30) day extension. The notice of extension shall include in addition to the information set forth in subsection (b) above, 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. The Claimant shall be afforded at least forty-five (45) days to provide the specified information, if any. The deadline for the Board of Trustees or Appeals Committee to render its decision is tolled from the date on which the notification of the extension is sent to the Claimant until the date a response from the Claimant is received.

Any notice of an adverse benefit determination shall include, in addition to the information set forth in subsection (b) above (1) the internal rule, guideline, protocol, standard, or other similar criterion, applied in making the determination, including the basis for disagreeing with the view of health care professionals, vocational professionals, or with the disability determinations by the Social Security Administration (if no such criterion was used, then an affirmative statement to that effect must be provided); (2) an explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation; and (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.

If the application for benefits or a claim is denied, the Claimant or the Claimant's duly authorized representative may petition the Board of Trustees or Appeals Committee for review of the decision. The petition for review shall be filed by the Claimant or the Claimant's duly authorized representative with the Administrative Office within one hundred and eighty (180) days of receipt of the notification of adverse benefit determination. The Claimant shall have access to relevant documents, records and other information as set forth in subsection (c) above, including 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 Administrative Office shall automatically provide to the Claimant, free of charge, any new evidence or rationales (if any) as soon as possible and sufficiently in advance of the date on which the appeal determination is to be made in order to give the Claimant a reasonable opportunity to address the new evidence or rational prior to the appeal date. The Claimant or the Claimant's duly authorized representative shall have the right to review and respond to new evidence or rationales considered, relied upon or generated by the Plan in connection with the Claimant's claim during the review process. The Board of Trustees 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 of Trustees 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 and shall not be the subordinate of any such person.

A decision by the Board of Trustees or the Appeals Committee shall be made at the next succeeding regular Trustees' meeting or Appeals Committee meeting following the request for review, unless the request for review is received within thirty (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 Claimant shall be notified of the decision of the Board of Trustees or the Appeals Committee in writing no later than five (5) days from the date the determination is made. The notice of denial shall include, in addition to the information set forth in subsection (c) above (1) the internal rule, guideline, protocol, standard, or other similar criterion, applied in making the determination, including the basis for disagreeing with the view of health care professionals, vocational professionals, or with the disability determinations by the Social

Security Administration (if no such criterion was used, then an affirmative statement to that effect must be provided); and (2) an explanation of the scientific or clinical judgment for the determination if the denial was based on medical necessity or other similar exclusion or limit.

All notices and disclosures under this subsection shall be provided in a culturally and linguistically appropriate manner. The Administrative Office will also provide customer service with oral language services in the non-English language and provide written notices in the non- English language upon request.

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