from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has required a response whichever comes first.

The individual reviewing your appeal shall give no deference to the initial claim decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgement, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgement and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision. However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claims Procedures for Claims Not Requiring a Determination of Disability: Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, terminations, promotion or other similar matters with respect to any individual (such as claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits: If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Plan Administrator. The applicable section of such form(s) must be completed by 1) you, 2) the Plan Administrator and 3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no later than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits: On any wholly or partially denied claim, you or your authorized representative must appeal once to the Insurance Company for a full or fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1) you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and

2) you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are 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, 3) a statement of your right to bring civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

16) Statement of ERISA Rights – As a participant in the AFL-CIO Mutual Benefit Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

* Examine, without charge, at the Plan Administrator's office, all documents governing the Plan 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 and copies of the latest annual report (Form series 5500) and updated Summary Plan Description. A reasonable charge may be made 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.

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.

If your claim for a welfare benefit is denied 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 a 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. 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 suite in a Federal court. The court will decide who will 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 frivolous.

If you have questions about your Plan, you should contact the Plan Administrator. If you have 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Suite N-1513, Washington, DC 20210. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Summary Annual Report for
AFL-CIO MUTUAL BENEFIT PLAN

This is a summary of the annual report for the AFL-CIO MUTUAL BENEFIT PLAN, (Employer Identification No. 84-2844698, Plan No. 501) for the period January 1, 2022 to December 31, 2022. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

INSURANCE INFORMATION

The plan has a contract with Hartford Life and Accident Company to pay the following types of claims incurred under the terms of the plan.

All life, disability, accidental death and dismemberment claims.

The total premiums paid for the plan year beginning January 1, 2022 and ending December 31, 2022 were $21,232,635.

BASIC FINANCIAL STATEMENT

The value of plan assets, after subtracting liabilities of the plan, was $39,129,190 as of December 31, 2022 compared to $47,115,062 as of January 1, 2022. During the plan year the plan experienced a decrease in its net assets of $7,985,872. This decrease includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year. During the plan year, the plan had total income of -$6,351,593. This income included a loss from investments of -$7,180,037. Plan expenses were $1,634,279. These expenses included $626,149 in administrative expenses and $1,008,130 in benefits paid to participants and beneficiaries.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report;
2. Financial information and information on payments to service providers;
3. Assets held for investment;
4. Loans or other obligations in default or classified as uncollectible;
5. Transactions in excess of 5 percent of the plan assets; and
6. Insurance information including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write the office of:

The Fund c/o Union Privilege
1100 First Street, N.E., Suite 850
Washington, D.C. 20002

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. These portions of the report are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan:

The Fund c/o Union Privilege
1100 First Street, N.E., Suite 850
Washington, D.C. 20002

and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

U.S. Department of Labor
Employee Benefits Security Administration
Public Disclosure Room
200 Constitution Avenue, NW, Suite N-1513
Washington, D.C. 20210

UNIONPLUS

Union printed in the U.S.A. FPO INS-SPD-SAR-2023

Summary Plan Description
AFL-CIO MUTUAL BENEFIT PLAN

(Life, Health, Accident Insurance issued by the Hartford Life and Accident Insurance Company, and Insurance Participants Assistance Program)

1) General – The terms of your insurance coverage are described in your Certificate of Insurance ("Certificate") provided under group insurance policy ("Policy") issued by the Hartford Life and Accident Insurance Company ("Insurance Company" or "The Hartford") and your eligibility for insurance coverage is subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the AFL-CIO Mutual Benefit Plan ("Plan"). If you are insured under the Policy, you are also a participant in the Plan and you may also be eligible for benefits under the Pan's Insurance Participants Assistance Program ("IPAP"), described in more detail below under "Eligibility" and "Benefits".

The following information, together with the information contained in the Certificate, constitutes the Summary Plan Description for the Plan required by the Employee Retirement Income Security Act of 1974 ("ERISA"). The Board of Trustees ("Trustees") of the Plan have full authority, in their discretion, to interpret, construe and apply the terms of the Plan, Trust Agreement ("Trust"), and all policies, procedures, actions and resolutions adopted in administering or operating the Trust or the Plan, and to make factual determinations regarding the Plan's construction, interpretation and application. They have the authority to remedy possible ambiguities, inconsistencies, or omissions and to decide all Plan questions. Trustee decisions are final and binding. The Trustees have delegated authority to and named the Insurance Company as the claims fiduciary for insurance benefits provided under the Policy. This means that the Insurance Company has full discretion and authority to determine eligibility for insurance benefits under the Policy and to construe and interpret all terms and provisions of the Policy. The Trustees are the fiduciary for the other benefits provided under the Plan, including the benefits under the IPAP. A copy of the Plan Document and the Policy is available for your review during normal business working hours in the office of the Plan Administrator.

2) Plan Sponsor – The Board of Trustees serves as the sponsor of the Plan. The Board of Trustees can be contacted at Board of Trustees, AFL-CIO Mutual Benefit Plan c/o Union Privilege 1100 First Street NE, Suite #850, Washington, DC 20002. (202) 293-5330.

3) Identification Number – The AFL-CIO Mutual Benefit Plan has been assigned EIN 84-2844698 by the Internal Revenue Service.

4) Type of Plan – The Plan is an employee welfare benefit plan that makes available certain benefits to qualified individuals.

5) Plan Administrator – The Trustees of the Plan serve as the administrator of the Plan. The Trustees have retained Gallagher Affinity Insurance Services, Inc., to provide administrative support for the insurance programs. Communications and questions regarding your Policy should be directed to Gallagher Affinity Insurance Services, Inc. at 8430 Enterprise Circle, Suite 200, Lakewood Ranch, FL 34202 or (866) 978-2970. The Trustees have also delegated certain administrative responsibilities relating to the Plan to Union Privilege ("UP"). If you would like to contact the Board of Trustees or UP regarding the Plan, please write to UP at 1100 First Street NE, Suite #850, Washington, DC 20002, 202-293-5330.

6) Service of Process – For legal actions involving your Policy, the designated agent for service of process is The Hartford, One Hartford Plaza, Hartford, CT 06155. For legal actions involving the Plan, service of process may be delivered to UP on behalf of the Board of Trustees at 1100 First Street, Suite #850, Washington, DC 20002.

7) **Trustees** – As of September 1, 2023, the Trustees are: Mr. Steve Fantauzzo, Mr. Greg Hamblet, Ms. Lorretta Johnson, Mr. Ken Rigmaiden, Mr. Kevin Stringer, and Mr. Paul Whitehead. The composition of the Board of Trustees may change from time to time, and all correspondence to the Trustees should be directed care of UP at the address listed in paragraph 2.

8) **Eligibility to Participate in the Plan** – Generally, in order to be a Participant of the Plan who is eligible for benefits under the Insurance Participants Assistance Program ("IPAP"), you must: (1) be a member, associate member, or former member (collectively "Members") of a union which is affiliated with the AFL-CIO and that enters into a participation agreement with the Plan, and (2) satisfy the insurability conditions established by The Hartford for that insurance program. For a description of the eligibility requirements of the life, health and accident insurance programs available under the Plan, please refer to your Certificate.

9) **Eligibility for IPAP Benefits** – There are three different grant benefits offered under the IPAP – a Layoff Assistance Grant, a Hospital Grant, and a Disaster Relief Grant. In order to be eligible for one of the grants under the IPAP, you must be a Participant of the Plan who satisfies the general eligibility requirements described in this paragraph and the specific grant eligibility requirements described below. The general eligibility requirements of the IPAP grant program require that you are a Participant who: (i) is covered by a paid policy under the Union Plus Insurance program; (ii) is a policyholder in good standing (i.e., you are in good standing with your union) at the time of the qualifying event; (iii) have been a policyholder through the Union Plus Insurance program for at least twelve (12) consecutive months prior to submitting an application for a grant; and (iv) meet the specific grant eligibility requirements described below. For a description of the benefits available under your Union Plus Hartford Insurance program, please refer to your Certificate. For information on how to apply for insurance benefits contact Gallagher Affinity Insurance Services, Inc.

Layoff Assistance: To be eligible for Layoff Assistance you must, (a) satisfy the general eligibility requirements for benefits under the IPAP described above, (b) participate in an insurance program that does not terminate when you are no longer actively at work, and that requires you to make premium payments to maintain coverage; and (c) complete the required application to demonstrate you are unemployed for at least 30 days due to involuntary layoff, strike, or lockout. The waiver may be used once in any period of 12 consecutive months.

If you are eligible for Layoff Assistance, the Plan will pay your monthly premium to the Insurance Company for up to 3 months, provided that your insurance program does not itself include a premium waiver provision in the event of unemployment.

Hospital Grant: To qualify for a Hospital Grant, you must satisfy the general eligibility requirements for benefits under the IPAP described above, complete the required application and provide documentation to the Plan that you or a member of your household had unreimbursed hospital expenses; (i) that are associated with a hospitalization(s) event that took place during the 24-month period prior to the date that you submit an application for a Hospital Grant , but at least 12 months after you became a Union Plus Insurance policyholder; and (ii) that are lesser of 10% of your annual income or $2,400.

To demonstrate eligibility for a Hospital Grant, you must provide documentation of your annual income by supplying your most recent W-2 or pay stubs covering the applicable period. You must also include the applicable hospital and insurance statements that document (a) the dates and charges for the hospitalization ("Hospital Charges"), (b) the amount of the Hospital Charges covered by insurance, and (c) the amount of Hospital Charges for which the patient was financially responsible.

If you qualify, the Plan will pay a Hospital Grant of $1,200 directly to you. You may only receive three Hospital Grants under the IPAP per your lifetime, but no more than one Hospital Grant per year regardless of the number of policies you have. You may only receive one Hospital Grant under IPAP for a specific hospitalization, If you already received a Hospital Grant for a specific hospitalization event through one insurance policy or through another program offered by the Plan, you cannot receive an IPAP Hospital Grant for the same hospitalization event.

Disaster Relief Grant: To qualify for a Disaster Relief Grant, you must satisfy the general eligibility requirements for benefits under the IPAP described above, complete the required application and provide documentation at the Plan that you (i) are a union member in good standing with an eligible union; (ii) are a Union Plus Insurance policyholder in good standing for at least 12 consecutive months at the time of the "Incident Period" listed in a Federal Emergency Management Agency ("FEMA") Disaster Declaration; (iii) have your primary residence located in a county or parish affected by a natural disaster listed in a FEMA Disaster Declaration offering "Individual Assistance".

In order to demonstrate your eligibility for a Disaster Relief Grant, you must supply required information to Union Plus within 24 months of documented "Incident Period" date(s) listed in the FEMA Disaster Declaration. This information must include (but is not limited to): (i) the address of your primary residence; (ii) the county or parish of your residence; (iii) if applicable, an alternative mailing address; (iv) your phone number; (v) your policy number.

If you are determined to be eligible for a Disaster Relief Grant, you will receive a $500 grant paid directly to you. You may receive three Disaster Relief Grants per your lifetime, but no more than one Disaster Relief Grant per year regardless of the number of policies you may have. You may receive one Disaster Relief Grant for any unique disaster event per year. If you already received a Disaster Relief Grant for a unique event through one insurance policy or through another program offered by the Plan, you cannot receive an IPAP Disaster Relief Grant for the same unique event.

10) **Termination of Coverage & Loss of Eligibility** – For a statement of the circumstances that will result in the termination of your insurance coverage or the denial of insurance benefits, please refer to your Certificate. Your rights upon termination or amendment of the Policy are explained in your Certificate. Failure to provide complete and accurate information on an application for IPAP benefits may result in a loss of eligibility. Also, the Trustees can, at their discretion, terminate or amend the Plan at any time and can stop offering members the ability to enroll in any or all insurance programs, and can also terminate or amend or change the eligibility rules for the IPAP at any time. The Trustees may establish whatever rules are necessary for the administration of the IPAP, and have the right to discontinue benefits under the Program at their discretion. Failure to provide complete and accurate information on any application may result in a loss of eligibility.

11) **Contributions** – All contributions for the insurance benefits of the Plan come from Members who pay the entire cost of their insurance coverage. Your required contribution is determined by the Insurance Company and the Plan based on actuarial calculations. IPAP benefits are provided through assets held in trust by the AFL-CIO Mutual Benefit Fund.

12) **Funding Medium** – Insurance benefits are provided through the Insurance Company. IPAP benefits are provided through assets held in trust by the AFL-CIO Mutual Benefit Fund.

13) **Plan Year** – The Plan's fiscal year ends December 31.

14) **IPAP Benefits Claims and Appeals Procedures** – You can apply for a Hospital Grant or Disaster Relief Grant electronically at unionplus.org/assistance. Documentation to demonstrate eligibility should be mailed separately to UP at 1100 First Street NE, Suite #850, Washington, DC 20002. If you do not have a computer, call 1-800-472-2005 and request an application by mail. To apply for a Layoff Assistance Grant, call 1-800-393-0864.

The Plan will send you a notice of its determination regarding your application for IPAP grant benefits within 90 days after the date all the materials necessary to process the claim are received. If circumstances require an extension of time, the Plan will provide you a notice explaining why an extension of time is needed and the expected decision date. In no event will the extension exceed a period of 90 days. If the Plan denies your claim, you will be sent a written notice explaining why. You have the right to appeal a denial of your claim with the Plan's Board of Trustees within 60 days from receipt of the denial notice. Your appeal must be in writing and must be sent to the Trustees care of the address in Paragraph 2. On appeal, you will have the right (a) to submit information relating to your claim for benefits; and (b) upon request, to have reasonable access to, and free copies of, all information relevant to your claim for benefits. In making a decision on review, the Trustees will review and consider all information without regard to whether such information was submitted or considered in the initial claim determination. The Trustees will normally make a decision within 60 days following receipt of an appeal, but if special circumstances exist, the Trustees may require an extension of time up to 60 days. If an extension is needed, you will be notified of the special circumstances that require an extension and the expected decision date. If the extension is due to your failure to provide information necessary to decide the appeal, the period of time shall be tolled until you provide the additional information. The Trustees will send you a notice of the decision on your appeal (whether approved or denied). If the Board of Trustees denies your appeal, the notice will provide (a) the specific reason or reasons for the denial; (b) references to the Plan provisions on which the denial is based; (c) a statement that you are 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 for benefits; and (d) a statement of your right to bring action under Section 502(a) of ERISA.

The Board of Trustees has the power and sole discretion to interpret, apply, and construe the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of Trustees is final and binding.

If your claim is denied, in whole or in part, you are not required to appeal the decision. However, you must exhaust your administrative remedies by appealing the denial before you have the right to bring an action in state or Federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit.

15) **Insurance Claim Procedures** – The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability: Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits: If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: (1) the specific reason or reasons for the decision; (2) specific references to the Policy provisions on which the decision is based; (3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; (5) a statement that you have the right to bring civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; (6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was replied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; (7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; (8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; (9) a statement that you are 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 for benefits; and (10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits: On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. You may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. You may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45-day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled