

YOUR GROUP INSURANCE PLAN BENEFITS

IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND

CLASS 0001

AD&D, LIFE

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000
www.GuardianAnytime.com

If Your Group Certificate includes any of the following coverages: Guardian Insured: Group Accident, Group Cancer, Group Critical Illness, Group Hospital Indemnity, Group Dental or Group Vision, the following consumer complaint notice is applicable. (Employer Funded Coverages, if any, are excluded from this Rider.)

New Mexico Residents
Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

httsp://www.osi.stat.nm.us/ConsumerAssistance/index.aspx

CCN-2019-NM B999.0042

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

The group life insurance described in this Certificate is attached to the group Policy effective January 1, 2026. This section replaces any Certificate previously issued under this Plan or under any other Plan providing similar or identical benefits issued to the Policyholder by Guardian.

The Policy is governed by the laws of the State of New York. Nothing in the Policy invalidates or impairs any rights or benefits granted to a person insured under the Policy as stated in the certificate of coverage and will not be less than those required by New York law.

GROUP TERM LIFE INSURANCE
On a Non-Contributory Basis
One Year Term, Renewable
Participating

Guardian certifies that the Employee to whom this Certificate is issued is entitled to the benefits described herein. However, the Employee must: (a) satisfy all of this Plan's eligibility and effective date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under this Plan; and (c) all required premium payments must have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND
Group Policy Number: 00092400

READ YOUR CERTIFICATE CAREFULLY. CERTAIN WAR RISKS ARE NOT ASSUMED. IN CASE OF ANY DOUBT, CONTACT YOUR COMPANY FOR FURTHER EXPLANATION.

IMPORTANT NOTICE: The Policy permits the Policyholder to change, reduce, restrict or terminate the Employee rights or benefits under the Policy without an Employee's consent. Such change, reduction, restriction or termination may occur at a time when the Employee's

health status has changed and may affect his or her ability to procure individual coverage.



Matthew Darula, Head of Product, Strategy and Offerings

B034.1473-R

GC-LIF-12-NY

TABLE OF CONTENTS

DEFINITIONS 1

GENERAL PROVISIONS

Incontestability 3
Examination And Autopsy 3
Premiums 3
Grace Period in Payment of Premiums - Termination of Group P 4
Term Of Policy; Renewal Privilege 4
The Contract 5
Clerical Error; Misstatements 6
Statements 6
Dividends 7
The Certificate 7
Claims Of Creditors 8
Records To Be Furnished 8
Conformity With Law 8
Workers' Compensation 8

ELIGIBILITY FOR LIFE COVERAGE - EMPLOYEE COVERAGE

Eligible Employees 9
Conditions Of Eligibility 9
When Employee Coverage Starts 10
Exception to When Employee Coverage Starts 10
When Employee Coverage Ends 11
Your Right To Continue Life Insurance Coverage
During A Family Leave Of Absence 12

EMPLOYEE TERM LIFE INSURANCE

Basic Term Life Insurance 14

CONVERTING THIS EMPLOYEE BASIC TERM LIFE INSURANCE 16

GROUP TERM LIFE SCHEDULE OF BENEFITS

Employee Basic Term Life Insurance Schedule 19
Changes To Insurance 19

STATEMENT OF ERISA RIGHTS 23

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B034.1410

All Options

Active Work or Actively At Work: These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Policyholder, on a Full-Time basis at: (1) one of the Policyholder's usual places of business; (2) some place where the Policyholder's business requires You to travel; or (3) any other place You and the Policyholder have agreed on for Your work.

B034.1412-R

All Options

Activities Of Daily Living: This term means the ability to perform the following, with or without equipment or adaptive devices:

- **Bathing:** wash in a tub or shower; or take a sponge bath; and towel dry.
- **Dressing:** put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
- **Toileting:** get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
- **Transferring:** move in and out of a chair or bed.
- **Continence:** control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
- **Eating:** get food into the body by any means once it has been prepared and made available.

B034.1413

All Options

Eligibility Date: For Employee coverage, this term means the earliest date You are eligible for coverage under this Plan.

B034.1415

All Options

Employee: This term means a person who works for the Policyholder and whose income is reported for tax purposes using a W-2 or 1099 form.

B034.1416-R

All Options

Policyholder: This term means IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND .

B034.1417-R

All Options

Enrollment Period: This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B034.1418

All Options

Plan: This term means the group life insurance coverage described in the Policy and this Certificate.

B034.1424

All Options

We, Us and **Our:** These terms mean The Guardian Life Insurance Company of America.

You or **Your:** These terms mean the insured Employee.

B034.1427

All Options

GENERAL PROVISIONS

B034.1428

All Options

Incontestability

The Plan is incontestable after two years from its date of issue, except for non-payment of premiums.

No statements in any application, made by a person insured under the Policy relating to his or her insurability will be used in contesting the validity of insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during his or her lifetime. The application must be signed by the covered person and a copy furnished to him or her or his or her beneficiary.

B034.1429

All Options

Examination And Autopsy

We have the right to have a doctor of Our choice examine the person for whom a claim is being made under the Plan as often as We feel is reasonably necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

B034.1430

All Options

Premiums

Premiums due under the Policy must be paid by the Policyholder at an office of the Company or to a representative that We have authorized. The premiums must be paid as specified, unless by agreement between the Policyholder and the Company, the interval of payment is changed. In that event, adjustment will be made to provide for payment annually, semi-annually, or quarterly.

The premium due under the Policy on each due date will be the sum of the premium charges for the insurance coverages provided under the Policy.

We may change such rates: (1) on the first anniversary and on the first day of any policy month thereafter; (2) on any date the extent or terms of coverage for You are changed by amendment of this Policy to add or delete an affiliate or associated company, to modify Employee or Dependent eligibility or to increase or reduce benefits; or (3) on any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements. We shall not have the right to change the rates under (1) above more often than once during any twelve consecutive months.

We must give the Policyholder 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

B034.1431-R

All Options

Grace Period in Payment of Premiums - Termination of Group Policy

A grace period of 31 days, without interest charge, will be allowed the Policyholder for each premium payment except the first. If any premium is not paid before the end of the grace period, the Policy automatically ends at the end of the grace period. However, if the Policyholder gives Us advance written notice of an earlier termination date during the grace period, the Policy will end as of such earlier date.

If the Policy ends during or at the end of the grace period, the Policyholder will still owe Us premium for all the time the Policy was in force during the grace period.

The Policy ends immediately on any date when an insurance coverage under the Policy ends and, as a result, no benefits remain in effect under the Policy.

B034.1432-R

All Options

Term Of Policy; Renewal Privilege

The Policy is issued for a term of one year from the Policy Effective Date shown on the first page of this certificate. All Policy years and Policy months will be calculated from the Policy Effective Date. All periods of insurance hereunder will begin and end at 12:01 A.M. Standard Time at the Policyholder place of business.

The Policyholder may renew the Policy for a further term of one year, on the first and each subsequent Policy anniversary. All renewals are subject to the payment of premiums then due.

We have the right to decline to renew this Policy, or any coverage under it, on any Policy Anniversary, if, on that date: (1) less than two Employees are insured; or (2) with respect to non-contributory insurance, all of those Employees eligible are not insured; or (3) with respect to contributory insurance, less than 75% of those Employees eligible for any other contributory insurance are insured.

The Policyholder may cancel the Policy at any time by giving Us 31 days advance written notice. This notice must be sent to Our Home Office and the Policyholder will owe Us all unpaid premiums for the period the Policy is in force. We may cancel this Policy by giving the policyholder 31 days advance written notice for an action or inaction that affects Our ability to administer the Plan, such as non-payment of premiums or failure to furnish, requested necessary information.

B034.1434-R

All Options

The Contract

The entire contract between the Company and the Policyholder consists of: (a) the Policy; (b) the Policyholder's application, a copy of which is attached to or endorsed on the Policy; and (c) the certificate of coverage(s). The provisions of the Certificate are incorporated into and made part of the entire contract.

Nothing in the Policy invalidates or impairs any rights or benefits as stated in the certificate of coverage or granted by New York law.

The rights of the Policyholder, Employee, or beneficiary will not be affected by any provision other than one contained in the Policy or the riders or endorsements thereon or in the amendments thereto signed by the Policyholder and the Company, or in the copy of the Policyholder's application attached to the Policy or individual statements, if any, submitted in connection therewith.

We can amend the Policy at any time, with the consent of the Policyholder insured Employee or any other person having a beneficial interest therein, as follows:

We can amend the Policy:

- upon written request made by the Policyholder and agreed to by Us; or
- on any date our obligation under the Policy is changed because of statutory or other regulatory requirements

If We amend the Policy, except upon request made by the Policyholder, we must give the Policyholder written notice of such amendment.

Except for amendments by which we exercise a specifically reserved right under the Policy or which concern only administrative changes, any amendments to the Policy which diminish rights, benefits and/or coverage will be provided to the Policyholder for signed acceptance.

GC-LIF-12-NY

Any amendments to the Policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of the Company, has the authority to act for Us to: (a) determine whether any contract, plan or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or plan, or any requirements of the Company; (c) bind Us by statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

B034.1435-R

All Options

Clerical Error; Misstatements

Neither clerical error by the Policyholder or the Company in keeping any records pertaining to insurance under the Policy, nor delays in making entries thereon, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

If the age of an Employee, or any other relevant facts, is found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by Us, or the amount of insurance, the true facts will be used in determining whether insurance is in force under the terms of the Policy, and in what amount. But adjustment based on those other relevant facts is limited to the first two years that coverage is in force under the Policy as shown under "Incontestability".

B034.1436-R

All Options

Statements

All statements made by You, for the issuance, reinstatement or renewal of the Policy will be deemed representations and not warranties.

No such statement may be used to contest the validity of insurance under the Policy, or be used in defense of a claim hereunder unless the statement: (a) is contained in a written instrument signed by the covered person; and (b) a copy has been furnished to such person or to his or her beneficiary.

B034.1437

All Options

Dividends

The portion, if any, of the divisible surplus of the Company allocable to the Policy at each Policy anniversary will be determined annually by the Board of Directors of the Company and it will be credited to the Policy as a dividend on such anniversary, provided the Policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under the Policy will be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

To determine dividends, if any, under the Policy, the financial experience under the Policy will be combined with the financial experience under any other group insurance policies issued to the policyholder that insure a group of its employees. This does not include any Policy that provides retirement benefits.

In the event that you are contributing toward the cost of the coverage under any group Policy issued to the Policyholder and the aggregate dividends under the Policy and any other group Policy or policies issued to the Policyholder are in excess of the Policyholder's share of the aggregate cost, such excess will be applied by the Policyholder for the sole benefit of the employees.

Payment of any dividend to the Policyholder will completely discharge Our liability with respect to the dividend so paid.

B034.1438-R

All Options

The Certificate

We will issue to the Policyholder, for delivery to each Employee insured under the Policy, a certificate of coverage. The certificate will state the essential features of the insurance to which the Employee is entitled and to whom the benefits are payable.

In the event the Policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the Policyholder for delivery to affected Employees.

B034.1439-R

All Options

Claims Of Creditors

Except when prohibited by the laws of the jurisdiction in which the Policy was issued, the insurance and other benefits under the Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

B034.1440

All Options

Records To Be Furnished

The Policyholder must keep a record of the insured Employee's containing, for each Employee, the essential particulars of the insurance which apply to him or her. The Policyholder must periodically forward to Us, on Our forms, such information concerning the Employee's in the classes eligible for insurance under the Policy as may reasonably be considered to have a bearing on the administration of the insurance under the Policy and on the determination of the premium rates. For benefits which are based on an Employee's salary, changes in an Employee's salary must promptly be reported to Us. The Policyholder's payroll and other such records which have a bearing on the insurance must be furnished to Us at Our request at any reasonable time.

B034.1441-R

All Options

Conformity With Law

If the provisions of the Policy do not conform to the requirements of any state or federal law or regulation that applies, any such provision will be changed to conform by amendment and the procedures set forth in "The Contract" and "The Certificate." An amendment, signed by the policyholder and Us that effects Your rights or the rights of a covered person or beneficiary will be delivered to You, a covered person, or beneficiary.

B034.1442

All Options

Workers' Compensation

This Policy is not in place of and does not affect any requirement for coverage by Workers' Compensation.

B034.1443

All Options

ELIGIBILITY FOR LIFE COVERAGE - EMPLOYEE COVERAGE

B034.1444

All Options

Eligible Employees

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Plan, You are eligible if You are in an eligible class of Employees working 200 hours in the last plan year and are an active Full-Time Employee.

If You are a partner or proprietor, We will treat You like an Employee if You meet this Plan's conditions of eligibility.

B034.2592-R

All Options

Conditions Of Eligibility

You are eligible for life coverage if You are:

- legally working in the United States or working outside of the United States for a United States based Policyholder in a country or region approved by Us; and
- Regularly working at least the number of hours in the normal work week set by the Policyholder at: (1) the Policyholder's place of business; (2) some place where the Policyholder's business requires You to travel; or (3) any other place You and the Policyholder have agreed upon for the performance of occupational duties.

You are **not** eligible for life coverage if You are:

- A temporary or seasonal Employee.

B034.1448-R

All Options

Multiple Employment: If You work for both the Policyholder and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple life insurance coverage under this Plan. But, if this Plan uses the amount of Your earnings to set the rates, determine class, figure insurance amounts, or for any other reason, such earnings will be figured as the sum of Your earnings from all covered Policyholders.

B034.1454-R

When Employee Coverage Starts

For coverage to start, an employee must meet the eligibility requirements established by the Iron Workers District Council of Western New York and Vicinity Welfare Fund.

Your coverage is scheduled to start on Your Eligibility Date.

Exception to When Employee Coverage Starts

If You are not capable of performing the major duties of Your occupation for the Policyholder on a Full-Time basis on the date Your coverage is scheduled to start, You will be insured for Life insurance if: (1) You were insured under the prior insurer's group life policy at the time of the transfer; (2) You were a member of an eligible class under the prior carrier's group life policy and are eligible under this Plan; (3) premiums for You were paid up to date; (4) premiums are not currently being waived under the Waiver of Premium provision, or You were not eligible, under the terms of the prior insurer's group life policy, to have premiums waived under the Waiver of Premium provision; and (5) You are not receiving or eligible to receive benefits under the prior insurer's group life policy.

Any Life benefit payable will be the lesser of: (1) the Life benefit payable under this Plan; or (2) the Life benefit payable under the prior insurer's group Life policy had it remained in force; reduced by any amount paid by the prior insurer's group life policy.

If You are covered under the Exception to When Employee Coverage Starts, You will not be eligible for the Waiver of Premium Benefit provision under this Plan until such a time You are Actively At Work as defined by this Plan.

You will remain insured under this provision until the first to occur of: (1) the date You are fully capable of performing the major duties of Your occupation for the Policyholder on a Full-Time basis; (2) the date insurance terminates for one of the reasons stated in When Employee Coverage Ends; (3) the last day of a period of 12 consecutive months which begins on this Plan's effective date; (4) the date You become eligible for the Waiver of Premium Benefit provision under the prior insurer's group life policy; or (5) the last day You would have been covered under the prior insurer's group life policy, had the prior plan not terminated.

Sometimes a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls : (1) on a holiday; (2) on a vacation day; (3) on a non-scheduled work day; (4) during a layoff of less than 180 days in duration; (5) during an approved leave of absence not due to sickness or injury, of 90 days or less; or (6) on a day during a period of absence that is less than 7 days in duration; and if: (a) You were fully capable of performing the major duties of Your regular occupation for Your Policyholder on a full-time basis at 12:01 AM Standard Time for Your place of residence on the scheduled effective date; and (b) You were performing the major duties of Your regular occupation and working Your regular number of hours on Your last regularly scheduled work day; Your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost, will not start if You are on an approved leave and such coverage or part of coverage was not previously in force for You under a prior plan which this Plan replaced.

Any part of Your coverage which is subject to Proof Of Insurability that You are insurable will not start unless You send such proof to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on the effective date You're approved.

B034.3337-R

All Options

When Employee Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your active Full-Time service ends for any reason. Such reasons include: (1) disability; (2) death; (3) retirement; (4) layoff; (5) leave of absence; (6) the end of employment; and (7) expiration of the employment contract.
- The date You stop being an eligible Employee under this Plan.
- The date You are no longer working in the United States, or working outside the United States for a United States based Policyholder in a country or region approved by Us.
- The date the group Plan ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. And, You may have the right to replace certain group benefits with converted policies. Read this Plan carefully for details.

B034.1467-R

Your Right To Continue Life Insurance Coverage During A Family Leave Of Absence

Important Notice: This section may not apply to Your Policyholder's Plan if Your Policyholder is not subject to the Family and Medical Leave Act. You must contact Your Policyholder to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

Which Coverages Can Be Continued: Group Life insurance may be continued, under a uniform, non-discriminatory policy applicable to all Employees. You must contact Your Policyholder to find out if You may continue this coverage.

If Your Coverage Would End: Your group life insurance coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted to: (1) allow You to care for a **Seriously Injured or Ill** spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; (4) allow You to care for Your spouse, child, parent or **Next Of Kin** who is a **Covered Servicemember** with a **Serious Illness or Injury** incurred in the line of duty on **Active Duty;** or (5) due to a **Qualifying Exigency** while your spouse or child is on **Active Duty** in the Armed Forces or has been notified of an impending call or order to **Active Duty** in the Armed Forces in support of a **Contingency Operation.** To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

When Continuation Ends: Continued coverage will end on the earliest of the following:

- The date You return to Active Work.
- In the case of a leave granted to You to care for a **Covered Servicemember.** The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to You under this section for all reasons. If You take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which Your Policyholder's Plan is terminated or You are no longer eligible for coverage under this Plan.
- The end of the period for which premium has been paid.

B034.1468-R

All Options

Definitions: As used in this section, the terms listed below have the following meanings:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a **Serious Injury or Illness** is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in **Outpatient Status;** or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a **Covered Servicemember,** that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Qualifying Exigency:** This term means: (1) short- notice deployment; (2) military events and related activities; (3) childcare and school activities; (4) financial and legal arrangements; (5) counseling; (6) rest and recuperation; (7) post-deployment activities; and (8) additional activities not encompassed in the other categories, but agreed to by the Policyholder and Employees.
- **Serious Injury or Illness:** This term means, in the case of a **Covered Servicemember,** an injury or illness incurred by him or her in line of duty on active duty in the armed forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

B034.1469-R

All Options

EMPLOYEE TERM LIFE INSURANCE

B034.1525

All Options

Basic Term Life Insurance

If You die while covered for this insurance, We will pay Your beneficiary the amount shown in the Schedule Of Benefits.

Payment Of Benefits: We will pay this insurance as soon as We receive written proof of death and proof of claim which is acceptable to Us. This should be sent to Us as soon as possible.

When the benefit is payable, We will pay it in a single lump sum check, unless another method of payment is requested by the certificate holder or beneficiary and agreed to by Us.

B034.1526

All Options

Seatbelt And Airbag Benefits: If You die as a direct result of an automobile accident while properly wearing a seatbelt, We will increase Your term life benefit amount by $10,000.00. not to exceed 10% of the death benefit without an additional premium cost. And, if You die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase Your term life benefit amount by an additional $5,000.00, for a total increase of $15,000.00 not to exceed 10% of the death benefit without an additional premium cost.

A police officer investigating the accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

B034.1527

All Options

The Beneficiary: You decide who receives this benefit when You die. You should have named Your beneficiary during Your initial enrollment. You can change Your beneficiary at any time by giving written notice; unless You have assigned this insurance. The change will take effect on the date the notice of change is signed, subject to action taken by Us prior to receipt of this notice.

If You named more than one person, but did not specify what their shares should be, they will share equally. If someone You named dies before You, that person's share will be divided equally by the beneficiaries still alive; unless You have specified otherwise.

If there is no beneficiary when You die, We will pay this benefit to one of the following: (1) Your estate; (2) Your spouse; (3) Your parents; (4) Your children; or (5) Your brothers and sisters.

B034.1528

All Options

Assigning This Life Insurance: You may, subject to the following conditions, assign all or any part of Your rights or interest in such insurance which You now have or may later acquire. If You assign this insurance, You transfer all or part of Your rights in this insurance to Your assignee.

We will recognize an assignee as the owner of the rights assigned only if: (1) the assignment is in writing and signed by You; and (2) a signed or certified copy of the written assignment has been received by Us.

The assignment will be effective on the date the assignment is signed; but, We will not be responsible for legal, tax, or other effects of any assignment, or for any benefits We pay under the Policy before We receive any assignment.

The Company assumes no responsibility as to the validity or effect of any such assignment. You should speak to Your attorney before making any assignment. If You decide to assign Your insurance, ask Your policyholder for details, or write to the Company.

B034.1530-R

All Options

Payment Of Funeral Expenses: We have the option of paying up to $500.00 of this benefit to any person who incurred expenses for Your funeral.

B034.1532

CONVERTING THIS EMPLOYEE BASIC TERM LIFE INSURANCE

If Employment Or Eligibility Ends: Your group life insurance ends if: (1) Your active Full-Time employment ends; or (2) You stop being a member of an eligible class. If either happens, You can convert Your Employee group basic life insurance to an individual life insurance policy customarily issued by Us for the risk classification to which You belong under the group policy.

You can convert the full amount of basic life insurance for which You were insured under this Plan on the date Your insurance ended due to termination or being amended, less any group life benefits for which You become eligible in the 45 days after Your insurance under this Plan ends.

Your conversion choices are based on Your disability status as shown below.

If You are not Totally Disabled, as defined for Waiver of Premium benefits, You can convert to any life insurance policy customarily issued by Us for the risk classification to which You belong under the group policy that is not term insurance.

You can also convert if You: (1) are Totally Disabled, as defined by the terms of the Waiver of Premium benefits; (2) are eligible for Waiver of Premium benefits based upon Your age; but (3) have not yet been approved for the Waiver of Premium benefit. In that case, You can convert to: (a) a permanent life insurance policy; or (b) a term life insurance policy; or (c) any individual policy customarily issued by Us for the risk classification to which You belong under the group policy .

If You have converted and are later approved for this Plan's Waiver of Premium benefit, You will decide and choose either to keep the converted policy inforce or to cancel the converted policy, and become covered under the Waiver of Premium benefit.

If You choose the Waiver of Premium benefit, then the converted policy, if any, is cancelled as of Our approval date.

If You: (a) are Totally Disabled, as defined in the Waiver of Premium benefit; but (b) are not eligible for the Waiver of Premium benefit based on Your age, You can convert to a permanent life insurance policy. You can convert the amount for which You were covered under this Plan, less any group life benefits You become eligible for in the 45 days after this insurance ends.

If This Plan Ends Or Group Life Insurance Is Dropped: Your group life insurance also ends: (1) if this Plan ends; or (2) life insurance is dropped from this Plan for all Employees or for Your class. If either happens, You may be eligible to convert Your Employee group basic life insurance to an individual life insurance policy customarily issued by Us for the risk classification to which You belong under the group policy.

Your conversion choices are based on Your disability status as shown below. You can convert to any permanent life insurance policy; or (b) any term life insurance policy for a period of one year , if You are not Totally Disabled, as defined by the terms of the Waiver of Premium benefits. But, the amount that You can convert is limited to the amount of Your basic life insurance under this Plan, less any group life benefits for which You become eligible in the 31 days after Your insurance under this Plan ends.

You can also convert if You: (1) are Totally Disabled, as defined for Waiver of Premium benefits; and (2) are eligible by the terms of the Waiver of Premium benefits; but (3) have not yet been approved for the Waiver of Premium benefit. In that case, You can convert to: (a) any permanent life insurance policy; or (b) any term life insurance policy; or (c) an interim term life insurance policy. You can convert the full amount of basic life insurance for which You were insured under this Plan on the date Your insurance ended, less any group life benefits for which You become eligible in the 45 days after Your insurance under this Plan ends.

B034.1539

If You have converted and are later approved for this Plan's Waiver of Premium benefit, You will decide and choose either to keep the converted policy in force or to cancel the converted policy, and become covered under the Waiver of Premium benefit.

If You: (a) are Totally Disabled, as defined in the section labeled "Waiver of Premium Benefit"; but (b) are not eligible for the Waiver of Premium benefit based on Your age, You can convert to any permanent life insurance policy customarily issued by Us for the risk classification to which You belong under the group policy. You can convert the amount for which You were covered under this Plan, less any group life benefits You become eligible for in the 45 days after this insurance ends.

The Converted Policy: The converted policy is any individual life insurance policy customarily issued by Us for the risk classification to which You belong under the group policy. It will start on the date coverage ended under the group policy. It does not provide any: (1) additional benefits for accidental death; or (2) waiver of premium benefits. The benefits provided by the converted policy may not be the same as the benefits provided by this Plan. The premium for the converted policy will be based on the form and amount of the policy at Your attained age and the class of risk to which You belong under this policy.

Interim Insurance: You may choose to convert to an individual interim term life insurance policy, if Your group insurance ends. (The interim term policy requires lower premiums than a permanent insurance policy.)

The interim term policy is available at Your option for one year from either: (i) the date You become Totally Disabled, as defined in this Plan's Waiver of Premium benefit or (ii) the date Your group life insurance ends.

If You are approved for this Plan's basic Waiver of Premium benefit during this year, the interim term policy is cancelled as of the date that You are approved for the Waiver of Premium benefit.

If You elect the interim term life insurance policy because the group plan ends or group life insurance is dropped, the interim term policy will end at the end of the year. In that case, You must convert to an individual permanent or term life insurance policy, or insurance will end. Premiums for the permanent policy will be based on Your age as of the date You convert from the interim term policy.

Conversion Notice: You will be provided with written notice, at Your last known address, of Your right to convert within 15 days before or after Your group life insurance ends. If such notice is provided more than 15 days but less than 90 days after Your group life insurance ends the time allowed for applying for conversion will be extended to 45 days after notice is provided. If notice is not given within 90 days after Your group life insurance ends the time allowed for applying for conversion will end at the end of such 90 days.

How And When To Convert: To get a converted policy, You must apply to Us in writing and pay the required premium. Except as provided for under Conversion Notice, You have 31 days after Your Employee group basic life insurance ends to do this. We will not ask for proof that You are insurable.

Death During The Conversion Period: If You die in the 31 days or the extended notice period allowed for conversion. We will pay Your beneficiary the amount that You could have converted. We will pay such amount whether or not You applied for conversion. If You have successfully converted to an individual conversion policy, Your death benefit will be paid under the converted policy. If You have not successfully converted to an individual conversion policy, Your death benefit will be paid under the group policy.

B034.1540

All Options

GROUP TERM LIFE SCHEDULE OF BENEFITS

Effective January 1, 2026 this Schedule of Benefits is attached to the Certificate. This Schedule of Benefits replaces any previously issued Schedule of Benefits

B034.1582

All Options

Employee Basic Term Life Insurance Schedule

Basic Term Life Insurance Amount

Insurance Amount $25,000.00

B034.1584

All Options

Reduction of Basic Life Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Plan starts, Your insurance amount is reduced on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such amount be reduced to $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Plan starts, Your insurance amount is reduced on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such amount be reduced to $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

B034.1619

All Options

Changes To Insurance

Changes In Insurance Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage will not become effective prior to the date You return to Active Work on a Full-Time basis.

Changes In Insurance Classification

If Your classification changes, insurance will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must: (1) make the required contribution for the new amount; and (2) furnish Proof Of Insurability to Us, which We approve in writing.

If the insurance amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B034.2026

The following notice applies if Your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group term life insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of 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.

Enforcement of 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 (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, 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 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 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 that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the 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.

Life Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination of Life Insurance Claims

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination l is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

Adverse Benefit Determination of Life Insurance Claims

If a claim is denied, Guardian will provide notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures; and
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination.

B997.0364

All Options

Appeals of Adverse Determinations of Life Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits; and
- Provide a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain information about such procedures, and a statement that the claimant's right to bring an action under ERISA section 502(a).

Waiver of Premium

If you apply for an extension of life insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium

The benefit determination period begins when claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the time period shown below. A written or electronic notification of any adverse determination must be provided.

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0365

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant s right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0366

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

All Options

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

The group Accidental Death and Dismemberment Coverage described in this Certificate is attached to the group Policy effective January 1, 2026. This Certificate replaces any Certificate previously issued under this Plan or under any other Plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is entitled to the benefits described herein. However, the Employee must: (a) satisfy all of this Plan's eligibility and effective date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under this Plan; and (c) all required premium payments must have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND

Group Policy Number: 00092400

Matthew Darula, Head of Product, Strategy and Offerings

B034.3329

TABLE OF CONTENTS

DEFINITIONS **1**

GENERAL PROVISIONS

Limitation Of Authority 3
Incontestability 3
Examination And Autopsy 3
Accidental Death and Dismemberment Claim Provisions 4

ELIGIBILITY FOR ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE EMPLOYEE COVERAGE

Eligible Employees 5
Conditions Of Eligibility 5
When Employee Coverage Starts 6
When Employee Coverage Ends 6

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Basic Accidental Death And Dismemberment Insurance 8

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT SCHEDULE OF BENEFITS

Employee Basic Accidental Death And Dismemberment (AD&D) Insurance Schedule 11
Changes To Insurance 11

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE **13**

STATEMENT OF ERISA RIGHTS **17**

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B034.2088

All Options

Accident: This term means an event or occurrence, resulting in bodily injury or death, independent of all other causes, while a covered person is insured by this Plan. Accident does not include: (a) willful self-injury, suicide, or attempted suicide while sane or insane; (b) sickness, disease, mental infirmity, or result of any medical or surgical treatment; (c) infection, except pyogenic infections which result from a bodily injury or bacterial infections which result from the unintentional ingestion of contaminated substances; (d) unintentional or nonvoluntary inhalation of gas or taking of poisons; (e) an injury the covered person suffers while taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony; (f) injury suffered while travelling on any type of aircraft if the covered person is an instructor or crew member; or has any duties at all on that aircraft; (g) injury suffered in declared or undeclared war or act of war or armed aggression; (h) injury suffered while the covered person is a member of any armed force; (i) injury suffered while the covered person is a driver in a motor vehicle Accident, if he or she does not hold a current and valid driver's license; (j) injury suffered while the covered person is legally intoxicated; or (k) injury suffered while the covered person is voluntarily using a controlled substance, unless: (1) it was prescribed for the covered person by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

B034.4323

All Options

Active Work or **Actively At Work:** These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Policyholder, on A Full-Time basis at: (1) one of the Policyholder's usual places of business; (2) some place where the Policyholder's business requires You to travel; or (3) any other place You and the Policyholder have agreed on for Your work.

B034.2091-R

All Options

Activities Of Daily Living: This term means the ability to perform the following, with or without equipment or adaptive devices:

- **Bathing:** wash in a tub or shower; or take a sponge bath; and towel dry.

- **Dressing:** put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
- **Toileting:** get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
- **Transferring:** move in and out of a chair or bed.
- **Continence:** control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
- **Eating:** get food into the body by any means once it has been prepared and made available.

B034.2092

All Options

Eligibility Date: This term means the earliest date You are eligible for coverage under this Plan.

B034.2106

All Options

Employee: This term means a person who works for the Policyholder and whose income is reported for tax purposes using a W-2 or 1099 form.

B034.2094-R

All Options

Policyholder: This term means IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND .

B034.2095-R

All Options

Enrollment Period: This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B034.2096

All Options

Plan: This term means the group Accidental Death and Dismemberment Coverage described in the Policy and in this Certificate.

B034.2102

All Options

We, Us and **Our:** These terms mean The Guardian Life Insurance Company of America.

You or **Your:** These terms mean the insured Employee.

B034.2105

All Options

GENERAL PROVISIONS

B034.2107

All Options

Limitation Of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, policy, or certificate is to be issued; (2) waive or alter any provisions of any contract or Policy, or any of Our requirements; (3) bind Us by any statement or promise relating to any contract, Policy or certificate issued or to be issued; or (4) accept any information or representation which is not in a signed application.

B034.2108

All Options

Incontestability

This Plan is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by an insured person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his or her lifetime.

If this Plan replaces a plan Your Policyholder had with another insurer, We may rescind this Plan based on written misrepresentations made by Your Policyholder or an Employee in a signed application for up to two years from the effective date of this Plan.

B034.2110-R

All Options

Examination And Autopsy

We have the right to have a doctor of Our choice examine the person for whom a claim is being made under the Plan as often as We feel necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

B034.2111

Accidental Death and Dismemberment Claim Provisions

Your right to make a claim for Accidental Death and Dismemberment benefits provided by this Plan is governed as follows:

Notice

You must send Us written notice of a loss for which a claim is being made within 20 days of the date the loss. This notice should include Your name and the Policy number

Claim Forms

We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, We will accept a written description and adequate proof of the injury or sickness that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

Proof Of Loss

You must send written proof to Our designated office within 120 days of the loss.

Late Notice Or Proof

We will not void or reduce Your claim if You cannot send Us notice and proof of loss within the required time. In that case, You must send Us notice and proof as soon as reasonably possible.

Legal Actions

No legal action against this Plan shall be brought until 60 days from the date proof of loss has been given as shown above. No legal action shall be brought against this Plan after two years from the date written proof of loss is required to be given.

Workers' Compensation

The Accidental Death and Dismemberment benefits provided by this Plan are not in place of and do not affect requirements for coverage by Workers' Compensation.

B034.2113

All Options

ELIGIBILITY FOR ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE - EMPLOYEE COVERAGE

B034.2114

All Options

Eligible Employees

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Plan, You are eligible if You are in an eligible class of Employees working 200 hours in the last plan year and are an active Full-Time Employee.

If You are a partner or proprietor, We will treat You like an Employee if You meet this Plan's conditions of eligibility.

B034.2590-R

All Options

Conditions Of Eligibility

You are eligible for Accidental Death And Dismemberment coverage if You are:

- legally working in the United States or working outside of the United States for a United States based Policyholder in a country or region approved by Us; and
- Regularly working at least the number of hours in the normal work week set by the Policyholder at: (1) the Policyholder's place of business; (2) some place where the Policyholder's business requires You to travel; or (3) any other place You and the Policyholder have agreed upon for the performance of occupational duties.

You are **not** eligible for Accidental Death And Dismemberment coverage if You are:

- A temporary or seasonal Employee.

B034.2118-R

All Options

Multiple Employment: If You work for both the Policyholder and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Accidental Death and Dismemberment Coverage under this Plan. But, if this Plan uses the amount of Your earnings to set the rates, determine class, figure insurance amounts, or for any other reason, such earnings will be figured as the sum of Your earnings from all covered Policyholders.

B034.2122-R

All Options

When Employee Coverage Starts

For coverage to start, an employee must meet the eligibility requirements established by the Iron Workers District Council of Western New York and Vicinity Welfare Fund.

Your coverage is scheduled to start on Your Eligibility Date.

Sometimes a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: (1) on a holiday; (2) on a vacation day; (3) on a non-scheduled work day; (4) during a layoff of less than 180 days in duration; (5) during an approved leave of absence not due to sickness or injury, of 90 days or less; or (6) on a day during a period of absence that is less than 7 days in duration; and if: (a) You were fully capable of performing the major duties of Your regular occupation for Your Policyholder on a full-time basis at 12:01 AM Standard Time for Your place of residence on the scheduled effective date; and (b) You were performing the major duties of Your regular occupation and working Your regular number of hours on Your last regularly scheduled work day; Your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost, will not start if You are on an approved leave and such coverage or part of coverage was not previously in force for You under a prior plan which this Plan replaced.

B034.2128-R

All Options

When Employee Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your active Full-Time service ends for any reason. Such reasons include: (1) disability; (2) death; (3) retirement; (4) layoff; (5) leave of absence; (6) the end of employment.
- The date You stop being an eligible Employee under this Plan.
- The date You are no longer working in the United States, or working outside the United States for a United States based Policyholder in a country or region approved by Us.

GC-AD&D-11-NY

- The date the group Plan ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Plan carefully for details.

B034.2135-R

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

B034.2164

All Options

Basic Accidental Death And Dismemberment Insurance

We will pay the benefits described below if You suffer an irreversible loss due to an Accident that occurs while You are insured. The loss must: (1) be a direct result of the Accident; (2) be independent of all other causes; and (3) occur within 365 days of the date of the Accident.

Payment Of Benefits: For covered loss of life, We pay the beneficiary of Your term life coverage under the Policyholder's Plan with Us.

For all other covered losses, We pay You if You are living. If You are not living, We pay the beneficiary of Your term life coverage under the Policyholder's Plan with Us.

We pay all benefits in a lump sum as soon as We receive written proof of covered loss and proof of claim which is acceptable to Us. This should be sent to Us as soon as possible.

Overpayment Recovery: If We overpaid a covered person, he or she must repay Us in full. We have the right to reduce his or her payment or apply any benefits payable toward the recovery of the overpayment.

The Beneficiary: You decide who receives this benefit when You die. You should have named Your beneficiary during Your initial enrollment. You can change Your beneficiary at any time by giving written notice. But, the change will not take effect until We or the Policyholder records the change.

If You Named more than one person, but did not specify what their shares would be, they will share equally. If someone You named dies before You, that person's share will be divided equally by the beneficiaries still alive; unless You have specified otherwise.

If there is no beneficiary when You die, We will pay this benefit to one of the following: (1) Your estate; (2) Your spouse; (3) Your parents; (4) Your children; or (5) Your brothers and sisters.

Covered Losses: Benefits will be paid only for losses listed in the Tables of Covered Losses shown below. Your insurance amount is shown in the Accidental Death and Dismemberment Schedule Of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT

Table Of Covered Losses

Covered Loss	Benefit
Loss of Life	100% of Your AD&D insurance amount.
Disappearance	100% of Your AD&D insurance amount.
Loss of a hand	50% of Your AD&D insurance amount.
Loss of a foot	50% of Your AD&D insurance amount.
Loss of sight in one eye	50% of Your AD&D insurance amount.
Loss of thumb and index finger of same hand	25% of Your AD&D insurance amount. No Benefit will be paid if benefits have been paid for "Loss of hand".
Loss of four fingers of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss if hand".
Loss of all toes of same foot	25% of Your AD&D insurance amount.

As used here:

Loss of:

- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- "Loss of sight" means total and permanent loss of sight.
- "Loss of thumb and index finger of same hand" or "Loss of four fingers of same hand" means complete severance at the metacarpophalangeal joints of the same hand.
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint.

B034.2169-R

Multiple Losses: For more than one covered loss due to the same Accident, We will pay up to 100% of Your Accidental Death and Dismemberment insurance amount. We will not pay more than 100% of Your Accidental Death and Dismemberment insurance amount for all losses due to the same Accident.

Seatbelt And Airbag Benefits

If You die as a direct result of an automobile Accident while properly wearing a seatbelt, We will increase Your benefit by $10,000.00. And, if You die as a direct result of an automobile Accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase Your benefit by an additional $5,000.00, for a total increase of $15,000.00, which may not exceed 10% of the Loss of Life benefit.

Repatriation Benefit

We pay an extra sum for covered loss of life due to an Accident which occurs at least 75 miles from Your home. In that case, We pay up to $5,000.00 for costs to transport Your body to a mortuary chosen by You or an authorized agent.

Exposure

If You suffer a covered loss shown in the Table of Covered Losses due to an accidental bodily injury caused by being unavoidably exposed to the elements, We will pay the amount which otherwise applies to the loss.

If covered loss benefits are deemed payable under Exposure, the covered loss benefit is only paid once, not in addition to the Exposure payments.

Disappearance

You will have a presumed accidental bodily injury due to an Accident if: (a) You are riding in a public conveyance that is involved in an Accident; (b) as a result of the Accident, the public conveyance is wrecked, sinks, is stranded or disappears; (c) Your body is not found within 365 days of the day the Accident; and (d) the Accident occurs while You are covered by this policy.

If covered loss benefits are deemed payable under Disappearance, the covered loss benefit is only paid once, not in addition to the Disappearance payments.

B034.2170

All Options

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT SCHEDULE OF BENEFITS

Effective January 1, 2026 this Schedule of Benefits is attached to the Certificate. This Schedule of Benefits replaces any previously issued Schedule of Benefits

B034.2329

All Options

Employee Basic Accidental Death And Dismemberment (AD&D) Insurance Schedule

Basic AD&D Insurance Amount

The Insurance Amount is $25,000.00

B034.2330

All Options

Reduction of Basic AD&D Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Plan starts, Your insurance amount is reduced on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such amount be reduced to $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Plan starts, Your insurance amount is reduced on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such amount be reduced to $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

B034.2365

All Options

Changes To Insurance

Changes In Insurance Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage will not become effective prior to the date You return to Active Work on a Full-Time basis.

Changes In Insurance Classification

If Your classification changes, insurance will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must: (1) make the required contribution for the new amount; and (2) furnish Proof Of Insurability to Us, which We approve in writing.

If the insurance amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B034.2549

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

You participate in a single or multiple employer insured Welfare Plan. This supplement and your certificate of insurance together may constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

  IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND Plan

- **Policyholder's Name:** (Plan Sponsor)

  IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND

  Address: 3445 WINTON PLACE SUITE 238
  ROCHESTER NY 14623

  Phone Number: 585-424-3510

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**160776208

- **Plan Number:** 501

- **Type of Administration:**contract administration

- **Plan Administrator:** (if other than Plan Sponsor)

  IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND

  Address: 3445 WINTON PLACE SUITE 238
  ROCHESTER NY 14623

  Phone Number: 585-424-3510

- **Agent for the Service of Legal Process:**

  IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND

  Address: 3445 WINTON PLACE SUITE 238
  ROCHESTER NY 14623

  Phone Number: 585-424-3510

  (Legal process may also be served on the Plan Administrator.)

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.

- **Date of End of Record Year:** January 1st .

- **Sources of Contribution:**Contributions to the plan are provided by:

  - the Employer

- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)

- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.

- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.

- **Assistance:** For information regarding rights under ERISA, 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, N.W., Washington, D.C. 20210.

B055.0388-R

All Options

The following notice applies if Your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group term accidental death and dismemberment insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of 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.

Enforcement of 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 (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, 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 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 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 that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the 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.

Accidental Death and Dismemberment Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination of Accidental Death and Dismemberment Insurance Claims

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

Adverse Benefit Determination of Accidental Death and Dismemberment Insurance Claims

If a claim is denied, Guardian will provide notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement, that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0367

Appeals of Adverse Determinations of Accidental Death and Dismemberment Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Waiver of Premium

If you apply for an extension of accidental death and dismemberment insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the time period shown below. A written or electronic notification of any adverse determination must be provided.

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0368

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant s right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0369

Guardian

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001

0000// /0001/R04390/B/*EOD*