

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 terms of your insurance coverage are described in your Certificate of Insurance ("Certificate") provided under a 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 Plan'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 Plan has designated and named the Insurance Company as the claims fiduciary for insurance benefits provided under the Policy. This means that the Insurance Company 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 Board of Trustees of the Plan is 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 working hours in the office of the Plan Administrator.

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.

Identification Number: The AFL-CIO Mutual Benefit Plan has been assigned employer identification number (EIN) 84-2844698 by the Internal Revenue Service.

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

Plan Administrator: The Trustees of the Plan 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, One Hartford Plaza, Hartford, CT 06155. 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.

Trustees: As of June 1, 2021, the individual Trustees on the Board of Trustees are: Mr. Steve Fantauzzo, Mr. Greg Hamblet, Ms. Lorretta Johnson, Mr. Kevin Stringer, Mr. Paul Whitehead, and Mr. James Williams. 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: For any insurance program available under the Plan, participation will be open to members, associate members, and former members (collectively, “Members”) of a union which is affiliated with the AFL-CIO and that enters into an agreement with the Plan that permits participation of its Members in the Plan, so long as the Member satisfies the insurability conditions established by The Hartford for that 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

In order to be eligible for benefits under the Insurance Participants Assistance Program, you must satisfy the general eligibility requirements under the Plan that are described in this Paragraph and the grant eligibility requirements described below. There are three different benefits offered under the IPAP – a Layoff Assistance Grant, a Hospital Grant, and a Disaster Relief Grant. The IPAP provides grants to individuals that (i) are covered by a policy under the Union Plus Insurance program; (ii) are a policyholder in good standing 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; and (iv) meet the specific grant eligibility requirements described below.

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

The benefits available under the Plan’s Insurance Participants Assistance Program are as follows:

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 and you to make premium payments to maintain coverage; and (c) complete the required application 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.

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 event(s) 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 the 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 Form 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 may have. You may only receive one Hospital Grant under IPAP for a specific hospitalization. If you already received a Hospital 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. You may receive one Disaster Relief Grant for any unique disaster event per year, up to a maximum of three Disaster Relief Grants during your lifetime.

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 Board of Trustees 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. Failure to provide complete and accurate information may result in a loss of eligibility.

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.

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.

For IPAP Benefits, 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 Layoff Assistance, call 1-800-393-0864.

Claims Determinations: As noted above, the Insurance Company determines the eligibility for insurance benefits, and the Plan determines the eligibility for IPAP benefits.

A decision will generally be made regarding your completed claim for benefits 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 ("QMCSO") 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 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 UP's and AGIA's offices, 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 UP and/or AGIA, copies of documents governing the operation of the Plan, including insurance contracts 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 you claim frivolous.

If you have questions about your Plan, you should contact UP. 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, Union Privilege, or AGIA, 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, 2021 to December 31, 2021. 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, 2021 and ending December 31, 2021 were \$21,437,570.

BASIC FINANCIAL STATEMENT

The value of plan assets, after subtracting liabilities of the plan, was \$47,115,062 as of December 31, 2021 compared to \$43,280,598 as of January 1, 2021. During the plan year the plan experienced an increase in its net assets of \$3,834,464. 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 \$5,493,931. This income included earnings from investments of \$4,082,585. Plan expenses were \$1,659,467. These expenses included \$657,089 in administrative expenses and \$1,002,378 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

