

Trustees of Teamsters Local 170 Health and Welfare
Fund

Group Life Insurance Benefits
Summary Plan Description

PLEASE READ THIS IMPORTANT NOTICE

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Sponsor provide a Summary Plan Description to Plan Participants.

This document, together with the attached Certificate of Insurance (“Certificate”) issued by Symetra Life Insurance Company (“Symetra”) to the Plan Sponsor, is your Summary Plan Description. It provides you an overview of the Plan and addresses certain information that may not be included in the attached Certificate.

This document is not intended to give a Plan Participant any substantive rights to benefits that are not already provided by the attached Certificate. If the terms of this summary document conflict with the terms of the insurance contract, then the terms of the insurance contract will control, unless superseded by applicable law.

Plan Name

Group Basic Term Life and AD&D Plan for Trustees of Teamsters Local 170 Health and Welfare Fund

Plan Effective Date

June 1, 2022

Policyholder

Trustees of Teamsters Local 170 Health and Welfare Fund
330 Southwest Cutoff, Suite 202
Worcester, Massachusetts 01604

Plan Sponsor, EIN and Number

Trustees of Teamsters Local 170 Health and Welfare Fund
Plan EIN: 04-2219623
Plan Number: 501

Type of Plan Administration

Symetra and Plan Administrator

Plan Administrator and Named Fiduciary

Trustees of Teamsters Local 170 Health and Welfare Fund
330 Southwest Cutoff, Suite 202
Worcester, Massachusetts 01604
Telephone Number: (508) 791-3416

Plan Year

June 1 to May 31

Type of Plan

Fully Insured Group Term Life Plan

Policy Number

01 020443 00

Insurance Company and Contact Information

Symetra Life Insurance Company
P. O. Box 2993
Hartford, CT 06104-2993
Toll Free Number: 1-800-943-2107
Fax Number: 1-860-392-3672

Claims Administrator

Claims administration for life insurance benefits under your Plan is provided by Symetra Life Insurance Company (Symetra) according to the terms of a Group Life Insurance policy. The Plan Administrator has designated Symetra as a Named Fiduciary for benefit claims.

If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.

Funding Medium and Type of Plan Administration

The Plan is fully insured. Benefits are provided under the terms of a Group Life Insurance policy entered into between Trustees of Teamsters Local 170 Health and Welfare Fund and Symetra. Claims for benefits are sent to the Insurance Company. Symetra (not Trustees of Teamsters Local 170 Health and Welfare Fund) is responsible for paying benefits. Trustees of Teamsters Local 170 Health and Welfare Fund is the Plan Administrator. As the Plan Administrator, Trustees of Teamsters Local 170 Health and Welfare Fund is responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs and filing an annual report about the Plan with the U.S. Department of Labor).

Insurance premiums for covered individuals are paid by the Plan Sponsor out of its general assets.

Trustees of Teamsters Local 170 Health and Welfare Fund provides a schedule of the applicable premiums; contact the Human Resources Manager of Trustees of Teamsters Local 170 Health and Welfare Fund if you need another copy.

Plan Interpretation

The Plan Administrator has delegated to Symetra the exclusive right, power, and authority, in its sole and absolute discretion, to interpret the Plan (including the terms of the Plan set forth in the attached Certificate) including (but not limited to) the sole and absolute discretionary authority to take all actions and make all decisions regarding questions of coverage, eligibility, and entitlement to benefits, and benefit amounts, and to process and approve or deny all claims for benefits.

Amendment or Termination

Trustees of Teamsters Local 170 Health and Welfare Fund, as the sponsor of the Plan, has the general right to amend or terminate the Plan or any component benefit program under the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Trustees of Teamsters Local 170 Health and Welfare Fund or any of its delegates who are authorized to amend or terminate the Plan.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Trustees of Teamsters Local 170 Health and Welfare Fund to the effect that you will be employed for any specific period of time.

Information in Attached Certificate of Insurance

Benefits under the Plan are described in the attached Certificate issued by Symetra to the Plan Sponsor. The Certificate contains important information about your coverage, including:

Eligibility and Participation Requirements	Termination Provisions
Enrollment Requirements	Continuation of Coverage
Description of Benefits	Effective Date of Coverage
Definitions	Benefit Reductions, Exclusions and Limitations

In order to understand your benefits under the Plan, you must read the attached Certificate.

Claims Procedures

The Plan's claims procedures are set forth in the attached certificate of insurance, as supplemented by the Symetra Disability Plan Claim Procedures and Symetra Non-Disability Plan Claim Procedures (including Group Life Claims). The Symetra Disability Plan Claim Procedures and Symetra Non-Disability Plan Claim Procedures (including Group Life Claims) are being furnished to you automatically, without charge, as a separate document accompanying this Summary Plan Description.

Statement of ERISA Rights

Your 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). ERISA provides that all plan participants shall be entitled to:

If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the employee welfare benefit plan. The people who operate your plan, called "fiduciaries," have a duty to do so prudently in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, 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 per 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, and if you have exhausted the claims procedures available to you under the Plan, 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 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 office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory), or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., 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.

Your Certificate of Insurance, issued by Symetra Life Insurance Company, is attached.

This Certificate is furnished to you automatically without charge.

If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.

Symetra Disability Plan Claim Procedures

Symetra's Disability Plan Claim Procedures are set forth in the attached certificate of insurance, as supplemented by the procedures set forth below. The Disability Plan Claim Procedures are followed by Symetra Life Insurance Company and First Symetra National Life Insurance Company of New York when processing group short term disability claims, group long term disability claims, and waiver of premium claims under a group life insurance plan.

These Disability Plan Claim Procedures are being furnished to you automatically, without charge, as a separate document accompanying the Summary Plan Description.

What you should do and what you should expect if you have a disability claim?

To claim benefits under the Plan, you* must first apply for the benefit according to Symetra's requirements. Claims can be submitted telephonically, electronically, or via paper application. You may request the claim form from Symetra by calling (877) 377-6773 or from the Plan Administrator by contacting your benefits coordinator. If Symetra's claim form or instructions for completing it are not available, you must submit to Symetra a written statement of the reasons you are entitled to benefits, and you must include your name, address and contact information, and your employer's name, address and contact information. After you have completed the claim form or written statement, you must submit it to Symetra at the following address:

Symetra Claims Department
P.O. Box 1230
Enfield, CT 06083

For purposes of the Plan's claims procedures, you will be considered to have filed your claim under the Plan when your claim form or written statement is received at this address.

The Plan Administrator has appointed Symetra as the claims administrator of the Plan for adjudicating claims for benefits under the Plan and for deciding any appeals of denied claims. Symetra shall have the authority, at its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All benefits decisions made by Symetra shall be final and binding to the full extent permitted by law.

Symetra has 45 days from the date your claim is filed to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Plan, and, if so, the amount of benefits. If more time is needed to review your claim due to circumstances beyond the Plan's control, Symetra must notify you in writing that the review period has been extended. The extension notice will describe the circumstances requiring the extension, the expected date of a decision, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues. This extension may be for up to 30 days beyond the end of the normal 45-day review period. A second 30-day extension may apply if, for reasons beyond the Plan's control, additional time, beyond the first 30-day extension, is needed to review your claim. In this case, Symetra will notify you in writing that the review period has been further extended. Symetra will provide the same information required in the first notice of extension.

If an extension of the review period is made because you must furnish additional information in order for Symetra to decide your claim, Symetra will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to Symetra. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period or the extended 75- or 105-day period. For example, if Symetra advises you on the 20th day after your claim was filed that your claim is incomplete because it lacks a physician's statement regarding your ability to perform various tasks, the number of days from the date of Symetra's request for the physician's statement until you provide the physician's statement will not count as part of the review period. In this example, the day you provided the physician's statement will be treated as the 21st day of the review period.

If needed in order to decide your claim, Symetra may require you to submit to a medical examination, at Symetra's expense. If a medical examination is required, Symetra will notify you of the date and time of the examination and the physician's name and location. This will be treated as a request for additional information, as described above, and the review period will be tolled until Symetra receives the results of the examination. It is important that you keep any appointments made for you by Symetra, since rescheduling examinations will delay the claim process.

If your claim is approved, you will receive the appropriate benefit from Symetra.

If your claim is denied, in whole or in part, you will receive a written notice from Symetra within the review period. The written notice of claim denial must include the following information:

1. The specific reason(s) the claim was denied, including an explanation of the basis for disagreeing with or not following:
 - the views that you presented to Symetra of health care professionals that treated you and vocational professionals that evaluated you;
 - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether Symetra relied upon the advice in denying your claim; and
 - the disability determination made by the Social Security Administration, if you presented such a disability determination to Symetra.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. A description of any additional material or information necessary to perfect your claim, and the reason this material or information is necessary.
4. If your claim was denied based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment 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.
5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying your claim or, alternatively, a statement that in denying your claim, Symetra did not rely upon any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan in existence.
6. 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.
7. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

Appeal procedure for denied disability claims

Whenever a claim is denied in whole or in part, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request to appeal Symetra's decision within 180 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal. This request for review should be directed to Symetra at the address given above for claims submissions. When requesting a review, you should state the reasons you believe the claim denial was improper, and you should submit any additional information, material, or comments which you consider appropriate. You may also review and, upon request, obtain copies of any documents that have a bearing on the claim, including the documents which establish and control the Plan.

Once your request has been received by Symetra, a full and fair review of your claim must take place. This review will give no deference to the original claim decision and will not be made by the person who made the initial claim decision, nor a subordinate of that person. Any medical or vocational experts consulted by Symetra in reviewing your claim will be identified. If your claim was denied in whole or in part based on a medical judgment, Symetra, in deciding your appeal of that determination, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. In no case will such health care professional be an individual who was consulted in connection with the original claim decision. In conducting the review, Symetra will take into account all comments, documents, and other information that you submit, whether or not it was submitted at the time of the initial claim decision.

In conducting the review, Symetra will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Symetra (or at the direction of Symetra) in connection with your claim. Symetra will provide you with this evidence as soon as possible and sufficiently in advance of the date on which the review period expires, as further described below, in order to give you a reasonable opportunity to respond to the new or additional evidence prior to that date.

Before Symetra can deny your appeal based on a new or additional rationale, Symetra must provide you, free of charge, with the new or additional rationale. Symetra will provide you with the new or additional rationale as soon as possible and sufficiently in advance of the date on which the review period expires, as further described below, in order to give you a reasonable opportunity to respond to the new or additional rationale prior to that date.

Symetra has 45 days from the date it receives your appeal to review the original claim decision for your claim and notify you of its decision. Under special circumstances, Symetra may require more time to review your claim. If this should happen, Symetra must notify you, in writing, that its appeal review period has been extended for an additional 45 days, noting the special circumstances requiring the extension and the date by which a decision on the appeal is expected.

If an extension of the appeal review period is made because you must furnish additional information in order for Symetra to decide your appeal, Symetra will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to Symetra. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period.

Once its review is complete, Symetra must notify you, in writing, of the results of the review and must include in its notice the following information:

1. The specific reason(s) the appeal was denied, including an explanation of the basis for disagreeing with or not following:
 - the views that you presented to Symetra of health care professionals that treated you and vocational professionals that evaluated you;
 - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether Symetra relied upon the advice in denying your claim; and
 - the disability determination made by the Social Security Administration, if you presented such a disability determination to Symetra.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. A statement that you are entitled to receive, upon request and free of charge, all documents, records, and copies of all documents, records, and other information relevant to your claim for benefits under the Plan.

4. If your claim was denied based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment 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.
5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying your claim or, alternatively, a statement that in denying your claim, Symetra did not rely upon any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan in existence.
6. The written notice will include a statement regarding your right to file suit in federal or state court to recover benefits under the terms of the Plan, including pursuant to ERISA Section 502(a) as applicable, together with a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for your claim.

* You may have an authorized representative, such as a guardian or an individual having a valid power of attorney, act on your behalf in pursuing a claim for benefits under this Plan. The Plan will take reasonable steps to determine whether an individual claiming to be acting on your behalf is, in fact, validly empowered to do so under the circumstances. Throughout this description of the Plan's claims and appeals procedures, the word "you" is used to refer to you and/or any representative acting on your behalf in claiming benefits under the Plan.

Symetra Non-Disability Plan Claim Procedures (including Group Life Claims)

The Plan's claims procedures are set forth in the attached certificate of insurance, as supplemented by the Symetra Non-Disability Claim Procedures set forth below. The Symetra Non-Disability Plan Claim Procedures are followed by Symetra Life Insurance Company and First Symetra National Life Insurance Company of New York when processing group life claims and any claims other than claims for group short term disability benefits, group long term disability benefits and group life waiver of premium benefits. These Symetra Non-Disability Plan Claim Procedures are being furnished to you automatically, without charge, as a separate document accompanying the Summary Plan Description.

What you should do and what you should expect if you have a non-disability claim, including a Group Life Claim

To claim benefits other than disability benefits under the Plan (including Group Life Claims), you must first complete Symetra's claim form according to Symetra's requirements. You may request the claim form from Symetra by calling (877) 377-6773 or from the Plan Administrator by contacting your benefits coordinator. If Symetra's claim form or instructions for completing it are not available, you must submit to Symetra a written statement of the reasons you are entitled to benefits, and you must include your name, address and contact information, and your employer's name, address and contact information. After you have completed the claim form or written statement, you must submit it to Symetra at the following address:

Symetra Claims Department
P.O. Box 1230
Enfield, CT 06083

For purposes of the Plan's claims procedures, you will be considered to have filed your claim under the Plan when your claim form or written statement is received at this address.

Symetra has 90 days from the date your claim is filed to decide your claim. If more time is needed to review your claim due to circumstances beyond the Plan's control, Symetra must notify you in writing that the review period has been extended. The extension notice will describe the circumstances requiring the extension, the expected date of a decision, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues. This extension may be for up to 90 days beyond the end of the normal 90-day review period.

If your claim is approved, you will receive the appropriate benefit from Symetra.

If your claim is denied, in whole or in part, you must receive a written notice from Symetra within the review period (which may have been extended beyond 90 days, as described above). The written notice of claim denial must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. A description of any additional material or information necessary to perfect your claim, and the reason this material or information is necessary.
4. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

Appeal procedure for denied non-disability claims (including Group Life Claims)

Whenever a claim is denied in whole or in part, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request to appeal Symetra's decision within 60 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal. This request for review should be directed to Symetra at the address given above for claims submissions. When requesting a review, you should state the reasons you believe the claim denial was improper, and you should submit any additional information, material, or comments which you consider appropriate. You may also review and, upon request, obtain copies of any documents that have a bearing on the claim, including the documents which establish and control the Plan.

Once your request has been received by Symetra, a full and fair review of your claim must take place. This review will give no deference to the original claim decision and will not be made by the person who made the initial claim decision, nor a subordinate of that person.

Symetra has 60 days from the date it receives your request to review the original claim decision for your claim and notify you of its decision. Under special circumstances, Symetra may require more time to review your claim. If this should happen, Symetra must notify you, in writing, that its appeal review period has been extended for an additional 60 days, noting the special circumstances requiring the extension and the date by which a decision on the appeal is expected.

Once its review is complete, Symetra must notify you, in writing, of the results of the review and must include in its notice the following information:

1. The specific reason(s) the appeal was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. A statement that you are entitled to receive, upon request and free of charge, all documents, records, and copies of all documents, records, and other information relevant to your claim for benefits under the Plan.
4. The written notice will include a statement regarding your right to file suit in federal or state court to recover benefits due to you under the terms of the Plan, including pursuant to ERISA Section 502(a) as applicable.

Suit may be filed only after the plan's review procedures described above have been exhausted and only if filed within the limitations set forth in the certificate of insurance.



Symetra Life Insurance Company

Group Life Insurance

CERTIFICATE



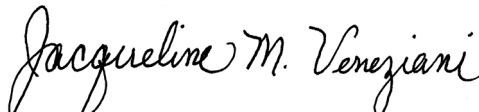
CERTIFICATE OF INSURANCE


Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, Washington 98004-5135
(An insurance company)

Policyholder: Trustees of Teamsters Local 170 Health and Welfare Fund
Policy Number: 01 020443 00
Policy Effective Date: June 1, 2022
Policy Anniversary Date: June first of each year beginning in 2023

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us. The Policy may be inspected at the office of the Policyholder.

Signed for The Company


Jacqueline M. Veneziani, Secretary


Margaret Meister, President

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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Schedule of Insurance
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General Provisions

Symetra® is a registered service mark of Symetra Life Insurance Company.

Schedule of Insurance

The benefits described herein are those in effect as of: June 1, 2022

Cost of Coverage:

Non-Contributory Coverage:

Basic Life Insurance

Basic Accidental Death and Dismemberment Insurance

Eligible Class(es) for Coverage: All Part-time active Plan Participants covered by a Collective Bargaining Agreement and all Part-time active Plan Participants working for Teamsters Union Local 170, Teamsters Local 170, Health & Welfare Fund who have accumulated 400 hours of credited employment within a 6 month continuous period, provided the appropriate contributions have been made to the fund, who are citizens or legal residents of the United States.

Class 2 All Eligible Part-Time Plan Participants

Eligibility Waiting Period for Coverage:

If You are a Plan Participant with a Participating Employer on or after the Policy Effective Date, Your coverage will become effective on the first of the month following the month You complete the participation requirements as defined in the Trustees of Teamsters Local 170 Health and Welfare Fund's plan document.

The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a full-time active Plan Participant with the Participating Employer under the Prior Policy.

The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a part-time Plan Participant with the Participating Employer.

To maintain eligibility after the initial eligibility period, You must have contributed 250 hours per eligibility period as defined below:

Eligibility Period

250 credited hours in:

March, April and May

June, July and August

September, October and November

December, January and February

Insurance Period

Gives full coverage in:

July, August and September

October, November and December

January, February and March

April, May and June

Life Insurance Benefit

Plan Participant

	<u>Benefit Amount</u>	<u>Benefit Maximum Amount</u>	<u>Guaranteed Issue Amount</u>
Basic Class 2	\$25,000	\$25,000	\$25,000

Accidental Death and Dismemberment Insurance Benefit (AD&D)

Plan Participant

	<u>Principal Sum</u>	<u>Principal Maximum Sum</u>
Basic Class 2	\$25,000	\$25,000

Schedule of Insurance

Additional Accidental Death and Dismemberment Insurance Benefits

Seat Belt and Air Bag Coverage

Seat Belt Benefit Amount: 100% of Basic AD&D Principal Sum
Seat Belt Maximum Amount: \$25,000
Seat Belt Minimum Amount: \$1,000

Air Bag Benefit Amount: 5% of Basic AD&D Principal Sum
Air Bag Maximum Amount: \$5,000

Repatriation Benefit

Benefit Amount: 5% of Basic AD&D Principal Sum
Maximum Amount: \$5,000

Child Education Benefit

Benefit Amount: 100% of Basic AD&D Principal Sum
Maximum Amount: \$3,000
Minimum Amount: \$1,250

Reduction in Amount of Life Insurance

We will reduce the amount of Life Insurance for You by any amount:

- 1) of individual Life Insurance issued in accordance with the Conversion Right; or
- 2) of Life Insurance in force, paid or payable under the Prior Policy.

Reduction in Coverage Due to Age

No reduction.

Definitions

Airworthiness Certificate

means:

- 1) the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Administration (FAA); or
- 2) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

Civil or Public Aircraft

means a Civil or Public Aircraft which:

- 1) has a current and valid Airworthiness Certificate;
- 2) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
- 3) is not operated by the militia, or armed forces of any state, national government or international authority.

Common Carrier

means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern.

Common Carrier will not mean any such conveyance which is hired or used for a sport, gamesmanship, contest, sightseeing, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

FAA

means:

- 1) the Federal Aviation Administration of the United States; or
- 2) the equivalent aviation authority for the country of the aircraft's registry, if the governmental authority is recognized by the United States.

Guaranteed Issue Amount

means the amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

Injury

means bodily Injury resulting:

- 1) directly from an accident; and
- 2) independently of all other causes;

which occurs while You are covered under The Policy.

Loss resulting from:

- 1) sickness or disease, except a pus-forming infection which occurs through an accidental wound;
or
- 2) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

Military Transport Aircraft

means a transport aircraft operated by:

- 1) the United States Air Mobility Command (AMC); or
- 2) a national military air transport service of a governmental authority recognized by the United States.

Definitions

Motor Vehicle

means a self-propelled, four or more wheeled:

- 1) private passenger: car, station wagon, van or sport utility vehicle;
- 2) motor home or camper; or
- 3) pick-up truck;

not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

Non-Contributory Coverage

means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

Normal Retirement Age

means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

Year of Birth	Normal Retirement Age	Year of Birth	Normal Retirement Age
1937 or before	65	1955	66 + 2 months
1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months
1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

On

means, when used with reference to any conveyance (land, water or air), in or On, boarding or alighting from the conveyance.

Participating Employer

means an employer who agrees to participate in the Trust, pays the required contribution and is a participant in accordance with the provisions of The Policy.

Physician

means a legally qualified Physician or surgeon other than a Physician or surgeon who is Related to You by blood or marriage.

Plan Participant

means an eligible participant who is employed by a Participating Employer and for whom the employer is required by a Collective Bargaining Agreement or Participation Agreement to make contributions to the Local 170 Health and Welfare Fund. Active Plan Participant shall also mean Plan Participant of the Local 170 Health and Welfare Fund and Plan Participant of the Teamsters Local Union 170 for whom contributions are made to the Fund.

Prior Policy

means, if applicable, the group life insurance policy carried by the Policyholder on the day before the Policy Effective Date.

Definitions

Related

means Your Spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter or grandchild.

Scheduled Aircraft

means a Civil or Public Aircraft operated by a scheduled airline which:

- 1) is licensed by the FAA for the transportation of passengers for hire; and
- 2) publishes its flight schedules and fares for regular passenger service.

Spouse

means Your Spouse who is not legally separated or divorced from You.

The Policy

means The Policy which We issued to the Policyholder under the Policy Number shown on the face page.

Trust

means the Policyholder stated on the face page of The Policy.

We, Us or Our

means the insurance company named on the face page of The Policy.

You or Your

means the person to whom this certificate is issued.

Eligibility and Enrollment

Eligible Persons: *Who is eligible for coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*

You will become eligible for coverage on the latest of:

- 1) the Policy Effective Date;
- 2) the date on which You complete the Eligibility Waiting Period for Coverage; or
- 3) the date You become a member of an Eligible Class.

Enrollment: *How do I enroll for coverage?*

The Policyholder will automatically enroll You. However, You will need to complete a beneficiary designation form.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may only enroll during an Annual Enrollment Period if designated by the Policyholder.

Any enrollment may be subject to the Evidence of Insurability Requirements provision.

Evidence of Insurability Requirements: *When will I first be required to provide Evidence of Insurability?*

We do not require Evidence of Insurability.

Evidence of Insurability: *What is Evidence of Insurability?*

Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

- 1) a completed and signed application approved by Us;
- 2) a medical examination;
- 3) attending Physicians' statement; and
- 4) any additional information We may require.

All Evidence of Insurability will be furnished at Your expense. We will then determine if You are insurable for initial coverage or an increase in coverage under The Policy.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

Period of Coverage

Effective Date: *When does my coverage start?*

Coverage, for which Evidence of Insurability is not required, will start on the date You become eligible.

Any coverage, for which Evidence of Insurability is required, will become effective on the later of:

- 1) the date You become eligible; or
- 2) the date We approve Your Evidence of Insurability.

However, all Effective Dates of coverage are subject to the Deferred Effective Date provision.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*

If, on the date You are to become covered:

- 1) under The Policy;
- 2) for increased benefits; or
- 3) for a new benefit;

You are not a Plan Participant due to a physical or mental condition such coverage will not start until the date You are a Plan Participant.

Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy?*

Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were insured under the Prior Policy, but on the Policy Effective Date You were not a Plan Participant and would otherwise meet the Eligibility requirements of The Policy. However, Your amount of Insurance will be the lesser of the amount of Life Insurance and Accidental Death and Dismemberment Principal Sum:

- 1) You had under the Prior Policy; or
- 2) shown in the Schedule of Insurance;

reduced by any coverage amount:

- 1) that is in force, paid or payable under the Prior Policy; or
- 2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

- 1) the last day of a period of 12 consecutive months after the Policy Effective Date;
- 2) the date Your insurance terminates for any reason shown under the Termination provision;
- 3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
- 4) the date You are a Plan Participant.

However, if the coverage provided through this provision ends because You are a Plan Participant, You may be covered under The Policy.

Effective Date for Changes in Coverage: *When will changes in coverage become effective?*

Any decrease in coverage will take effect on the first of the month following the date of the change.

Any increase in coverage will take effect on the latest of:

- 1) the first of the month following the date of the change;
- 2) the date requirements of the Deferred Effective Date provision are met; or
- 3) the date Evidence of Insurability is approved, if required.

Period of Coverage

Termination: *When will my coverage end?*

Your coverage will end on the earliest of the following:

- 1) the date The Policy terminates;
- 2) the last day of the month following the date You are no longer in a class eligible for coverage, or the class is cancelled;
- 3) the date the required premium is due but not paid;
- 4) the last day of the month following the date You or the Policyholder terminates Your participation;
- 5) the last day of the month following the date You are no longer a Plan Participant;
- 6) the last day of the insurance period that Your combined credited and banked hours do not qualify You for the next insurance period, except that You may continue Your insurance, provided You pay directly to the Fund prior to the insurance period, the balance of the required hours under Your Bargaining Agreement.

Waiver of Premium: *Does coverage continue if I am Disabled?*

Waiver of Premium is a provision which allows You to continue Your Life Insurance coverage without paying premium, while You are Disabled and qualify for Waiver of Premium.

If You qualify for Waiver of Premium, the amount of continued coverage:

- 1) will be the amount in force on the date You became Disabled;
- 2) will be subject to any reductions provided by The Policy; and
- 3) will not increase.

Eligible Coverages: *What coverages are eligible under this provision?*

This provision applies only to Your Basic Life Insurance.

Disabled: *What does Disabled mean?*

Disabled means You are prevented by Injury or sickness from doing any work for which You are, or could become, qualified by:

- 1) education;
- 2) training; or
- 3) experience.

In addition, You will be considered Disabled if You have been diagnosed with a life expectancy of 24 months or less.

Conditions for Qualification: *What conditions must I satisfy before I qualify for this provision?*

To qualify for Waiver of Premium You must:

- 1) be covered under The Policy and be under age 60 when You become Disabled;
- 2) be Disabled and provide Proof of Loss that You have been Disabled for nine consecutive months, starting on the date You first became Disabled; and
- 3) provide such proof within one year of the date You became Disabled.

In any event, You must have been a Plan Participant under The Policy to qualify for Waiver of Premium.

Period of Coverage

When Premiums are Waived: *When will premiums be waived?*

If We approve Waiver of Premium, We will notify You of the date We will begin to waive premium. In any case, We will not waive premiums for the first nine months You are Disabled. We have the right to:

- 1) require Proof of Loss that You are Disabled; and
- 2) have You examined at reasonable intervals during the first two years after receiving initial Proof of Loss, but not more than once a year after that.

If You fail to submit any required Proof of Loss or refuse to be examined as required by Us, then Waiver of Premium ceases.

However, if We deny Waiver of Premium, You may be eligible to convert coverage in accordance with the Conversion Right.

If You cease to be Disabled and return to work for a total of five days or less during the first nine months that You are Disabled, the nine month waiting period will not be interrupted. Except for the five days or less that You worked, You must be Disabled by the same condition for the total nine month period. If You return to work for more than five days, You must satisfy a new waiting period.

Benefit Payable before Approval of Waiver of Premium: *What if I die before I qualify for Waiver of Premium?*

If You die within one year of the date You became Disabled, but before You qualify for Waiver of Premium, We will pay the amount of Life Insurance which is in force for You provided:

- 1) You were continuously Disabled;
- 2) the disability lasted or would have lasted nine months or more; and
- 3) premiums had been paid for coverage.

Waiver Ceases: *When will Waiver of Premium cease?*

We will waive premium payments and continue Your coverage, while You remain Disabled, until the date You attain Normal Retirement Age if Disabled prior to age 60.

What happens when Waiver of Premium ceases?

When the Waiver of Premium ceases:

- 1) if You return to work in an Eligible Class, as an active Plan Participant, then You may again be eligible for coverage as long as premiums are paid when due; or
- 2) if You do not return to work in an Eligible Class, coverage will end and You may be eligible to exercise the Conversion Right if You do so within the time limits described in such provision. The amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right.

Effect of Policy Termination: *What happens to the Waiver of Premium if The Policy terminates?*

If The Policy terminates or a Participating Employer ceases to be a Participating Employer before You qualify for Waiver of Premium:

- 1) You may be eligible to exercise the Conversion Right, provided You do so within the time limits described in such provision; and
- 2) You may still be approved for Waiver of Premium if You qualify.

If The Policy terminates or a Participating Employer ceases to be a Participating Employer after You qualify for Waiver of Premium, Your coverage under the terms of this provision will not be affected.

Benefits

Life Insurance Benefit: *When is the Life Insurance Benefit payable?*

If You die while covered under The Policy, We will pay Your Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

Accelerated Benefit: *What is the benefit?*

In the event that You are diagnosed as Terminally Ill, and You request in writing that a portion of Your amount of Life Insurance be paid as an Accelerated Benefit while You are:

- 1) covered under The Policy for an amount of Life Insurance of at least \$10,000; and
- 2) under age 60;

We will pay the Accelerated Benefit Amount as shown below, provided We receive proof of such Terminal Illness.

The amount of Life Insurance payable upon Your death will be reduced by any Accelerated Benefit Amount paid under this benefit.

You may request a minimum Accelerated Benefit Amount of \$3,000, and a maximum of \$20,000. However, in no event will the Accelerated Benefit Amount exceed 80% of Your amount of Life Insurance. This option may be exercised only once for You.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of \$10,000 and are Terminally Ill, You can request any portion of the amount of Life Insurance Benefits from \$3,000 to \$8,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only \$3,000 now, You cannot request the additional \$5,000 in the future.

A person who submits proof satisfactory to Us of his or her Terminal Illness will also meet the definition of Disabled for Waiver of Premium.

Any benefits received under this benefit may be taxable. You should consult a personal tax advisor for further information.

In the event:

- 1) You are required by law to accelerate benefits to meet the claims of creditors; or
- 2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

Terminal Illness or Terminally Ill means a life expectancy of 24 months or less.

Proof of Terminal Illness and Examinations: *Must proof of Terminal Illness be submitted?*

We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You do not submit proof of Terminal Illness satisfactory to Us, or if You refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

Benefits

No Longer Terminally Ill: *What happens to my coverage if I am no longer Terminally Ill?*

If You are diagnosed by a Physician as no longer Terminally Ill and:

- 1) are in an Eligible Class, coverage will remain in force, provided premium is paid;
- 2) are not in an Eligible Class, but You continue to meet the definition of Disabled, coverage will remain in force, subject to the Waiver of Premium provision; or
- 3) are not in an Eligible Class, but You do not continue to meet the definition of Disabled, coverage will end and You may be eligible to exercise the Conversion Right, if You do so within the time limits described in such provision.

In any event, the amount of coverage will be reduced by the Accelerated Benefit paid.

Conversion Right: *If coverage under The Policy ends, do I have a right to convert?*

If Life Insurance coverage or any portion of it under The Policy ends for any reason, You may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for:

- 1) the Accidental Death and Dismemberment Insurance Benefits; or
- 2) any amount of Life Insurance for which You were not eligible and covered; under The Policy.

If coverage under The Policy ends because:

- 1) The Policy is terminated;
- 2) coverage for an Eligible Class is terminated; or
- 3) Your Participating Employer is no longer a Participating Employer;

then You must have been insured under The Policy for five years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

- 1) \$10,000; or
- 2) the Life Insurance Benefit under The Policy less any amount of Life Insurance for which You may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, the full amount of coverage which ended may be converted.

Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

Conversion: *How do I convert my coverage?*

To convert Your coverage, You must complete a Notice of Conversion Right form. The Insurer must receive this within 31 days after Life Insurance terminates.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:

- 1) complete and return the request form in the proposal; and
- 2) pay the required premium for coverage;

within the time period specified in the proposal.

Any individual policy issued to You under the Conversion Right:

- 1) will be effective as of the 32nd day after the date coverage ends; and
- 2) will be in lieu of coverage for this amount under The Policy.

Benefits

Conversion Policy Provisions: *What are the Conversion Policy Provisions?*

The Conversion Policy will:

- 1) be issued on one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
- 2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:

- 1) the same terms and conditions of coverage as The Policy;
- 2) any benefit other than the Life Insurance Benefit; and
- 3) term insurance.

However, Conversion is not available for any amount of Life Insurance which was, or is being, continued in accordance with the Waiver of Premium provision until such coverage ends.

Death within the Conversion Period: *What if I die before coverage is converted?*

We will pay the amount of Life Insurance You would have had the right to apply for under this provision if:

- 1) coverage under The Policy terminates;
- 2) You die within 31 days of the date coverage terminates; and
- 3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

Effect of Waiver of Premium on Conversion: *What happens to the Conversion Policy if Waiver of Premium is later approved?*

If You apply and are approved for Waiver of Premium after an individual Conversion Policy has been issued, any benefit payable at Your death under The Policy will be paid only if the individual Conversion Policy is surrendered.

Accidental Death and Dismemberment Insurance Benefit: *When is the Accidental Death and Dismemberment Insurance Benefit payable?*

If You sustain an Injury which results in any of the following Losses within 365 days of the date of accident, We will pay Your amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss, after We receive Proof of Loss in accordance with the Proof of Loss provision.

This Benefit will be paid according to the General Provisions of The Policy.

We will not pay more than the Principal Sum, to any one person, for all Losses due to the same accident. Your amount of Principal Sum is shown in the Schedule of Insurance.

For Loss of:

Life.....	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes.....	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears.....	Principal Sum
Either Hand or Foot and Sight of One Eye.....	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	Principal Sum
Movement of Both Lower Limbs (Paraplegia).....	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia)	Three-Quarters of Principal Sum

Benefits

Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia).....	One-Half of Principal Sum
Either Hand or Foot.....	One-Half of Principal Sum
Sight of One Eye.....	One-Half of Principal Sum
Speech or Hearing in Both Ears.....	One-Half of Principal Sum
Movement of One Limb (Uniplegia).....	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand.....	One-Quarter of Principal Sum

Loss means with regard to:

- 1) hands and feet, actual severance through or above wrist or ankle joints;
- 2) sight, speech and hearing, entire and irrecoverable loss thereof;
- 3) thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
- 4) movement, complete and irreversible paralysis of such limbs.

Seat Belt and Air Bag Benefit: *When is the Seat Belt and Air Bag Benefit payable?*

If You sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Seat Belt and Air Bag Benefit if the Injury occurred while You were:

- 1) a passenger riding in; or
- 2) the licensed operator of;

a properly registered Motor Vehicle and were wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

If a Seat Belt Benefit is payable, We will also pay an Air Bag Benefit if You were:

- 1) positioned in a seat equipped with a factory-installed Air Bag; and
- 2) properly strapped in the Seat Belt when the Air Bag inflated.

The Seat Belt Benefit is the lesser of:

- 1) an amount resulting from multiplying Your amount of Principal Sum by the Seat Belt Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

The Air Bag Benefit is the lesser of:

- 1) an amount resulting from multiplying Your amount of Principal Sum by the Air Bag Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

If it cannot be determined that You were wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.

Accident, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which You were wearing a Seat Belt.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Motor Vehicle or its proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

Benefits

Seat Belt means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Repatriation Benefit: *When is the Repatriation Benefit payable?*

If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Repatriation Benefit, if the death occurs outside the territorial limits of the state or country of Your place of permanent residence.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The Repatriation Benefit will pay the least of:

- 1) the actual expenses incurred for:
 - a) preparation of the body for burial or cremation; and
 - b) transportation of the body to the place of burial or cremation;
- 2) the amount resulting from multiplying Your amount of Principal Sum by the Repatriation Benefit Percentage; or
- 3) the Maximum Amount for this Benefit.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Child Education Benefit: *When is the Child Education Benefit payable?*

If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Child Education Benefit to Your Child.

This Benefit will be paid:

- 1) after We receive proof that Your Child qualifies as a Student, as defined in this Benefit; and
- 2) according to the General Provisions of The Policy.

If You die, the Child Education Benefit provides an annual amount equal to the lesser of:

- 1) the amount resulting from multiplying Your amount of Principal Sum by the Child Education Percentage; or
- 2) the Maximum Amount for this Benefit.

The Child Education Benefit is payable to each of Your Children:

- 1) on the date; and
- 2) for whom;

We have received proof satisfactory to Us that he or she is a Student.

If he or she is a minor, We will pay the benefit to the Student's legal guardian.

We will pay the Child Education Benefit to a qualifying Student until the first to occur of:

- 1) Our payment of the fourth Child Education Benefit to or on behalf of that person; or
- 2) the end of the 12th consecutive month during which We have not received proof satisfactory to Us that he or she is a Student.

We will not pay more than one Child Education Benefit to any one Student during any one school year.

Benefits

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision of The Policy if:

- 1) a Principal Sum is payable because of Your death; and
- 2) no person qualifies as a Student.

Student means Your Child who on the date of Your death:

- 1) is a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning on the date of Your death; or
- 2) became a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning within 365 days after Your death and was a student in the 12th grade on the date of Your death.

If the institution establishes full-time status in any other manner, We reserve the right to determine whether the student qualifies as a Student.

Child means Your unmarried child, stepchild, legally adopted child, child in the process of adoption or foster child who is less than age 21 who:

- 1) regularly attends an accredited institution of learning; and
- 2) is primarily dependent on You for financial support and maintenance.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Exclusions: *What is not covered under The Policy?* (Applies to Accidental Death and Dismemberment Insurance only)

The Policy does not cover any Loss caused by:

- 1) for members of the military, war or act of war; or
- 2) Injury sustained while on active duty as a member of the armed forces of any country or international authority.

The Policy does not cover any Loss caused or contributed by:

- 1) intentionally self-inflicted Injury;
- 2) suicide or attempted suicide, whether sane or insane;
- 3) Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
- 4) Injury sustained while riding or driving in a scheduled race or testing any Motor Vehicle on tracks, speedways or proving grounds;
- 5) Injury sustained while committing or attempting to commit a felony;
- 6) the insured's being Intoxicated or under the influence of any narcotic;
- 7) Injury sustained while Intoxicated; or
- 8) Injury sustained while driving while Intoxicated.

Intoxicated means:

- 1) the blood alcohol content;
- 2) the results of other means of testing blood alcohol level; or
- 3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

General Provisions

Notice of Claim: *When should I notify The Company of a claim?*

You, or the person who has the right to claim benefits, must give Us written notice of a claim within 30 days after:

- 1) the date of death; or
- 2) the date of Loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*

Within 15 days of receiving a Notice of Claim, We will send forms to the claimant to provide Proof of Loss. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.

Proof of Loss: *What is Proof of Loss?*

Proof of Loss may include, but is not limited to, the following:

- 1) a completed claim form;
- 2) a certified copy of the death certificate (if applicable);
- 3) Your enrollment form;
- 4) Your beneficiary designation (if applicable);
- 5) if applicable, documentation of:
 - a) the date Your disability began;
 - b) the cause of Your disability; and
 - c) the prognosis of Your disability;
- 6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- 7) the names and addresses of all:
 - a) Physicians or other qualified medical professionals You have consulted;
 - b) hospitals or other medical facilities in which You have been treated; and
 - c) pharmacies which have filled Your prescriptions within the past three years;
- 8) Your signed authorization for Us to obtain and release medical, employment and financial information; or
- 9) any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

Sending Proof of Loss: *When must Proof of Loss be given?*

Written Proof of Loss should be sent to Us:

- 1) with respect to the Life Insurance Benefits, within 365 days; and
- 2) with respect to the Accidental Death and Dismemberment Insurance Benefits, within 90 days; after the Loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

- 1) it was not possible to give proof within the required time; and
- 2) proof is given as soon as possible; but
- 3) not later than one year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*

While a claim is pending We have the right at Our expense:

- 1) to have the person who has a Loss examined by a Physician when and as often as We reasonably require; and
- 2) to have an autopsy performed in case of death where it is not forbidden by law.

General Provisions

Claim Payment: *When are benefit payments issued?*

When We determine that benefits are payable, We will pay the benefits due in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

Claims to be Paid: *To whom will benefits for my claim be paid?*

Life Insurance Benefits and benefits for Loss of life under the Accidental Death and Dismemberment Insurance Benefits will be paid in accordance with the life insurance beneficiary designation.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

- 1) the executors or administrators of Your estate;
- 2) all to Your surviving Spouse;
- 3) if Your Spouse does not survive You, in equal shares to Your surviving children; or
- 4) if no child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to \$500 to any person equitably entitled to payment because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:

- 1) \$200 at Your death; and
- 2) monthly installments of not more than \$200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will make any payments, other than for Loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:

- 1) Your estate;
- 2) a person who is a minor; or
- 3) a person who is not legally competent;

then We may pay up to \$1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Beneficiary Designation: *How do I designate or change my beneficiary?*

You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Policyholder. Only satisfactory forms sent to the Policyholder prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Policyholder.

In no event may a beneficiary be changed by a power of attorney.

Claim Denial: *What notification will my beneficiary or I receive if a claim is denied?*

If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:

- 1) give the specific reason(s) for the denial;
- 2) make specific reference to the provisions upon which the denial is based;
- 3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
- 4) provide an explanation of the review procedure.

General Provisions

Claim Appeal: *What recourse will my beneficiary or I have if a claim is denied?*

On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

- 1) must request a review upon written application within:
 - a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
 - b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
- 2) may request copies of all documents, records and other information relevant to the claim; and
- 3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

Policy Interpretation: *Who interprets policy terms and conditions?*

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Incontestability: *When can The Policy be contested?*

Except for non-payment of premiums, the Life Insurance Benefit of The Policy cannot be contested after two years from the Policy Effective Date. This provision does not apply to the Accidental Death and Dismemberment Insurance Benefits.

In the absence of Fraud, no statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

Assignment: *Are there any rights of assignment?*

Except for the dismemberment benefits under the Accidental Death and Dismemberment Insurance Benefit, You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to, the following:

- 1) the right to make any contributions required to keep the insurance in force;
- 2) the right to convert; and
- 3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

- 1) it is duly executed; and
- 2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

- 1) for the validity or effect of any assignment; or
- 2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

Legal Actions: *When can legal action be taken?*

Legal action cannot be taken against Us:

- 1) sooner than 60 days after the date written Proof of Loss is furnished; or
- 2) three years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

General Provisions

Workers' Compensation: *How does The Policy affect Workers' Compensation coverage?*

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Insurance Fraud: *How does The Company deal with fraud?*

Insurance fraud occurs when You, Your dependent and/or the Policyholder provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, Your dependent and/or the Policyholder commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You, Your dependent and/or the Policyholder perpetrate insurance fraud.

Misstatements: *What happens if facts are misstated?*

If material facts about You were not stated accurately:

- 1) the premium may be adjusted; and
- 2) the true facts will be used to determine if, and for what amount, coverage should have been in force.