Dear Participant:

This booklet summarizes the benefits offered by the Western States Insulators and Allied Workers' Health Plan.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including factual questions about your eligibility for benefits and the amount of any benefits payable to you. No individual trustee, employer or union representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board.

The Board has authorized the Administrative Office to respond in writing to your written questions. If you have an important question about your benefits, you should write to the Administrative Office for a definitive answer.

As a courtesy to you, the Administrative Office also may respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

Plan rules and benefits may change from time to time. If this occurs, you will receive a written notice explaining the change. Please be sure to read all plan communications and keep information about benefit changes with this booklet.

Board of Trustees

Este folleto es un sumario en inglés del servicio y derechos en la Western States Insulators and Allied Workers' Health Plan. Si usted tiene dificultad a entender algo en este folleto, contacta BeneSys Administrators en 7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566. Horas de oficina son de las 9:00 A.M. hasta 5:00 P.M., Lunes a Viernes. También puede llamar a la oficina del administrador al (925) 398-7046 para asistencia.

Western States Insulators and Allied Workers' Health Plan

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QUESTIONS AND ANSWERS

What is the Western States Insulators and Allied Workers' Health Plan (WSIAWHP)?
The Western States Insulators and Allied Workers' Health Plan (WSIAWHP) provides free medical examinations to eligible employees and retirees. The examination includes specified diagnostic tests which vary depending on the age of the individual. Test results are reviewed by the Plan's medical consultant, who provides the individual with a confidential written evaluation. These tests are meant to supplement your normal medical care and not to replace your need for a personal physician.

The examinations are performed by specified local medical providers who contract with the Plan to provide the service at a fixed fee.

The Plan does not pay for tests obtained at other facilities or tests performed more frequently than the Plan allows. The Plan does not pay for any test performed during the examination which is not specifically included under this program.

Who is eligible to participate in the Plan?
You are eligible for the medical examination program if (1) you worked at least 350 hours in covered employment during the current or two preceding calendar years, or (2) you are retired and receiving pension benefits from the Western States Insulators and Allied Workers' Pension Plan. Covered employment means work under a collective bargaining agreement requiring contributions to this Plan. Children of a participant (including natural, adopted or step-children) born before January 1, 1986, or a current spouse of a participant married before January 1, 1986, are eligible for a medical examination and optional CT Scan, to the same extent as a current participant, through December 31, 2027. To be eligible, the participant must have begun participation in the Plan prior to January 1, 1986. If such benefit coverage for eligible children exceeds 3% of the annual Plan benefits in any applicable calendar year from 2020 to 2027, then their examination will be deferred to the following calendar year.

This Plan complies with the Federal Law regarding special enrollment due to the fact that all employees are automatically enrolled in this Plan as soon as the above eligibility requirements are met. There is no option to decline coverage.

Why should you have a WSIAWHP examination?
Insulators and Allied workers are at an increased risk for developing certain illnesses including asbestosis (scarring of the lungs), lung cancer and mesothelioma. In addition, the WSIAWHP examinations are designed to detect other common medical conditions at an early stage (such as high blood pressure, diabetes, heart disease, and high cholesterol in the blood). Male participants above age fifty are screened for prostate cancer.

What is WorkCare and what are its responsibilities?
WorkCare, Inc. ("WorkCare") is the medical advisor to the program. As the medical advisor, it coordinates the activities of the physicians who perform the actual examinations, reviews the test results of all examinations and writes letters to each participant summarizing his/her examination results. Finally and very importantly, WorkCare has the responsibility for permanently retaining both the medical records and chest x-rays for each participant, but does not have the responsibility for your medical care

What kind of examination is performed?
The type of examination you receive will depend on your age. The basic examination will include a complete history and physical examination, chest x-ray(s), lung function test, blood and urine test, a vision and a hearing test. CT scans can be substituted for the basic examination once every 5 years, or as clinically indicated. In addition, counseling will be given at the time of the exam to include findings from these tests and, when appropriate, issues of tobacco use, smoking, alcohol/drug abuse, obesity, nutrition, misuse or nonuse of seat belts, female breast self-examination, exercise, sexual behavior, and dental care. For Participants age fifty and older a resting electrocardiogram (EKG) and prostatic specific antigen are added.

How often can I receive an examination under this program?
The frequency of examination is:

Ages 20-39:	every 3 years
Ages 40-49:	every 2 years
Age 50 and older:	every year

The Plan will not cover examinations received more frequently than this schedule permits. You may contact the Administrative Office or WorkCare to find out the date of your last examination.

How do I schedule a medical examination and where are the examinations given?
In order to schedule an appointment, you can reach out to your union office, the Administrative Office or WorkCare which will verify your eligibility and assist in scheduling an appointment. Upon receipt of your request to schedule an appointment, you will be notified of your eligibility to receive a medical examination within 15 days of receipt of the claim. If an extension of time to determine eligibility is necessary due to matters beyond the control of the Plan, the Administrative Office will notify you before the expiration of the initial 15 day period of the reasons for requiring an extension and the date by which a decision will be rendered. If the extension is necessary because you need to submit any additional information, the notice will describe the specific information required to determine your claim, and you will be given 45 days from receipt of the notice to provide the specified information. Please see page 16 for additional information regarding the procedures for appealing an adverse claims decision.

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 your claim; (4) a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; (5) a statement of your right to bring an action under ERISA Section 502(a); (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 denial if it was based on medical necessity or other similar exclusions or limits.

Your eligibility for a physical may also be authorized by your union.

Why can't my examination be completed by my personal physician?
WorkCare has identified clinics and physicians which agree to follow the WSIAWHP examination guidelines for a contracted fee. These clinics are informed about this particular program, and are supplied with the Plan's questionnaires. Each physician has agreed to forward all examination results, including original x-rays, to WorkCare for review and permanent storage. Using established physicians ensures that examinations and tests are performed as per protocol. WorkCare will send copies of your examination results to your personal physician, upon your consent.

Are WSIAWHP examinations mandatory?
No, the WSIAWHP examinations are not mandatory, but it is recommended that all participants who are eligible have the examination offered through the program.

How much does it cost and where are my records kept?
As a plan participant, when you go in for a WSIAW HP examination, you do not have to pay. All results of the examination are kept by WorkCare. These records are maintained with strict confidentiality. No one will have access to these results without your permission. After reviewing your records, WorkCare will send you a letter summarizing the results of your examination. Your records and x-rays will be stored indefinitely by WorkCare, and are always available to you or your personal physician. WorkCare can be contacted if you have any questions about the program or the results of your exam.

Where can I get more information about the WSIAWHP?
For more information about the Plan, please contact the Administrative Office:

BeneSys Administrators
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566
Telephone: (925) 398-7046
Toll Free: (800) 320-0184

For claims payment information, please contact the Administrative Office claims department:
P.O Box 1427
San Ramon, CA 94583

What happens if I am no longer eligible for the WSIAWHP?
If you lose coverage under the WSIAWHP because of a reduction or termination of your employment (through layoff, disability, resignation, discharge, retirement, strike or lockout) you may pay for continued coverage for up to 18 months. The premium for continued coverage is 102% of the cost to the Plan for similarly situated individuals who have not incurred a qualifying event. For an additional charge (150% of the Plan's total cost of coverage) and subject to certain notice requirements, the 18 month period may be extended for up to 29 months for any individual with a Social Security disability award effective within a period of up to 60 days following the time of the reduction or termination of employment. **Notice of the disability award must be provided to the Administrative Office within 60 days after it is issued and within the initial 18 month period of COBRA eligibility.**

The maximum continuation is 36 months, even if more than one event occurs giving rise to COBRA continuation rights. The 18 or 29 month period of COBRA eligibility is reduced by months of free or subsidized coverage provided in the event of unemployment or disability.

COBRA continuation coverage will end before the 18 or 29 month period expires if (1) you fail to pay the required contribution on time; (2) you become covered, after the date of election, by another group health plan (except a plan which excludes or limits benefits for a preexisting condition affecting you); (3) you become entitled, after the date of election, to Medicare; or (4) your employer ceases contributions to the Fund and establishes or provides coverage for a class of employees previously covered under this Plan. Continuation coverage will no longer be available under this Plan if this Plan terminates or if your employer ceases to participate or discontinues making contributions.

Your employer is responsible for notifying the Administrative Office of your termination or reduction of hours. Sometimes, filing a bankruptcy proceeding under Title 11 of the United States Code can be a qualifying event. If this bankruptcy proceeding is filed with respect to a former employer and results in loss of coverage for any retired employee of that former employer covered under this Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. In this context, a loss of coverage includes a substantial elimination of coverage within one year before or after the date the bankruptcy proceeding was filed. In this situation the COBRA coverage would continue until the death of the retired employee.

Within 30 days after the Administrative Office is informed in writing of an event entitling you to COBRA coverage, the Office will provide detailed information concerning the coverage available and its cost. You must inform the Administrative Office where you want these notices to be sent. Otherwise, the notice will be sent to your last known address. Notify the Administrative Office whenever you change your address.

You have 60 days from the date you lose coverage or the date the election notice is provided to elect COBRA coverage. Anyone electing COBRA coverage must pay for it retroactive to the date he or she lost coverage under the Plan. Payment for this retroactive coverage is due within 45 days after the date COBRA coverage is elected. No benefit claim will be honored unless the required payment has been received for the period in which the claim was incurred. Monthly payments for COBRA are to be paid to the Administrative Office and are due by the first day of the month. You will be given a grace period of 30 days to make each monthly payment. COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month, but before the end of the grace period, your coverage under this Plan will be suspended as of the first day of the month and then retroactively reinstated when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you are covered by a regional plan and relocate to another area where your employer has an active workforce, you may elect COBRA coverage under the plan provided for the active employees working in that area. Under no circumstances would such a transfer prolong the 18 or 29 month continuation period.

Additional COBRA Election Period and Tax Credit in Case of Eligibility for Benefits under TAA: If you are certified by the US Department of Labor (DOL) as eligible for benefits under the Trade Adjustment Assistance Reauthorization Act of 2015 (TAA), you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your dependents did not elect COBRA during your election period, but are later certified by the DOL for TAA benefits or receive pensions managed by the Pension Benefit Guaranty Corporation (PBGC) you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than 6 months after your coverage ended under the Plan.

Also under TAA, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at (202) 693-3560 or 1-888-365-6822. More information about TAA is available at the website www.dol.gov/agencies/eta/tradeact. The Administration Office may also be able to assist you with your questions.

Notice of Unavailability of COBRA Coverage: In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Administration Office, an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Certificate of Former Coverage: If you lose coverage under the Plan, you will be furnished with a certificate of former plan coverage. You may need the certificate if your new plan excludes coverage for pre-existing conditions. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage stops. You may also request a certificate within 24 months after losing coverage.

What happens if I am no longer eligible because of military service?
If you enter full-time military service, including Reserve and National Guard duty, you may elect to continue health care coverage for yourself under the provisions of USERRA. If that occurs, your eligibility is automatically preserved until your return to covered employment after termination of your military service. The period of coverage for you ends on the earlier of:

- As of December 10, 2004, the end of the 24-month period starting on the day your military leave of absence begins (or 18-month period for a military leave of absence beginning before December 10, 2004); or
- The day after the day on which you're required but fail to apply for or return to work (i.e., for periods of military service over 180 days, you're generally required to return to work within 90 days of your discharge).

Once the Plan Administrator receives notice that you have been called to active duty, the Plan will offer the right to elect USERRA coverage. You may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is **an alternative** to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run

simultaneously, not consecutively. Contact the Administrative Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Be sure to notify the Administrative Office that you will be absent from employment due to military service. You must also notify the Administrative Office that you want to elect continuation coverage under the USERRA provisions.

What happens if I am on approved leave under the FMLA?
Your employer must continue to pay for your health coverage during any approved leave under the Federal Family and Medical Leave Act (FMLA). In general, you may qualify for up to 26 weeks of unpaid FMLA leave per year if (1) your employer has at least 50 employees, (2) you worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months, and (3) you require leave for one of the following reasons: a) birth or placement of a child for adoption or foster care; b) to care for your child, spouse, parent, or next of kin with a serious medical condition; c) your own serious health condition; or d) reasons related to a family member's service in the military. Details concerning FMLA leave are available from your employer.

Requests for FMLA leave must be directed to your employer; the Plan cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self payments. If the dispute is resolved in your favor, the Plan will obtain the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you.

If your employer continues your coverage during an FMLA leave and you fail to return to work, you may be required to repay the employer for all contributions paid to the Plan for your coverage during the leave. You will be eligible for COBRA coverage if you do not return to work.

CONTENTS OF MEDICAL EXAMINATIONS

- Complete medical history (questionnaire provided)
- Complete physical examination
- Chest x-ray (PA view)
- Spirometry
- Blood Chemistry to include HDL cholesterol
- Complete blood count
- Urinalysis
- Visual acuity
- Audiogram
- Counseling at the time of the exam (to include findings from the above and, when appropriate, issues of tobacco use, smoking, alcohol/drug abuse, obesity, nutrition, misuse or nonuse of seat belts, female breast self-examination, exercise, sexual behavior, and dental care).
- CT scans – not more than once every 5 years (can be substituted for the basic examination or as clinically indicated)

Beginning at age 50, add:

- Resting electrocardiogram
- Prostatic Specific Antigen

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Disclosure

The Plan and any Business Associate, as defined below, will disclose your Protected Health Information to the Board of Trustees only to permit the Board of Trustees to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. §§ 160-64). Any disclosure to and use by the Board of Trustees of your Protected Health Information will be subject to and consistent with this section.

Restrictions on Use and Disclosure of Protected Health Information

(1) The Board of Trustees will not disclose your Protected Health Information, except as permitted or required by the notice of Privacy and the Privacy Rule, as amended, or required by law.

(2) The Board of Trustees will ensure that any agent, including any subcontractor, to whom it provides your Protected Health Information agrees to the restrictions and conditions of the Plan Documents, including this section, with respect to your Protected Health Information.

(3) The Board of Trustees will not use or disclose your Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees.

(4) The Board of Trustees will report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

(5) The Board of Trustees will make Protected Health Information available to the Plan Participant who is the subject of the information in accordance with 45 C.F.R. § 164.524.

(6) The Board of Trustees will make your Protected Health Information available for amendment, and will on notice amend your Protected Health Information, in accordance with 45 C.F.R. § 164.526.

(7) The Board of Trustees will track disclosures it may make of your Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(8) The Board of Trustees will make its internal practices, books, and records, relating to its use and disclosure of your Protected Health Information, available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 C.F.R. §§ 160-64.

(9) The Board of Trustees will, if feasible, return or destroy all of your Protected Health Information, in whatever form or medium (including any electronic medium under the Board of Trustees custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who

is the subject of the Protected Health Information, when your Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all your Protected Health Information, the Board of Trustees will limit the use or disclosure of any of your Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Authorization

Authorization is required for the use and disclosure of your Protected Health Information for purposes other than the permitted uses and disclosures specified in the Privacy Rule. When your authorization is needed, you will be asked to fill out an authorization form. The signing of the form is completely voluntary, and once signed, may be revoked in writing at any time.

Definitions

Business Associate means a person or entity who provides certain functions, activities or services to the Western States Insulators and Allied Workers' Health Plan involving the use and/or disclosure of Protected Health Information.

Protected Health Information means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted or maintained in any other form.

SECURITY STANDARDS FOR ELECTRONIC PROTECTED HEALTH INFORMATION

(1) The Board of Trustees will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan.

(2) Adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) will be supported by reasonable and appropriate security measures.

(3) The Board of Trustees will ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information.

(4) The Board of Trustees will make its policies and procedures and documentation relating to these safeguards available to the Department of Health and Human Services for purposes of determining the Plan's compliance with 45 C.F.R. § 164.314(b).

Electronic Protected Health Information shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.

WESTERN STATES INSULATORS AND ALLIED WORKERS' HEALTH PLAN

CLINICS AND CONTACT PERSONS

WorkCare currently has access to over 3,000 clinics. Once the Administrative Office has determined your eligibility for a medical examination, you will be directed to contact WorkCare in order to locate a clinic close to you and set up an appointment:

WorkCare
5700 Stoneridge Mall Road, Suite 245
Pleasanton, CA 94588
Phone: (833) 893-0522, ext. 2201.
Email: lilly.kirchhofer@workcare.com

SUMMARY PLAN DESCRIPTION INFORMATION

The following information is furnished to you in accordance with the requirements of the Employee Retirement Income Security Act, Title 1, Subtitle B, Part 1, Section 101 and 103, and in combination with other information contained in this booklet, constitutes your Summary Plan Description.

Name of Plan: Western States Insulators and Allied Workers' Health Plan

Plan Sponsor: Board of Trustees
Western States Insulators and Allied Workers' Health Plan
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Employer Identification Number: EIN 94-6170245

Plan Identification Number: 501

Type of Plan: The Western States Insulators and Allied Workers' Health Plan is a collectively-bargained, jointly-trusteed health and welfare plan which provides medical examination benefits for eligible employees and retired employees.

Type of Administration: The plan is administered and maintained by the joint Board of Trustees consisting of an equal number of Employer Trustees and Union Trustees. The Board of Trustees has engaged BeneSys Administrators to perform certain routine administrative services as a contract administrator.

Name and Address of Agent for Service of Legal Process:
Lisa Schwantz
Kraw Law Group, APC
605 Ellis Street, Suite 200
Mountain View, CA 94043

Service of legal process may also be made upon any Trustee or the Board of Trustees.

Board of Trustees:

Union Trustees

Michael Patterson
c/o Western States Insulators and
Allied Workers' Health Plan
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Daniel Haguewood
c/o Western States Insulators and
Allied Workers' Health Plan
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Matthew Gonzales
c/o Western States Insulators and
Allied Workers' Health Plan
7180 Koll Center Parkway, Suite 200
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Richard Chamberlain
c/o Western States Insulators and
Allied Workers' Health Plan
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Employer Trustees

Rick Sutphin
c/o Western States Insulators and
Allied Workers' Health Plan
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Craig Skeie
c/o Western States Insulators and
Allied Workers' Health Plan
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Greg Zevely
c/o Western States Insulators and
Allied Workers' Health Plan
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Eric Fults
c/o Western States Insulators and
Allied Workers' Health Plan
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Plan Fiscal Year: The fiscal year ends every year on the last day of December.

Effective date of the Plan: The Plan was originally established on April 1, 1967. The current program of benefits became effective on January 1, 1994.

Funding: The contributions necessary to finance the plan are made by participating employers in accordance with collective bargaining agreements or participant agreements at fixed rates per hour.

Maintenance of the Plan: The plan is maintained pursuant to various collective bargaining agreements between unions and employers or employer associations. A complete list of participating employers may be obtained upon written request to the plan administrator and is also available for examination at the Administrative Office. Copies of collective bargaining agreements are available at the Administrative Office and from your local union.

PLAN TERMINATION

The Board of Trustees has the right to terminate or amend the Plan pursuant to its authority under the Trust Agreement. In the event of termination any assets remaining after payment of eligible benefit claims and expenses shall be used for the exclusive purpose of providing continued benefits for eligible participants and beneficiaries or else shall be transferred to a successor plan or plans.

The Plan complies with all applicable federal laws, as well as state laws not preempted by federal law. To the extent that any Plan provision violates such laws, that Plan provision shall be deemed void, and the remaining Plan provisions shall continue in full force and effect.

APPEALS

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 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 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 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 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 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 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 shall be final and binding upon the participant and all persons claiming through the participant. The Board has 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 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.

EXCEPTED BENEFITS

The benefits offered under this Plan are limited in scope and are considered excepted benefits not subject to the requirements of the Affordable Care Act.

YOUR RIGHTS

As a participant in the Western States Insulators and Allied Workers' Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). ERISA provides that all plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- ▷ Examine without charge, at the Administrative Office and at other specified locations such as union halls, all Plan 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 Employee Benefits Security Administration.

- ▷ Obtain, upon written request to the Plan Administrator, 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 Administrator may make a reasonable charge for the copies.

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

Continue Group Health Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 for late enrollees) after your enrollment date in your coverage.

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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a 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. 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 Administrator. 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 area office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory. The San Francisco Regional Office is located at 90 7th Street, Suite 11-300, San Francisco, CA 94103 phone (415) 625-2481. Or you may contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S., Department of Labor, 200 Constitution Ave., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at Toll Free: (866) 444-EBSA (3272).