Summary Plan Description

AFL-CIO Mutual Benefit Plan
(Life, Health and Accident Insurance issued by the
Hartford Life and Accident Insurance Company, and
Insurance Participants Assistance Program)

General: The benefits described in your Certificate of Insurance ("Certificate") are provided under a group insurance policy ("Policy") issued by the Hartford Life and Accident Insurance Company ("Insurance Company" or "The Hartford") and are 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"), which is a benefit plan that the AFL-CIO established to make certain benefits available to eligible participants. If you are insured under the Policy, you are also a participant in the Plan. You may also be eligible for the Insurance Participants Assistance Program offered through the Plan, 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 Plan has designated and named the Insurance Company as the claims fiduciary for insurance benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits under the Policy and to construe and interpret all terms and provisions of the Policy. A copy of the Plan Document and the Policy is available for your review during normal working hours in the office of the Plan Administrator.

Plan Sponsor: The Plan is maintained by the American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO"), located at 815 16th Street NW, Washington, DC 20006.

Identification Number: The AFL-CIO has been assigned employer identification number (EIN) 530228172 by the Internal Revenue Service. The Plan Number is 501.

Type of Plan: The Plan is an employee welfare benefit plan. At present, the Plan administers life insurance, accidental death and dismemberment insurance, and other supplemental health insurance coverage provided through insurance companies, and provides cardholder assistance benefits, insurance assistance benefits and mortgage assistance benefits.

Plan Administrator: The Trustees of the Fund serve as the Administrator of the Plan. The Trustees have retained Association Group Insurance Administrators (AGIA) to provide administrative support for the insurance programs. Communications and questions regarding your Policy should be directed to AGIA at 1155 Eugenia Place, Carpinteria, CA 93013, or (800) 393- 0864. The Trustees have also delegated certain administrative responsibilities relating to the Plan to Union Privilege ("UP"), and 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.

Service of Process: The person designated as agent for service of legal process, in the event legal action involving your Policy is necessary, is The Hartford, 200 Hopmeadow Street, Simsbury, CT 06089. Service of legal process may also be made upon UP, a plan trustee, or the Board of

Trustees, care of UP at 1100 First Street, NE, Suite 850, Washington, DC 20002.

Trustee: The Board of Trustees of the Fund are Ms. Karen Aronowitz, Mr. Paul Booth, Mr. Greg Hamblet, Mr. Kevin Stringer, Mr. Donald Wharton 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 1100 First Street, NE, Suite 850, Washington, DC 20002.

Eligibility: As noted above, there are a number of different insurance programs administered by the Plan. For any insurance program administered by the Plan, participation will be open to active members, associate members, and retired or alumni members of a union that has entered into an agreement with the Plan to permit its members to participate in the insurance program. However, these members must also separately satisfy insurability conditions established by the insurance company offering that program. For a description of the eligibility requirements of the life and accident insurance programs, please refer to your Certificate.

The Plan also provides the Insurance Participants Assistance Program ("IPAP"), which is available to certain participants in the insurance programs. There are two different benefits offered under the Insurance Assistance Program – Layoff Assistance and a Hospital Grant. You are eligible for the IPAP if you have participated in at least one of the insurance programs administered by the Plan for at least one year, and meet the specific qualifying criteria described below relating to the benefit for which you are applying. Information about applying for Layoff Assistance or Hospital Grant is available at UnionPlus.org/Assistance

To be eligible for Layoff Assistance you must: (a) 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 (b) complete the required application and demonstrate you are unemployed for at least 30 days due to an involuntary layoff, strike, or lockout. The waiver may be used once in any period of 12 consecutive months.

To be eligible for a Hospital Grant you must: (a) participate in a program that requires you to make premium payments to maintain coverage and (b) complete the required application and demonstrate that you, or a member of your household, has unreimbursed hospital expenses that are (1) a result of a hospitalization event or events that took place during the 12-month period before you apply for a Hospital Grant, and (2) equal to 10% or more of your annual household income. You are not eligible to receive more than one Hospital Grant in your lifetime, either through the IPAP or another program offered by the Plan.

Benefits: For a description of the benefits available under your insurance program, please refer to your Certificate. For information on how to apply for insurance benefits contact AGIA.

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. If you are eligible for a Hospital Grant, the Plan will pay you a one-time grant of $1,000.

Termination of Coverage: 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 AFL-CIO can, at its 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.

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. All contributions for the IPAP are made by Union Privilege.

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. Plan Year: The Plan's fiscal year ends on December 31.
Submitting a Claim for Insurance benefits: The Insurance Company has the full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

If you would like to file a claim for benefits, you should obtain a claim form(s) from AGIA. The applicable section of such form(s) must be completed by (1) you, (2) your Employer, and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Administrator at Insurance Services, Attn: Life Claims, P.O. Box 9842, Phoenix, AZ 85068-9843. The Insurance Company will evaluate your claim and determine if benefits are payable.

Submitting a Claim for IPAP Benefits: You can apply for a Hospital 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. Documentation must include a Union Verification Form that you can print from the above website. The Plan will evaluate your claim and determine if benefits are payable. To apply for Layoff Assistance, call 1-800-393-0864.

Processing of Claims and Appealing Denials of Claims: As noted above, the Insurance Company determines the eligibility for insurance benefits, and the Plan determines the eligibility for IPAP benefits. However, the rules relating to the processing of claims and appealing denials of claims are essentially the same for both types of benefits.

A decision will generally be made regarding your completed claim within 45 days if it requires a determination of disability, and within 90 days for all other claims. However, the time for decision may be extended for two 30 day periods if it requires a determination of disability, or for two 90 day periods for other claims. If an extension is needed, you will be notified in writing that an extension is necessary due to identified matters, and given an expected decision date. If an extension is needed because additional information is needed from you, you will be notified and the time for decision may be tolled from the date of notification until the date your response is

received. If your claim is approved, you will be notified.

You will be notified of any adverse benefit determination and be advised of: 1) specific reasons for the decision, 2) specific references to the Policy or Plan provisions on which the decision is based, 3) any additional information necessary for you to perfect the claim and an explanation of why it is necessary, 4) the review procedures and applicable time limits , 5) your right to bring a civil action under section 502(a) of ERISA after you appeal the decision if you receive a written denial on appeal, and 6) for claims involving a determination of disability: (A) if an internal guideline was relied upon in making the denial, either (i) the specific guideline or (ii) a statement that such guideline was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

- If you want any wholly or partially denied claim to be reviewed, you must file an appeal. You must complete this claim appeal process before you file an action in court. Your appeal request must be submitted in writing. If your appeal relates to insurance benefits, it should be sent to the Insurance Company. The Insurance Company address for Disability appeals is Hartford Life Insurance Company, Attn: Association/Affinity Disability Claims, P.O. Box 2999, Hartford, CT 06104-2999. The Address for Life and ADD appeals is Hartford Life Insurance Company, Attn: Association/Affinity Markets Life & AD&D Claims, P.O. Box 2999 Hartford, CT 06104-2999. If your appeal relates to IPAP benefits, it should be sent to the Board of Trustees of the Plan, care of Union Privilege, 1100 First Street, NE, Suite 850, Washington, DC 20002. The appeal must be received no later than 180 days from the date you received your claim denial if it relates to a determination of disability, or 60 days from the date you received your claim denial for any other claim. As part of your appeal you may request, free of charge, copies of all information relevant to your claim, and you may submit additional information relating to your claim. On appeal, all information submitted by you relating to the claim shall be taken into account, without regard to whether such information was submitted or considered in the initial benefit determination.

A final decision on your appeal will be made within 45 days if it relates to a determination of disability, and within 60 days for all other claims. This time may be extended for one additional 45 day period if your claim relates to a determination of disability, or one 60 day period for other claims. If an extension is needed, you will be notified in writing that an extension is necessary due to identified special circumstances and given an expected decision date. If an extension is needed because additional information is needed from you, you will be notified and the time for decision shall be tolled from the date of notification until the date your response is received. If your claim requires a determination of disability, the individual reviewing your appeal shall give no deference to the initial benefit decision and shall not be the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of any experts whose advice was obtained in connection with an initial adverse decision relating to disability, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based on medical judgment, a medical professional will be consulted. That medical professional will have appropriate training and experience in the relevant field of medicine and will not be an individual consulted regarding the initial

benefit decision, nor a subordinate of such individual.

If your appeal is granted, you will be notified. You will also be notified of any final adverse benefit determination and advised of: 1) specific reasons for the decision, 2) specific references to the Plan or Policy provisions on which the decision is based, 3) your right to bring a civil action under section 502(a) of ERISA, 4) your right to request and receive, free of charge, copies of all information relevant to your claim; 5) for claims involving a determination of disability: (A) if an internal guideline was relied upon in making the decision on appeal, either (i) the specific guideline or (ii) a statement that such a guideline was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other information required by applicable law.

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, before filing suit against the Plan, you must exhaust your administrative remedies by appealing the denial. Failure to exhaust these administrative remedies will result in the loss of your right to file suit in state or federal court.

Qualified Medical Child Support Orders: The Fund will provide dependent coverage to a child if it is required to do so under the terms of a Qualified Medical Child Support Order ("QMSCO") under ERISA and if the Fund is permitted to do so under the eligibility requirements for the policy under which the parent is insured. A copy of the Fund's procedures for determining whether an order is a QMCSO can be obtained from the Fund office.

STATEMENT OF ERISA RIGHTS: As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at UP's and AGIA's office, all documents governing the Plan, including insurance contracts, 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.

2. Obtain, upon written request to UP or to AGIA, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. A reasonable charge may be made for the copies.

3. 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 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 medical child support order, you may file suit in a state or federal court. Since the Plan requires you to complete an administrative appeal prior to filing in court, your right to file suit in state or federal court may be affected if you do not complete the required appeal. 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.

If you have any questions about your Plan, you should contact UP. 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, Union Privilege, or AGIA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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 also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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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. 53-0228172, Plan No. 501) for the period January 1, 2015 to December 31, 2015. 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, 2015 and ending December 31, 2015 were $20,792,667.

BASIC FINANCIAL STATEMENT

The value of plan assets, after subtracting liabilities of the plan, was $29,313,028 as of December 31, 2015 compared to $28,203,334 as of January 1, 2015. During the plan year the plan experienced an increase in its net assets of $1,109,694. This increase 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 $2,714,663. This income included realized gains of $157,660 from the sale of assets and earnings from investments of $5,171,030. Plan expenses were $1,604,969. These expenses included $573,397 in administrative expenses and $1,031,572 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

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