IUPAT VIP Voluntary Group Insurance Plan

Plan Terms and Conditions

Effective September 1, 2026

Supersedes prior Plan Terms and Conditions dated August 3, 2024 and July 27, 2026.

Important Plan Summary

This summary is here to help you understand the Plan. It does not replace the full Plan Terms and Conditions, the group policy, the certificate, the policy booklet, any endorsement, any state-specific requirement, or applicable law. If anything in this summary conflicts with those documents, those documents control.

You are responsible for reading the full Plan Terms and Conditions before you submit your enrollment, and again after you receive your post-enrollment confirmation. If you do not agree with the Plan Terms and Conditions, or if any enrollment information is wrong, contact Union One before your coverage start date or before your first premium is taken — whichever comes first — to change or cancel your election as the Plan allows.

1. What This Plan Is

The IUPAT VIP Plan is voluntary group insurance. It is not an individual policy, and no member receives an individual policy. If you are eligible and approved, coverage is provided under the group policy, and you receive a Certificate of Coverage.

To be eligible, you must be a U.S.-based, active, full dues-paying IUPAT member and meet the Plan's other eligibility rules. But enrollment is still your choice. You are not required to enroll because you are an IUPAT member, because you work under an IUPAT collective bargaining agreement, or for any other reason.

IUPAT membership is an eligibility requirement only. The IUPAT does not manage your enrollment, collect your premium, decide your eligibility under the group policy, or decide claims. Union One handles enrollment, billing, premium collection, member communications, recordkeeping, and administrative support. Sun Life is the insurance carrier and decides claims and appeals under the group policy.

No employer pays any part of your premium. You pay the full premium for any coverage you elect.

2. Who Does What

The Sun Life and Health Insurance Company (Sun Life) is the insurance carrier. Sun Life underwrites the coverage and decides claims and appeals.

Union One Benefits Administration, Inc. (Union One) is the Third-Party Administrator (the company that handles day-to-day Plan administration on behalf of the carrier and policyholder). Union One handles enrollment, billing, premium collection, member communications, and recordkeeping. Union One does not insure the coverage and does not pay claims.

3. Eligibility

To enroll, you must meet the Plan's eligibility rules — and you must keep meeting them. Eligibility includes:

- active IUPAT membership;
- full dues-paying status;
- employment under an IUPAT collectively bargained agreement (CBA);
- a bargaining-unit position;
- U.S. residence;
- active work and minimum hours;
- age requirements; and
- any other policy requirement.

4. Member Responsibility

You are responsible for the accuracy of everything you give Union One — your elections, eligibility answers, income, hours, dependent information, beneficiary designations, contact information, and payment information.

An honest mistake, misunderstanding, wrong election, or failure to read the enrollment questions does not create coverage or benefits for a person who was not eligible.

5. Premiums, Payments, and Refunds

Paying premium does not make someone covered if that person was not eligible. It also does not continue, restart, or fix coverage that ended or never should have started.

You are responsible for keeping your payment information current and paying your premium on time.

Refunds follow the Plan's refund rules, including the 90-day refund framework, non-refundable fees, and appeal rights. See Section 18.4 for details.

6. Plan Changes

The Plan may change over time. Rates, benefits, eligibility rules, limits, exclusions, carriers, fees, and procedures may all change. When required, you will receive notice.

If you file a claim, the rules in effect on the date of your loss, disability, death, or covered event will apply. Those rules may not be the same as the rules in effect when you first enrolled.

7. Claims

Short-Term Disability (STD), Long-Term Disability (LTD), Life, Accidental Death and Dismemberment (AD&D), Spouse/Domestic Partner Life, Child Life, and CI and Accident each have their own rules, limits, exclusions, and claim requirements.

STD and LTD claims require proof of disability, regular care from a doctor, income and hours verification, and cooperation with Sun Life's review. Approval of an STD claim does not guarantee approval of an LTD claim.

Life Insurance and AD&D are separate coverages. A Life claim may be paid even if AD&D is denied. AD&D may be denied under its own accident-only rules.

Accident and Critical Illness claims must be filed within 31 days after a covered loss occurs or begins, or as soon as reasonably possible. Claims require proof of a covered condition or covered accidental injury, timely medical documentation, and cooperation with Sun Life's claim review process. Accident benefits are payable only for covered injuries resulting from a covered accident and are subject to applicable definitions, benefit schedules, exclusions, and claim requirements. Accident and Critical Illness are separate coverages, and approval or denial of one claim does not affect eligibility under the other.

8. Dependents and Beneficiaries

Keep your beneficiaries and dependents up to date.

Divorce, the end of a domestic partnership, a child aging out, or other dependent status changes may end dependent coverage.

You are responsible for reporting any change that affects dependent eligibility or beneficiary information promptly.

9. Review Before Coverage Starts

The full Plan Terms and Conditions are at https://iupatvip.com/plan-termsandconditions/. After enrollment, you will receive a confirmation email with your coverage elections and Plan materials. Read the full Plan Terms and Conditions before your coverage start date. The deadline and process for changing or cancelling your election before coverage starts are described in the disclaimer above and in Section 18 of the full Plan Terms and Conditions.

10. Full Terms Control

By continuing enrollment, I acknowledge that I have reviewed this Important Plan Summary and understand that it is only a summary. The full Plan Terms and Conditions, the group policy, certificate, policy booklet, endorsements, state-specific requirements, and applicable law control my coverage, eligibility, benefits, premiums, refunds, claims, and rights under the Plan.

The summary above highlights the main rules. The full Terms and Conditions below contain the complete rules. Please scroll through and review the full document before continuing.

Full Plan Terms and Conditions

1. Enrollment Election and General Acknowledgement

I hereby elect to participate in the IUPAT VIP Voluntary Group Insurance Plan ("IUPAT VIP" or the "Plan") by enrolling in the group benefit(s) I have selected.

Voluntary Plan; No Endorsement; No Employer or Union Contribution. The IUPAT VIP Plan is a voluntary group insurance program. I am not required to enroll as a condition of my IUPAT Membership, my employment with any IUPAT-covered employer, or for any other reason. The Plan is offered through the union as a convenience for members but is not endorsed by the International Union of Painters and Allied Trades, any local, any joint council, any employer, or any other entity. No employer contributes to premium for this Plan, and the union does not profit from member participation. My IUPAT Membership, my employment, and my participation in this Plan are separate. I am personally responsible for all premium for any coverage I elect.

Role of Union One; Third-Party Administrator. Union One Benefits Administration, Inc. ("Union One") is the Third-Party Administrator ("TPA") of the Plan. Union One is a licensed TPA in the states in which it administers the Plan. Union One handles enrollment, billing, premium collection, member communications, recordkeeping, and other administrative services on behalf of the insurance carrier and the group policyholder.

Union One is not the insurance carrier. Union One does not underwrite, insure, or pay claims. Insurance coverage under the Plan is underwritten and provided by Sun Life and Health Insurance Company (Sun Life) under the applicable group policy, certificate, booklet, endorsement, and state-specific requirements. The primary Sun Life group contract number for the Plan is 259136-1-G, unless a different contract, certificate, booklet, endorsement, or state-specific requirement applies to a particular coverage, class, state, or insured person. Claims are reviewed, paid, and denied by Sun Life under the group policy. Union One assists me with enrollment, premium administration, and routing of inquiries, but final authority on eligibility and on all claim and appeal decisions rests with Sun Life. License information for Union One can be obtained by contacting Union One or the applicable state insurance regulator.

I certify that I am an active, U.S.-based, full dues-paying Member of the International Union of Painters and Allied Trades (“IUPAT”) currently employed and working for an employer under a U.S.-based IUPAT collectively bargained agreement.

I have read the completed enrollment documents. I understand that false statements or misrepresentations during enrollment may result in loss of coverage, cancellation of coverage from the original effective date, denial of benefits, or forfeiture of premium, as permitted by the group policy and applicable law.

Submitting my enrollment does not guarantee coverage. Coverage will not become effective unless the insurance company (or its designated underwriter) approves my enrollment, confirms eligibility as required, and receives any required premium — and coverage then becomes effective under the group policy.

I attest that the information I provided is true and correct to the best of my knowledge. Knowingly defrauding an insurer — including submitting a fraudulent application, enrolling in benefits I know I am ineligible for, or filing a claim that contains false or deceptive statements — may violate state and/or federal law.

If I unknowingly, accidentally, or personally enter incorrect information on my enrollment, Union One and/or the insurance carrier may correct my enrollment and premium record once the issue is identified. Before I can file or proceed with any claim, I may be required to pay any missed premium or premium shortfall caused by the incorrect information. If the incorrect information affects my eligibility, or cannot be corrected under the policy or administrative rules, my coverage may be rescinded (treated as if coverage never became effective).

If coverage is rescinded, premium paid for the rescinded coverage will be refunded as required by the policy and administrative rules. The coverage will be treated as if I never enrolled and never became covered. If the incorrect information caused me to pay a lower premium than I should have, I must pay the premium shortfall before I can file or proceed with a claim.

Corrections to Enrollment Information; Name, Date of Birth, and Contact Information. Different categories of enrollment information are treated differently when an error is identified:

- Administrative information (name spelling, mailing address, email address, telephone number, and similar contact details) may be corrected upon submission of documentation acceptable to Union One. Corrections of administrative information do not by themselves affect coverage, rate, or benefits, but I must keep this information current under Section 15.
- Rate-affecting information (including a date of birth used to compute age-banded premium, occupation classification, full-time classification, or income used to determine premium) will be corrected, and premium will be retroactively adjusted to the rate that should have applied. I am responsible for any premium shortfall before I am eligible to file or proceed with a claim, as provided in this Section 1.
- Eligibility-affecting information (including a date of birth used for age eligibility under Section 9, my IUPAT Membership status, my bargaining-unit position under Section 2.1, my dues-paying status, my employment under an IUPAT CBA, my U.S. residence, or my dependent eligibility under Section 10): if the corrected information shows I or my dependent was not eligible, coverage may be rescinded under this Section 1 or Section 19, no benefit will be payable for the rescinded coverage, and premium will be refunded under Section 18.4. An innocent mistake does not create coverage for a person who was not eligible, consistent with Section 1.1.

Identity Verification When Records Differ. If my name on Plan records differs from my name on union records, bank records, claim documents, or other source records — for example, after marriage, divorce, a legal name change, or a misspelling — I am responsible for providing documentation acceptable to Union One and the carrier to verify my identity

and reconcile the records. Acceptable documentation may include a marriage certificate, divorce decree, court order changing name, government-issued ID, or other documentation acceptable to Union One. Claims may be delayed while identity verification is pending.

Nothing in these Terms and Conditions supersedes, amends, or replaces the applicable group policy, certificate, booklet, endorsement, or state-specific requirement. If there is any conflict between these Terms and Conditions and the group policy, the group policy and applicable law control. Copies of the current group policy booklets, Plan Terms and Conditions, and related Plan materials are available at https://iupatvip.com/plan-termsandconditions/ and may also be requested by emailing info@unionone.com or calling the IUPAT VIP Customer Service Center at (224) 357-7880.

1.1 Foundational Plan Rules

The following foundational rules apply to all elements of the Plan and to every section of these Terms and Conditions. To the extent any other section appears to conflict with these rules, these foundational rules and the group policy control.

Self-Enrollment, Self-Certification, and Self-Reporting. The Plan is administered as a self-enrollment, self-certification program. I am responsible for:

- Self-enrolling through the Plan's authorized enrollment channels.
- Self-certifying my eligibility — IUPAT Membership, employment under a IUPAT CBA, bargaining-unit position, full dues-paying status, active work, hours, age, U.S. residence, income, dependent eligibility, and any other Plan eligibility requirement.
- Self-reporting any change in those facts, and any event affecting eligibility under Section 2.2 (loss of Membership, dues status, employment, hours, residence, dependent eligibility, retirement, leave, or death).
- Self-reporting any side work, second jobs, or other work activity during a disability claim under Section 14.3.

Union One, the insurance carrier, and the policyholder rely on the information I self-certify and self-report. Coverage, premium, claim, and refund decisions are made based on that information and the records available to Union One and the carrier. Failure to self-report, late self-reporting, inaccurate self-certification, or misrepresentation may result in rescission of coverage, denial of claims, recovery of paid claims, retroactive premium adjustment, or other consequences under Section 1, Section 19, and the group policy.

Group Insurance, Not an Individual Policy. Coverage under this Plan is voluntary group insurance issued under a group policy held by the policyholder. No individual policy is issued to any Member. Eligible, approved Members receive coverage and a Certificate of Coverage under the group policy. Paying premium does not create an individual policy or rights independent of the group policy.

Payment of Premium Does Not Create Coverage. Paying, drafting, or accepting premium — by ACH, one-time payment, or any other method — does not by itself create, continue, or reinstate coverage. It does not waive eligibility requirements and does not prevent denial or rescission if the Member, Spouse, Domestic Partner, child, or other person was not eligible. Eligibility is determined under the group policy and these Terms, not by the fact that premium was paid or accepted.

Example: If I paid premium after I was no longer eligible, that payment does not keep coverage active.

Claims Governed by Plan Terms in Effect at Time of Loss. Claim, eligibility, and benefit decisions are governed by the group policy, these Terms, and the Plan rules in effect on the applicable date of loss, disability, death, or covered event. They are not governed by the terms in effect when I enrolled or by what I remember from enrollment. Continued participation in the Plan after the effective date of a change means I accept the revised Terms, procedures, premiums, fees, and rules.

Member Responsibility for Elections; Mistakes Do Not Create Coverage. I am solely responsible for the accuracy of my elections, attestations, eligibility representations, beneficiary and dependent designations, income, hours, employment information, and anything else I submit. Coverage and claims are determined by actual eligibility under the group policy — not by what I intended to elect, believed I had elected, or paid premium for.

An innocent mistake, misunderstanding, accidental election, or failure to read the questions does not entitle me, my Spouse, Domestic Partner, dependents, beneficiaries, estate, or anyone else to coverage or benefits we were not eligible for.

Plain English; Separate Confirmation of Key Eligibility Statements. These Terms are written in plain English. During enrollment, I am presented with separate confirmation questions covering the key eligibility statements:

- active, full dues-paying IUPAT Membership;
- employment under a U.S.-based IUPAT CBA;
- U.S. residence;
- active work status; and
- certification of hours and income.

I have been given the opportunity to read each statement and to ask questions before submitting my enrollment. A claim of lack of understanding does not create coverage or benefits for which I was not eligible.

Administrative Error Distinguished from Member Error. If a Union One system, process, or representative permits enrollment, premium acceptance, or a benefit election for a person or coverage that was not eligible — due to system, processing, data, or vendor error and without any false statement or misrepresentation by the Member — that administrative error does not create coverage, waive eligibility requirements, or entitle the affected person to benefits. Union One may correct the record, adjust premium, rescind coverage, or take other action permitted by the group policy and applicable law. Premium refund treatment is handled under Section 18.4.

Enrollment and Plan Records; Audit Trail. Union One maintains an enrollment and Plan administration record system that is designed to capture, where available: the attestation language I am shown, my electronic signature, the date and time of submission, my IP address or other available system data, my coverage elections, my beneficiary designations, and any later changes. Union One may rely on any available data from those records for the period required by applicable law and its retention policy.

The audit-trail data is not the sole source of truth. My acts of submitting enrollment, electing coverage, paying premium, and accepting these Terms independently constitute my elections, attestations, and acceptance of the Plan's rules. Missing or incomplete audit-trail data — due to system, vendor, data migration, or any other cause — does not invalidate my enrollment, elections, beneficiary designations, or obligations under the Plan. Eligibility, enrollment, beneficiary designations, and Plan obligations may be established by any reasonable evidence, including enrollment confirmations, premium payment records, carrier records, and other Plan administration records.

2. Eligibility to Enroll and Maintain Coverage

2.1 Initial Eligibility

These rules outline the requirements for being initially eligible for coverage on the effective date for which I enroll.

- Membership Requirement. I must be an actively working, full dues-paying Member of the International Union of Painters and Allied Trades, living in the United States.
- Employment Requirement. I must be employed under an IUPAT U.S.-based collectively bargained contract on the effective date of coverage. If I do not have a current employer connected to an IUPAT collectively bargained contract, I am not eligible to enroll.
- Active Work Requirement. I must be actively working on my effective date of coverage. "Actively working" means working a full day as scheduled by my employer and performing the duties of my regular occupation. If I am not actively working on the date coverage would otherwise begin, coverage will be delayed until I return to active work, subject to the group policy.
- Minimum Hours Requirement. Full-time Members must work at least 15 hours per week, or at least 750 hours in the previous calendar year, or be on track for at least 750 hours in the current year (pro rata).
- Life and AD&D Age Requirement. Coverage may terminate under the policy when employment/membership ends.
- Disability Prior to Coverage. If my date of disability is before my coverage effective date, that disability is not eligible for benefits. If I am disabled and not actively working on the coverage effective date, I will not be covered under the policy until I return to active working status, subject to the group policy.
- Both Membership and Employment Required, continuously. The Membership and Employment Requirements are separate, independent conditions. Both must be satisfied on the effective date and continuously throughout coverage. Either alone is not enough. Failing either prong — for example, leaving the IUPAT while still working under an IUPAT contract, or remaining an IUPAT Member after my employer closes or loses its IUPAT contract — terminates my eligibility, even if I continue paying dues, premium, or both.
- United States Residence and Employment. "U.S.-based" and "living in the United States" mean I reside, and am employed under an IUPAT CBA, in one of the 50 states or the District of Columbia. Members residing or working in U.S. territories (Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, Northern Mariana Islands), Canada, Mexico, or any other location outside the 50 states and D.C. are not eligible unless a separate approved plan or eligibility pathway applies. If I move outside the eligible area after enrollment, I must notify Union One promptly; coverage may terminate.
- "On Track" Hours and Year-End Verification. If I enroll based on being "on track" for the applicable annual minimum, I represent that I expect to reach the threshold (pro rata) based on my regular schedule. Union One may request supporting documentation at any time — pay stubs, employer letters, schedules, or other records. If I do not reach the minimum at year-end, or cannot verify on-track status at the time of a claim, I may be deemed ineligible, my premium may be adjusted, coverage may be rescinded, and any pending or paid claim may be denied or recovered.
- Separate Confirmation of Each Eligibility Requirement at Enrollment. The enrollment process is designed to present each of these eligibility requirements as a separate confirmation. By submitting my enrollment, I confirm each requirement separately, including my IUPAT Membership, my employment under an IUPAT U.S.-based collectively bargained agreement, my U.S. residence, my active work status, my hours, and my Life and AD&D age eligibility.

- Bargaining Unit Position Required. The Employment Requirement is satisfied only if I personally hold a position covered by the IUPAT CBA and bargaining unit. Working for a company that has an IUPAT CBA is not by itself enough. Supervisors, managers, confidential employees, owners, independent contractors, temporary administrative employees, leased employees, and any other employees not in the bargaining unit are not eligible, even if their employer is an IUPAT-organized employer. If my position changes from a bargaining-unit position to a non-bargaining-unit position, my eligibility ends as of the date of the change.
- Full Dues-Paying Member Status Required. I must be a full dues-paying Member of the IUPAT in good standing. The following do not satisfy this requirement and do not qualify me for the Plan, regardless of IUPAT affiliation, employment, or premium payment: probationary employees not yet at full dues-paying status; initiation candidates; members on withdrawal card, honorable withdrawal, or similar; members on suspended dues, dues-arrears status, or agency-fee-payer status; retirees; and members whose dues are paid by anyone other than the Member (except as the policy expressly permits). If my status changes to any of these after enrollment, my eligibility ends as of that date.
- Conflicting Records; Pending Status Until Verified. If records from Union One, the union, the employer, the carrier, or any other source conflict about my local, Membership status, dues, employer, employment, hours, income, or any other eligibility fact, Union One may place my enrollment or coverage in pending status until the conflict is resolved. Claims may be delayed or denied during the pending period. I am responsible for providing documentation acceptable to Union One. If the conflict cannot be reconciled to establish eligibility, coverage may be rescinded under Section 1, no benefit will be payable, and premium will be refunded under Section 18.4.
- Hiring Hall, Dispatched, and Seasonal Members. Members who obtain work through an IUPAT hiring hall, dispatch system, or similar referral arrangement satisfy the Employment Requirement if the dispatched work is under an IUPAT U.S.-based CBA and the Member personally holds a bargaining-unit position. Active Work, Minimum Hours, and income are measured on combined dispatched hours, earnings, and employer records (including local dispatch records). A normal between-assignment period is not by itself a termination, provided I remain on the dispatch list and otherwise eligible. Seasonal Members who meet the annual hours threshold remain eligible during the off-season, provided they remain attached to an IUPAT-covered employer (layoff, callback, or seasonal furlough) and remain full dues-paying. Loss of dispatch list status, loss of attachment to the covered employer, or failure to meet the annual hours threshold terminates eligibility under Section 2.2.
- Local Mergers, Renumbering, and Reorganizations. The Membership Requirement runs to IUPAT Membership generally, not to a specific local. If my local merges, is renumbered, is reorganized, or otherwise changes identity, my eligibility is not affected if I remain an active, full dues-paying IUPAT Member in good standing in the successor or renumbered local. Union One updates its records upon notification, and false termination or eligibility flags from local reorganization will be corrected upon acceptable documentation. I must notify Union One of any change to my local affiliation.
- Duplicate Enrollments and Records. If I appear under two or more enrollment records, member IDs, email addresses, phone numbers, or other identifiers, Union One reconciles them to a single surviving record. The most recent valid enrollment controls current elections; the most recent valid beneficiary designation controls; combined premium history is reconciled to the surviving record. Duplicate elections exceeding policy maximums are void, and excess premium is refunded under Section 18.4. Claims under duplicate records pay only under the surviving record; benefits are not stacked.
- Statements by Union, Local, or Employer Representatives Are Not Binding. Statements about Plan eligibility, the meaning of these Terms or the group policy, the consequences of enrollment, or the availability of benefits made by union representatives, local officers, business agents, stewards, employer representatives, or any other third party who is not an authorized representative of Union One, the Plan Administrator, or the carrier are not binding. Eligibility and coverage are determined exclusively under the group policy and these Terms. I should not rely on such statements to enroll, maintain coverage, interpret my rights, or make decisions about other insurance.
- Customer Service Statements Are Informational. Information from Union One customer service, billing, or claims assistance staff is intended to help me understand the Plan. Verbal or written statements by Union One personnel do not amend the group policy or these Terms, waive eligibility, create coverage that does not exist, extend deadlines, or bind Sun Life's claim determinations. Final authority rests with the group policy, these Terms, Union One administrative rules, and Sun Life. For important decisions (cancellation, claim filing, election change, conversion to an individual policy, beneficiary change, eligibility), I should request written confirmation.

2.2 Ongoing Eligibility

Once covered, I must continue to meet the Plan eligibility requirements. Ongoing eligibility is not automatic just because premiums continue to be drafted.

Union One is not automatically informed by my employer or my union when my work, union, dues, or employment status changes. I must notify Union One if my work status, union status, dues status, employment status, hours, or eligibility changes — or if I become ineligible.

If I fail to notify Union One in a timely manner and continue paying premium for coverage I am not eligible for, I generally qualify for a refund of no more than ninety (90) days of premium paid after the date I became ineligible, less non-refundable fees. The 90-day limit, the right to appeal for additional refund, the documentation needed, and how to submit an appeal are set out in Section 18.4 and are subject to the group policy and applicable law.

- I must remain an actively working, full dues-paying Member of the International Union of Painters and Allied Trades living in the United States.
- I must remain employed under an IUPAT U.S.-based collectively bargained contract and continue to satisfy the applicable minimum hours requirements.
- I must immediately notify Union One of any change in union status, dues status, employment status, active work status, hours, earnings, layoff, leave of absence, disability, retirement, termination, employer closure, or any other event that may affect eligibility.
- If I have questions about eligibility or if my eligibility changes, I will call Union One at (224) 357-7880 or email info@unionone.com.

When Loss of Minimum Hours Terminates Coverage. If my regularly scheduled hours drop below the applicable minimum (15/week Full-time), or I will not meet the applicable annual threshold (750 hours Full-time, pro rata for partial years), my eligibility ends on the date my hours dropped below the threshold. Continued premium drafts do not extend eligibility. At any claim, hours will be verified back to the period required by the group policy. If hours during the relevant period were below the minimum, the claim may be denied and coverage may be rescinded or terminated retroactively to the date eligibility ended, with refunds handled under Section 18.4. I must notify Union One immediately if my hours change.

Employer Closure or Loss of IUPAT Contract. If my employer closes, ceases operations, loses its IUPAT CBA, terminates my employment, or otherwise ends my employment under an IUPAT U.S.-based CBA, my eligibility ends on the date my covered employment ended — even if I continue paying dues, remain an IUPAT Member, or continue ACH authorization. Continued payment after covered employment ends does not extend coverage. I must notify Union One immediately of any such event.

Change of IUPAT Employer; Inter-Employer Gaps. If I leave one IUPAT-covered employer for another, my eligibility depends on continuous satisfaction of the Membership, Employment, and Active Work Requirements. During any gap between covered employments, I am not actively working under an IUPAT CBA and eligibility is paused.

If the gap is brief (generally no more than thirty (30) days) and I notify Union One within the gap, coverage may continue without re-enrollment — provided premium continues to be paid, the new employment is under an IUPAT U.S.-based CBA, I personally hold a bargaining-unit position, and I satisfy all other eligibility requirements on my first day of active work. If the gap exceeds Union One's permitted period or I do not notify Union One timely, coverage terminates on the date prior covered employment ended and I must re-enroll under Section 3.4 and the policy. Re-enrollment is subject to the late-entrant rules (special rules for people who could have enrolled earlier but did not) and the pre-existing condition limitation (a limit on benefits for conditions treated or present before coverage began, as defined by the policy and Section 8). Premium drafted during a non-qualifying gap does not extend coverage and is refunded under Section 18.4.

Retroactive Correction of Union or Dues Status. If the union, local, or Union One later determines that I was inactive, suspended, on withdrawal card, transferred out of covered status, not full dues-paying, or otherwise out of compliance for a prior period, that determination applies retroactively. Coverage for the corrected period is treated as not in effect; claims for events in that period may be denied, and any claims paid may be recovered as overpayments under Section 14.3. Premium paid during the corrected period is refunded under Section 18.4. Retroactive correction is based on the records of the union and the local, which control on questions of Membership and dues status.

3. Coverage Effective Dates, Delays, and Changes

3.1 Coverage Effective Date

I am responsible for paying the required premium for any coverage I elect under the IUPAT VIP Plan. My coverage will generally become effective at 12:01 a.m. on the latest date required by the group policy, including the date I am eligible, the date designated by the Contract Holder or Plan Administrator for an approved enrollment period, the date I am in active employment/membership, the date my enrollment is approved, and the date any required premium contributions are received.

If I am not in active employment/membership on the date coverage would otherwise begin, coverage will begin only when I return to active employment/membership and satisfy all other policy requirements.

Premiums Collected Before Active Work Begins. Premiums collected before my active work begins (for example, premiums drafted during a period of layoff, leave, disability, or other inactive status that delayed my coverage effective date) will be applied to coverage upon my return to active work and satisfaction of all other policy requirements. If I do not return to active work and satisfy all other policy requirements, no coverage becomes effective and the premiums collected will be refunded under Section 18.4, less non-refundable fees. Premium collection during a pre-effective-date delay does not create coverage, accelerate the effective date, or waive the active work requirement.

Enrollment During Leave, FMLA, Layoff, or Other Inactive Status. Members enrolling during an approved enrollment period who are, on the otherwise-applicable effective date, on FMLA leave, other approved leave of absence, military leave, layoff, strike, disability, light duty, or any other status that is not Active Work, are subject to the Active Work delay. Coverage will not begin until I return to Active Work and satisfy all other policy requirements. This rule applies to new

enrollments. Continuation of an already-effective coverage during a period of leave or other inactive status is governed by Section 4, not this Section 3.1.

3.2 Waiting Period for Coverage Adjustments

Once I elect coverage, I must wait one full year from my original effective date before making coverage changes, unless the group policy or Union One administrative rules allow otherwise. This includes:

- salary or income updates used for disability coverage purposes;
- Short-Term Disability (STD) or Long-Term Disability (LTD) coverage increases, which must be made during an approved enrollment period occurring after the one-year waiting period is satisfied; and
- Life Insurance increases, which must be made during an approved enrollment period and are subject to applicable policy limits and administrative rules.

After any coverage increase is made, I must wait another full year before making any subsequent increase, unless the policy or Union One administrative rules allow otherwise. Any increase or added coverage may be subject to active work requirements, policy approval, pre-existing condition limitations, proof of insurability, and other policy conditions.

3.3 Adding Lines of Coverage Later

If I enroll but choose to opt out of Life, AD&D, STD, LTD, Accident or C.I. coverage, I may only add that coverage during a future approved enrollment period and only if I satisfy the applicable policy and administrative requirements.

- Disability Insurance. Pre-existing condition limitations apply to any disability coverage added later if I previously opted out or if I increase coverage.
- Life Insurance. Any later Life election or increase is subject to the policy, active work requirements, the applicable maximum amount, age requirements, and any carrier approval or administrative rules.
- AD&D Insurance. AD&D amounts are tied to the corresponding Life amounts under the AD&D policy. If Life coverage is not active or ends, corresponding AD&D coverage may be unavailable or may end, subject to the policy.
- Newly Eligible Member vs. Late Entrant. A “Newly Eligible Member” is a person who first satisfies all eligibility requirements (IUPAT Membership, covered employment, U.S. residence, active work, and minimum hours) on a date after the most recent approved open enrollment period has closed. A “Late Entrant” is a person who was eligible to enroll during an approved open enrollment period but did not enroll. Newly Eligible Members may enroll during a special enrollment window described in the group policy and Union One administrative rules and may, where the policy permits, receive guaranteed acceptance coverage. Late Entrants may enroll only during a future approved open enrollment period and may be subject to additional requirements, including evidence of insurability, underwriting approval, pre-existing condition limitations, reduced guaranteed-acceptance amounts, or other late-entrant rules, subject to the group policy. The fact that the enrollment system processed a Late Entrant’s enrollment, or accepted premium, does not waive these requirements or convert a Late Entrant into a Newly Eligible Member.

3.4 Re-Enrolling After Cancellation

If I voluntarily cancel coverage or my coverage is cancelled due to non-payment, I must wait one full year from the date of cancellation before re-enrolling, and I may only re-enroll during an approved enrollment period, subject to policy terms, active work requirements, eligibility, and any applicable pre-existing condition or late entrant rules.

4. Coverage Continuity, Temporary Breaks in Active Work, and Reinstatement

Coverage is conditioned on continued eligibility. A temporary continuation of coverage during certain absences does not mean I remain eligible indefinitely.

- Short-Term Disability and Long-Term Disability. If I experience a temporary break in active work status due to injury, sickness, layoff, part time status, or strike exceeding six (6) months for STD and/or LTD coverage, my coverage will terminate. For any other employee approved leave of absence, coverage lasts until the end of the month. Once terminated, I will not be eligible to file a claim unless and until my coverage is reinstated or I re-enroll in coverage, subject to the group policy and Union One administrative rules.
- Life Insurance. If I become disabled, am on an approved leave of absence, am temporarily laid off, or am on strike, I may continue Life Insurance coverage for up to twelve (12) months, provided premiums are paid during that period and the group policy permits continuation. After twelve (12) months, Life Insurance coverage will terminate unless I elect conversion, if available.
- Military Leave. If I am on military leave, I may continue Life Insurance coverage for up to twenty-four (24) months, provided premiums are paid during that period and the group policy permits continuation. After twenty-four (24) months, Life Insurance coverage will terminate unless I elect conversion, if available.

- Reinstatement Request Window. I may have up to six (6) months from the date my coverage terminates due to a change in eligibility to request reinstatement, subject to the group policy and Union One administrative rules. To exercise reinstatement rights, I must notify Union One within thirty-one (31) days of my return to active work.
- Member Responsibility. I must notify Union One of any break in active work status or any change to my union, dues, or employment status. I cannot continue coverage if I leave the union, stop being a full dues-paying Member, retire, or otherwise cease to satisfy eligibility requirements. Failure to provide timely notice may result in termination of coverage, denial of claims, loss of conversion rights, and forfeiture of premiums paid.

Retirement Is a Permanent Termination of Eligibility. Retirement is not a temporary break in active work and does not qualify for any temporary continuation of coverage under this Section 4. Retirement is a permanent termination of eligibility. Coverage ends on the retirement date, regardless of whether premium continues to be drafted, subject only to conversion rights under Section 9.4 and any other rights expressly provided by the group policy. I am required to notify Union One immediately upon retirement.

Disability That Begins During a Continuation Period. If I become disabled during a period of approved temporary continuation under this Section 4 (for example, during the six-month STD/LTD break, the twelve-month Life continuation, or the twenty-four-month military leave continuation), the disability is eligible for benefits only if it begins while my coverage is still in force (active) under the continuation period and I otherwise satisfy the policy definition of disability and all other policy requirements, including the pre-existing condition limitation in Section 8. Disability that begins after my continuation period has expired is not covered, regardless of whether I continue to pay premium. Continued premium payment after the continuation period has expired does not extend coverage.

5. Policy Review, Electronic Delivery, and State-Specific Requirements

I understand it is my responsibility to understand the group policy and its provisions. I am responsible for obtaining, reviewing, and reading the entire group policy booklet for each elected line of coverage. A copy will be available by contacting Union One Benefits Administration, Inc. ("Union One") at info@unionone.com or (224) 357-7880.

Copies of the current group policy booklets, Plan Terms and Conditions, and related Plan materials are available at https://iupatvip.com/plan-termsandconditions/. Members may also request copies by emailing info@unionone.com or calling the IUPAT VIP Customer Service Center at (224) 357-7880.

I acknowledge and consent to receiving electronic copies of group plan documents, notices, policy information, enrollment confirmations, premium notices, renewal notices, claim information, lapse notices, and other Plan-related communications in lieu of paper copies to the extent permitted by applicable law. I may change this election only by providing thirty (30) days prior written notice to Union One.

State-specific requirements may change or supplement the provisions described in the policy booklet. If I live in a state with such requirements, those requirements apply to my coverage and are made part of my Group Insurance Certificate. Sun Life provides state-specific requirement information at www.sunlife.com/us/en/employers/products-and-services/paid-family-medical-leave/. If I cannot access the website or want a printed copy, I may call Sun Life at 1-800-786-5433.

Which State's Requirements Apply. If I have lived in more than one state during my participation in the Plan, state-specific requirements that apply to my coverage are determined under the group policy and applicable law. Generally, the controlling state is my state of residence at the time of the covered event (date of disability, date of death, date of covered loss, or other applicable date), or as otherwise determined by the policy and applicable law. The state in which I enrolled, the state in which I previously lived, and the state in which I work or worked may not be the controlling state. I must keep my state of residence current with Union One.

Some coverages have limitations and exclusions, including pre-existing condition limitations, limitations on specific disabling conditions such as mental health, substance abuse, and self-reported symptoms, occupational injury/sickness exclusions, suicide exclusions, and other exclusions described in the policy. Limitations may vary based on the state in which I reside.

Independence from Other Plans. The IUPAT VIP Plan stands on its own. Eligibility, premium, coverage, exclusions, limitations, claim procedures, refund rules, and benefits under this Plan are governed exclusively by the group policy and these Terms. Any coverage I have through another union plan, employer plan, association plan, individual policy, or any prior plan does not change the eligibility, terms, or claim rules of this Plan. Benefits under other plans are not coordinated with this Plan except as expressly provided in the deductible-income (other income that may reduce a disability benefit), integration, and offset (another payment that may reduce the benefit) provisions of Sections 6, 7, and 12. Approval, denial, payment, or termination of benefits under another plan does not bind Sun Life's decision under this Plan.

Application to a National Plan; State Variations. The IUPAT VIP Plan is a national plan offered to eligible Members across multiple U.S. states. These Terms and Conditions are written to apply consistently across states. To the extent any provision of these Terms and Conditions conflicts with, is preempted by, or is otherwise unenforceable under the law of any state where I reside, work, or am eligible, that provision is applied for me as modified by that state's law, and the remainder of these Terms and Conditions continues to apply to the full extent permitted. Provisions that may vary by state include, without limitation: grace periods, refund timing and amounts, beneficiary auto-revocation on divorce, slayer and

wrongdoer statutes, electronic communication consent, recordkeeping, complaint procedures, TPA disclosures, statute-of-limitations periods, and consumer-protection requirements. Nothing in these Terms and Conditions is intended to waive or override any right I have under applicable state law that cannot be waived by agreement.

6. Short-Term Disability (STD) Terms

6.1 Nature of Coverage

STD is disability income insurance only. It provides coverage only for the limited benefits or services specified in the policy. It is not basic hospital, basic medical, major medical, Medicare supplement, workers compensation, or state disability insurance.

Covered Income for STD and LTD Purposes. For STD and LTD enrollment, premium, and benefit calculation purposes, "Pre-disability Earnings," "monthly earnings," "annual earnings," and similar terms refer only to earnings from my IUPAT-covered employment under a U.S.-based IUPAT collectively bargained agreement, as defined in the group policy. Earnings from non-covered employment (including second jobs, side businesses, self-employment, 1099 work, gig work, rental income, investment income, pension or retirement income, or any other source not derived from my IUPAT-covered employment) and earnings of any other household member do not count as Pre-disability Earnings, monthly earnings, or annual earnings, regardless of the income amount I entered at enrollment or the premium I paid. At the time of claim, income will be verified, and any benefit will be calculated based on verified covered earnings only, subject to the group policy. If the income I entered at enrollment included non-covered earnings, my benefit may be reduced, my premium may be adjusted, and excess premium will be treated under Section 18.4.

6.2 STD Benefit Highlights

STD Feature- 24 wks.	Member Acknowledgement
Elimination Period	14 days for disability due to accident; 14 days for disability due to sickness. Benefits begin the day after the Elimination Period is completed, if the claim is approved and all policy requirements are met.
Benefit Amount	STD benefits are elected in $50 increments with a minimum election of $100, subject to the Maximum Weekly Benefit and policy limits.
Maximum Weekly Benefit	Option 1: $500 Option 2:$1,200, not to exceed 60% of Pre-disability Earnings.
Maximum Benefit Duration	Up to 24 weeks of benefits for a continuous period of disability, subject to the policy.
Premium While on Claim	Contributions are required for STD coverage while receiving payments under the STD plan.
Integration / Deductible Income	My scheduled STD benefit may be reduced by deductible sources of income, disability earnings, and other amounts described in the policy. The IUPAT VIP STD plan uses an all-source integration ceiling under which the scheduled STD benefit is reduced only to the extent combined disability income exceeds the applicable ceiling described in the policy.

STD Feature- 50 wks.	Member Acknowledgement
Elimination Period	14 days for disability due to accident; 14 days for disability due to sickness. Benefits begin the day after the Elimination Period is completed, if the claim is approved and all policy requirements are met.
Benefit Amount	STD benefits are elected in $50 increments with a minimum election of $100, subject to the Maximum Weekly Benefit and policy limits.
Maximum Weekly Benefit	Full-time Members: $1,200, not to exceed 60% of Pre-disability Earnings.
Maximum Benefit Duration	Up to 50 weeks of benefits for a continuous period of disability, subject to the policy.
Premium While on Claim	Contributions are required for STD coverage while receiving payments under the STD plan.
Integration / Deductible Income	My scheduled STD benefit may be reduced by deductible sources of income, disability earnings, and other amounts described in the policy. The IUPAT VIP STD plan uses an all-source integration ceiling under which the scheduled STD benefit is reduced only to the extent combined disability income exceeds the applicable ceiling described in the policy.

To be approved for STD benefits, I must satisfy the policy definition of disability, be under the regular care of a doctor, have disability begin while covered, satisfy the elimination period, and provide satisfactory proof of claim and income documentation.

Recurrent Disability and Separate Claims. If I return to active work and later become disabled again from the same cause or a related cause within the recurrent disability window described in the policy, the second period of disability may be treated as a continuation of the original claim, with no new elimination period and continuation of the original maximum benefit duration. If the periods of disability are separated by longer than the recurrent disability window, or if the second disability arises from an unrelated cause, the second period is treated as a separate claim, subject to a new elimination period, new proof of claim, and a new maximum benefit duration, and subject to the policy's pre-existing condition rules. The same principles apply to LTD claims under Section 7.

7. Long-Term Disability (LTD) Terms

7.1 Nature of Coverage

LTD is disability income insurance only. It provides coverage only for the limited benefits or services specified in the policy. It is not basic hospital, basic medical, major medical, Medicare supplement, workers compensation, or state disability insurance.

STD and LTD Are Separate Coverages. STD and LTD are separate coverages with separate definitions of disability, separate elimination periods, separate benefit formulas, separate maximum benefit durations, separate deductible income rules, separate pre-existing condition rules, and separate claim review processes. STD and LTD are adjudicated separately by Sun Life. Approval of an STD claim does not entitle me to LTD benefits and does not bind Sun Life's evaluation of an LTD claim. LTD may be denied even where STD was approved, including without limitation denials based on the LTD definition of disability, the LTD pre-existing condition limitation, the LTD elimination period, the LTD proof-of-claim requirements, or any other LTD policy term.

7.2 LTD Benefit Highlights

LTD Feature- 24 wks.	Member Acknowledgement
Elimination Period	180 days. Benefits begin the day after the Elimination Period is completed, if the claim is approved and all policy requirements are met.
Monthly Benefit	$100 increments with a minimum election of $100 or 60% of monthly earnings, rounded as described in the policy.
Maximum Monthly Benefit	Full-time Option 1: $2,500, not to exceed 60% of Pre-disability Earnings. Full-time Option 2: $5,000, not to exceed 60% of Pre-disability Earnings.
Maximum Benefit Duration	Full-time Option 1: generally 24 months if disability begins under age 66; 12 months if disability begins at age 69 or older. Full-time Option 2: generally 60 months if disability begins under age 65; 12 months if disability begins at age 69 or older.
Premium While on Claim	No contributions are required for LTD coverage while receiving payments under the LTD plan.

LTD Feature- 50 wks.	Member Acknowledgement
Elimination Period	360 days. Benefits begin the day after the Elimination Period is completed, if the claim is approved and all policy requirements are met.
Monthly Benefit	$100 increments with a minimum election of $100 or 60% of monthly earnings, rounded as described in the policy.
Maximum Monthly Benefit	Full-time Option 1: $2,500, not to exceed 60% of Pre-disability Earnings. Full-time Option 2: $5,000, not to exceed 60% of Pre-disability Earnings.
Maximum Benefit Duration	Full-time Option 1: generally 24 months if disability begins under age 66; 12 months if disability begins at age 69 or older. Full-time Option 2: generally 60 months if disability begins under age 65; 12 months if disability begins at age 69 or older.
Premium While on Claim	No contributions are required for LTD coverage while receiving payments under the LTD plan.

7.3 Own-Occupation to Any-Occupation Definition

The LTD policy uses different disability definitions depending on the coverage option and the length of time benefits have been paid. During the initial own-occupation period, my disabling condition must prevent me from performing each of the material and substantial duties of my regular occupation for any employer in the national economy, and I must be under the regular care of a doctor and have the required earnings loss.

For Members Option 1, after 24 months of payments, the policy transitions to an any-gainful-occupation definition. For Option 2, after 24 months of payments, the policy transitions to an any-gainful-occupation definition. This transition does not automatically end benefits. It changes the criteria used to adjudicate continuing disability and may or may not cause benefits to terminate depending on the facts, medical evidence, restrictions and limitations, education, training, experience, and policy requirements.

Job openings or actual job availability are not guaranteed, and the policy does not protect against whether I successfully secure employment.

7.4 LTD Limited Pay Periods for Certain Conditions

LTD benefits may be limited for certain conditions, including disabilities that are primarily due in whole or in part to mental illness, Chronic Fatigue Syndrome, and substance abuse or addiction, subject to the policy. These limitations may restrict the maximum period benefits are payable for those conditions. I should review the LTD policy booklet for the complete limitation language, definitions, exceptions, and state-specific requirements.

Substance Abuse and Related Conditions. STD and LTD benefits for disabilities due in whole or in part to alcohol abuse, alcoholism, drug abuse, drug addiction, substance abuse, or rehabilitation or detoxification for any of the foregoing may be subject to a limited maximum benefit duration under the group policy (often shorter than the policy's general maximum), special proof requirements, and a requirement that I participate in an approved treatment program as a condition of continued benefits. I should review the STD and LTD policy booklets for the complete limitation language, definitions, exceptions, and state-specific requirements.

8. Disability Pre-Existing Condition Limitations

For the first twelve (12) months of STD or LTD coverage, or for the first twelve (12) months after any increase or enhancement to disability coverage, no STD or LTD benefits will be paid if the disability results from a pre-existing condition, unless the policy provides otherwise.

A pre-existing condition includes an illness or injury for which, during the applicable three (3) month look-back period before coverage becomes effective or before an increase would otherwise become effective, I received medical treatment, consultation, care, services, diagnostic measures, prescribed drugs or medicines, or followed treatment recommendations. It may also include conditions for which a reasonable person would have sought medical care. State-specific variations may apply.

A pre-existing condition does not require a formal diagnosis of the specific condition that ultimately causes my disability. Subject to the policy and Sun Life's claim review, the pre-existing condition limitation may apply to an illness, injury, symptoms, underlying condition, or related condition for which, during the look-back period, a medical provider evaluated me, recommended testing, ordered diagnostic studies, referred me to a specialist, prescribed medication, recommended treatment, or otherwise took steps toward identifying, diagnosing, monitoring, or treating the condition.

Referrals, recommended tests, diagnostic workups, follow-up appointments, or specialist evaluations identified or recommended during the look-back period may be considered as part of the pre-existing condition review, even if the testing or follow-up occurred after the look-back period.

To qualify for benefits related to a pre-existing condition, I generally must be an eligible Member of the group and have paid premiums for at least twelve (12) consecutive months following my effective date of coverage, or the effective date of any increase or enhancement, and before my disability begins, or I must be treatment-free for the applicable three (3) month look-back period, subject to the policy.

Being "treatment-free" means the condition is absent or resolved during the look-back period and does not require ongoing medical treatment, prescription medication, consultation, diagnostic testing, or management. Simply discontinuing or avoiding treatment does not qualify as treatment-free if the condition still requires medical management or intervention.

The insurance carrier reviews pre-existing conditions at the time of claim. This review may require disclosure of medical records, doctor's notes, prescription drug history, income records, and other information. Failing to receive treatment does not exempt me from the look-back period for pre-existing conditions.

Existing or Pending Workers' Compensation, Disability, or Occupational Injury Claims. If, at the time of my enrollment or at the time of any increase or enhancement in disability coverage, I have an existing or pending workers'

compensation claim, occupational injury or illness claim, disability claim, Social Security Disability claim, state disability claim, or other claim involving an injury or illness, that condition is treated as a pre-existing condition under this Section 8 and may also be subject to the occupational injury or sickness exclusion described in the group policy. A disability that began before my coverage effective date is not eligible for benefits, regardless of when I file a claim. I am required to disclose any such existing or pending claim during enrollment.

9. Life Insurance Terms

9.1 Nature of Coverage

This is a Voluntary Group Term Life Insurance plan offered through the union. It is designed to provide a guaranteed acceptance option for supplemental Life Insurance while I am working and am an active, full dues-paying Member of the union — without medical questions or testing.

Because this is group coverage, it should not be my only or primary source of Life Insurance. The union or insurance company may terminate, cancel, change, or non-renew the policy at renewal. I should review all Life Insurance policy provisions carefully and should not replace existing Life Insurance without understanding the risks.

9.2 Member Life Benefit Amounts and Age Rules

- Member Life coverage may be elected in multiples of $10,000, with a minimum of $10,000 and a maximum equal to the lesser of 500% of annual earnings or $500,000, subject to the policy.
- Annual Earnings Measurement Period. For purposes of the 500% earnings cap and any Life or AD&D benefit calculation, “annual earnings” means earnings from my IUPAT-covered employment (as defined in Section 6.1) determined as of the amount that was paid to You during the last calendar year and reported on Your W-2 Wage & Tax Statement. It includes qualified deferred compensation, such as contributions to Internal Revenue Code Section 401k, 403b, or 457 deferred compensation arrangements including any amount of voluntary earnings reduction under a qualified Cafeteria Plan or Health Savings Account, excluding housing and/or car allowance. An unusually high earnings year (for example, a year with heavy overtime) does not lock in a permanent benefit cap if my earnings are lower at the time of loss. At the time of claim, earnings will be verified, and any benefit will be calculated based on the earnings period and definition required by the policy. If the annual earnings amount I entered at enrollment cannot be substantiated under the policy’s earnings definition at the time of loss, the payable benefit may be adjusted, my premium may be adjusted, and excess premium will be treated under Section 18.4.
- Any increase, decrease, delayed effective date, or change in Life coverage is subject to the group policy, active work requirements, and administrative rules.

9.3 When Life Insurance Coverage Ends

- If I become disabled, am on an approved leave of absence, am temporarily laid off, or am on strike, I may continue Life Insurance coverage for up to twelve (12) months, provided premiums are paid during that period and the policy permits continuation. After twelve (12) months, coverage will terminate unless I timely elect conversion, if available.
- If I am on military leave, I may continue Life Insurance coverage for up to twenty-four (24) months, provided premiums are paid during that period and the policy permits continuation. After twenty-four (24) months, coverage will terminate unless I timely elect conversion, if available.
- If I leave the union, retire, stop active work, stop being a full dues-paying Member, fail to pay required premiums, request cancellation, or cease to be in a covered class, Life coverage may terminate as provided in the policy.
- Dependent Life coverage ends when the dependent ceases to be a Qualified Dependent, when my Member Life coverage ends, when required premiums are not paid, or when another policy termination event occurs.

9.4 Conversion Rights

If I leave the union, retire, cease to be in a covered class, or otherwise lose Group Term Life Insurance coverage for a reason that allows conversion, I may be eligible to convert all or part of my Group Term Life Insurance coverage to an individual permanent Life Insurance policy without evidence of insurability, subject to the policy.

To convert coverage, I must submit the conversion request and pay the first premium within the timeframe required by the policy. Generally, I must apply within thirty-one (31) days after coverage terminates, or within the later notice period permitted by the policy, and in no event later than the outside deadline described in the policy. To obtain a conversion application, I may contact Sun Life at 1-800-786-5433 and reference Contract Number 259136-1-G. Representatives are available Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time. Estimated conversion rates may be viewed at Sun Life’s conversion website.

Important Notice About Conversion Cost
Converting Group Term Life Insurance to an individual permanent Life Insurance policy is typically significantly more expensive than group coverage and is generally recommended only for individuals who are unable to qualify for Life Insurance coverage elsewhere.

Member Responsibility for Conversion; Notice Subject to Policy and Law. I must apply for conversion within the deadline set by the group policy, generally within thirty-one (31) days after my coverage terminates. Conversion rights, deadlines, and any notice requirements are governed by the group policy and applicable law. Failure to notify Union One of the event that ended my eligibility — including leaving the union, retirement, employer closure, change in dues status, loss of covered employment, or other status change described in Sections 2.2 and 4 — may result in loss of conversion rights, in addition to the other consequences described in Section 4. I should not rely on continued premium drafts, union status, employer status, or any later communication to extend the conversion deadline. I must contact Union One or Sun Life promptly if I believe my coverage may be ending or if I want conversion information.

9.5 Accelerated Death Benefit and Suicide Exclusion

The Member Life policy includes an option to accelerate payment of death benefits if I become terminally ill, subject to the policy. If approved, the option may allow up to 80% of the Life amount in force, not to exceed $400,000, to be paid while I am living. The accelerated benefit may be taxable and may affect eligibility for Medicaid or other government programs. I should consult a tax or legal advisor with questions.

The Life policy contains a suicide exclusion. If death results from suicide within one year of the date coverage became effective, or within one year of an increase for the increased amount, the death benefit or increased amount may not be payable, and premiums paid for the applicable coverage or increase may be refunded, subject to the policy and applicable law.

Life Insurance Limited Exclusions; Independence from AD&D. Group Term Life Insurance under this Plan is subject only to the suicide exclusion described above and any other express exclusions stated in the Life Insurance policy booklet. The AD&D exclusions in Section 11 (including exclusions for assault or felony, intoxication, illegal drug use, hazardous activity, war, and similar causes) apply to AD&D only and do not by themselves bar a Life Insurance death benefit. As stated in Section 11, Life Insurance and AD&D are separate coverages: a Life Insurance benefit may be paid even where an AD&D benefit on the same death is denied, subject to the policy and applicable law (including any applicable state-law slayer, wrongdoer, or similar statute).

9.6 Beneficiary Designation

I am responsible for naming and keeping a current beneficiary on a form approved by Sun Life and filed through Union One. I may update my beneficiary at any time, subject to the policy.

If I do not have a valid beneficiary on file when I die, benefits will be paid in the default order stated in the policy booklet. I should review and update my beneficiary after major life events: marriage, divorce, birth or adoption of a child, the death of a beneficiary, or other family changes.

Beneficiary Change Record. Union One maintains a beneficiary-change record system designed to capture, where available: the date and time of each designation or change, my electronic signature or other authentication, my IP or other available system data, and the prior and updated designations. Union One may rely on any available data from those records for the period required by applicable law and its retention policy.

The audit-trail data is not the sole source of truth. My act of submitting a beneficiary designation or change through the Plan's authorized channels independently constitutes my election. Missing or incomplete audit-trail data does not invalidate a designation otherwise validly submitted. In any contested designation, Sun Life and Union One may rely on any reasonable evidence, including Plan administration records, communications with me, and the policy's default order.

Primary, Contingent, and Predeceased Beneficiaries. I may name one or more primary beneficiaries and one or more contingent beneficiaries. If a primary beneficiary predeceases me, that share is generally redistributed pro rata among surviving primary beneficiaries, unless I have specified another method. If all primary beneficiaries predecease me, benefits go to my contingent beneficiaries; if none, to the default order in the policy booklet. I should update my designation promptly after the death of any beneficiary.

Minor Beneficiaries. Sun Life generally will not pay benefits directly to a minor. Payment is made to a court-appointed guardian or conservator, to a custodian under the applicable Uniform Transfers to Minors Act, or to a trust if a trust is named. Benefits may be held until proper documentation is provided, which can cause significant delay. To avoid delays, I should consider naming a trust, an adult custodian under UTMA, or an adult guardian rather than naming a minor directly.

Competing Documents; Beneficiary Form Generally Controls. The most recent valid beneficiary designation on file generally controls payment of the Life Insurance death benefit. The death benefit is a non-probate transfer and is generally not controlled by a will, trust, or estate planning document unless my designation expressly names a trust. State law may override the beneficiary on file in limited circumstances — including automatic-revocation-on-divorce statutes, slayer or wrongdoer statutes, QDROs, or community property division. In any contested case, Sun Life adjudicates under the policy and applicable law and may interplead the benefit (ask a court to decide who should receive it) by depositing it with a court.

Unavailable, Uncooperative, or Disqualified Beneficiary. If a named beneficiary cannot be located, refuses required documentation, is incarcerated, lacks legal capacity, or is otherwise unable or unwilling to claim, Sun Life may — subject

to the policy and applicable law — hold the benefit, pay to a court-appointed representative or the next beneficiary in the default order, interplead the benefit with a court, or (for a beneficiary disqualified by law such as a slayer statute) pay in accordance with that law. A beneficiary's refusal to cooperate does not entitle other family members, the estate, or any other person to receive the benefit outside the policy's order of payment.

Post-Death Premium Collection. Premium drafted or collected after my death (because death has not been reported) does not extend, create, reinstate coverage, or increase the death benefit, AD&D benefit, or any other Plan benefit. The death benefit, if any, is the amount in force on the date of death. Premium collected after death is refunded under Section 18.4.

10. Dependent Life Insurance Terms

I cannot enroll my Spouse, Domestic Partner, or dependent children in Dependent Life Insurance unless I am also enrolled in Member Life Insurance at an equal or greater amount. Neither my Spouse/Domestic Partner nor I can be covered as both a Member and a dependent spouse/domestic partner under the Plan at the same time. A dependent child cannot be covered by more than one Member under the Plan at the same time.

- Spouse or Domestic Partner Life may be elected in multiples of $5,000, with a minimum of $5,000 and a maximum of $50,000, subject to the policy. The amount of insurance on a dependent cannot exceed 100% of the amount for which I am insured under Member Life coverage.
- Child Life coverage maximum is $20,000, subject to the policy. Children must generally be from live birth to age 26 to qualify for Child Life coverage, subject to state variances in policy. If my enrolled child is disabled or incapacitated, I may be eligible to continue coverage beyond age 26 by contacting the IUPAT VIP Customer Service Center at (224) 357-7880 or info@unionone.com and providing required proof within the policy deadline.
- Life insurance coverage for a dependent other than a newborn child will not take effect if that dependent is confined to a hospital or other health care facility, is home-confined, or is unable to perform the normal activities of someone of like age and sex, until the policy requirements are satisfied.
- I accept full responsibility for promptly notifying Union One if my spouse, domestic partner, or dependent no longer meets policy eligibility requirements. Failure to do so may result in claim denial, loss of continuation or conversion rights, and forfeiture of premiums.
- Premiums paid for an ineligible spouse, domestic partner, or dependent are refunded under the 90-day refund framework in Section 18.4, less non-refundable fees, subject to the right to appeal for additional refund. Any claims submitted for an ineligible spouse, domestic partner, or dependent will be denied, subject to the refund policy, the group policy, and applicable law.

Definitions of Spouse, Domestic Partner, Qualified Dependent, and Eligible Child. For purposes of Dependent Life Insurance and any related Dependent AD&D coverage:

- "Spouse" means my legal spouse under the laws of the U.S. state where the marriage was entered into, as defined in the group policy. A girlfriend, boyfriend, fiancé, engaged partner, ex-spouse, separated spouse where the policy requires legal marriage, or a person to whom I am not legally married is not a Spouse, regardless of cohabitation, length of relationship, or my belief about that person's status.
- "Domestic Partner" means a person who satisfies the Domestic Partner definition in the group policy, which may require a registered domestic partnership, a signed affidavit of domestic partnership filed with Union One on a form approved by Sun Life, shared residence, financial interdependence, and other requirements set out in the policy. A person who does not satisfy the policy's Domestic Partner definition is not a Domestic Partner under the Plan, regardless of cohabitation, length of relationship, or my belief about that person's status. If the group policy or carrier filing does not provide for Domestic Partner coverage, Domestic Partner coverage is not available under the Plan.
- "Qualified Dependent" and "Eligible Child" mean a person who satisfies the dependent eligibility definition in the group policy. For Child Life coverage, the child must generally be my natural, lawfully adopted, or step child, or another child for whom I am legal guardian, from live birth to age 26, and unmarried unless the policy permits otherwise. Disabled or incapacitated children dependent on me may continue past age 26 as described in this Section 10. Residency, financial dependence, and student-status requirements may apply under the group policy.

Events That End Dependent Eligibility. Dependent Life coverage on a Spouse, Domestic Partner, or child ends when the dependent ceases to be a Qualified Dependent, including upon:

- divorce, dissolution of marriage, legal separation where the policy treats legal separation as terminating spouse eligibility, or annulment of marriage to a Spouse;
- termination, dissolution, or revocation of a domestic partnership, or any other event that ends Domestic Partner status under the group policy;
- a child reaching the policy's maximum age (generally 26), marrying where the policy excludes married children, ceasing to be financially dependent where the policy requires dependence, ceasing to satisfy student-status requirements where applicable, or otherwise ceasing to be a Qualified Dependent;
- my Member Life coverage ending; non-payment of required premium; my request to cancel; or any other event described in the group policy.

I must notify Union One promptly of any event that ends dependent eligibility. Dependent coverage ends on the date of the qualifying event, not on the date I notify Union One. Continued premium payment does not create or extend coverage on an ineligible dependent, and any claim for a dependent who was ineligible on the date of loss will be denied. Premium refund treatment is governed by Section 18.4.

Example: If my ex-spouse is no longer eligible under the policy, paying premium does not keep that person covered.

Incorrect Dependent Information. If the date of birth, marital status, relationship, or other eligibility information I entered for a Spouse, Domestic Partner, or dependent child is incorrect, and the dependent was actually ineligible at enrollment or became ineligible earlier than my records show, coverage on that dependent is treated as never effective from the date of actual ineligibility. Any claim for the ineligible dependent is denied. Premium is refunded under Section 18.4. An innocent mistake does not create coverage for a dependent who was not eligible.

11. Accidental Death and Dismemberment (AD&D) Terms

AD&D coverage pays benefits only for covered accidental losses that result directly from accidental bodily injury and from no other cause, subject to the AD&D policy. AD&D is not Life Insurance, health insurance, workers compensation, disability insurance, or medical coverage.

- AD&D Amounts. Member AD&D amounts are generally equal to the amount for which I am insured under Optional Member Term Life coverage. Dependent AD&D amounts are generally equal to the corresponding Dependent Life amounts for a covered spouse, domestic partner, or child, subject to the policy.
- Covered Losses. AD&D may pay for covered losses such as loss of life, sight, speech, hearing, limb, hand, foot, certain fingers, paralysis, coma, brain damage, or loss of use, if all policy conditions are satisfied.
- Timing of Loss. Benefits are payable only if the covered accidental loss occurs within the timeframe required by the policy, including the 365-day accident-to-loss rules and special timing rules for coma and brain damage.
- Limit Per Accident. No more than the covered person's AD&D amount of insurance at the time of the accident will be paid for all losses resulting from injuries sustained in that accident.
- Additional AD&D Benefits. Additional benefits may be available under the AD&D policy for specific circumstances, including seat belt, air bag, and common carrier accidents, subject to all policy conditions and limits.
- AD&D Exclusions. Losses are not covered if they result from excluded causes, including suicide or attempted suicide, intentionally self-inflicted injuries, sickness or medical/surgical treatment of sickness, certain infections, war or act of war, certain military service, attempted felony, certain aviation activities, illegal drug use, alcohol intoxication, subject to the policy and applicable law.

AD&D and Life Insurance Are Separate Coverages. AD&D and Life Insurance are separate coverages with different definitions, requirements, exclusions, and proof-of-loss standards. They are adjudicated separately. A Life Insurance benefit may be paid on a death while an AD&D benefit on the same death is denied, and vice versa. Approval or payment of a Life Insurance claim does not entitle me, my beneficiaries, or any other person to an AD&D benefit, and the denial of an AD&D claim is not a denial of the underlying Life Insurance claim.

12. Accident Insurance Terms

12.1 Nature of Coverage

This is voluntary, group supplemental Accident Insurance offered through the International Union of Painters and Allied Trades (IUPAT). It pays scheduled, lump-sum benefits for specific covered losses resulting directly and independently from a Covered Accident, as defined in the Policy. It is not health insurance, major medical, disability income, or workers' compensation, and does not pay all expenses from an injury. Benefits are limited to items listed in the Schedule of Benefits and subject to all Policy definitions, limitations, and exclusions.

A Covered Accident is a sudden, unforeseeable external event causing bodily injury, occurring while insured, not contributed to by disease/sickness/bodily infirmity, and not otherwise excluded. A Covered Loss must result from a Covered Accident within required timeframes and match the Schedule of Benefits. Because this is supplemental coverage, it should not be your only financial protection after an accident. The union or insurer may amend, cancel, non-renew, or terminate as permitted by the group contract.

12.2 Eligibility and Enrollment

You become eligible when you meet the Policy's eligible class requirements and any waiting period (e.g., active work, union membership in good standing, covered employment). Coverage requires timely enrollment during an available period and authorization/payment of required premiums. Enrollment windows include: Initial Group Enrollment, Annual Group Enrollment, Initial Enrollment for newly eligible members, and qualifying Life Status Change events.

Life Status Changes may include marriage; loss of spouse (death/divorce/annulment/legal separation); birth/adoption or acquiring a child through marriage; employment status changes affecting eligibility; termination of a spouse's employment; or other Policy-recognized events.

Unless the Policy states otherwise, you must enroll within 31 days of a qualifying event. Late enrollment may delay or prevent coverage until a future period. No duplicate coverage is allowed: an individual may be insured only once under the Policy (e.g., not both as Member and Spouse; a Dependent Child can be insured only once).

12.3 Effective Date of Coverage

Coverage takes effect only after all eligibility requirements are satisfied and required premiums are agreed and paid, and timing depends on the enrollment event:

Group Enrollment Event: generally 12:01 a.m. local time at the Employer's address on the Policy Anniversary date following your enrollment, if eligible and premiums are paid.

Newly Eligible (Initial Enrollment Period): generally 12:01 a.m. local time on the first day of the month following enrollment, if requirements are met.

Life Status Change: generally 12:01 a.m. local time on the first day of the month following timely enrollment and premium payment.

Newborn/adopted children may have automatic coverage for a limited period per the Policy; continuing coverage beyond that period requires timely notice and any additional premium.

12.4 Benefit Amounts and Covered Loss Requirements

Benefits are payable only for Covered Losses listed in the Schedule of Benefits and subject to all Policy terms.

Covered categories may include: fractures and dislocations; burns and skin grafts; emergency dental and eye injuries; concussion, coma, paralysis; ambulance, emergency room, urgent care, and hospital; surgery, therapy, rehab, and diagnostic testing; prosthetics, medical appliances/devices; and other scheduled accident benefits.

Requirements may include physician diagnosis, treatment within specified time periods, frequency limits, maximums, and documentation. Accident Insurance pays flat scheduled amounts and does not reimburse every medical expense or replace medical/worker's comp/disability coverage.

12.5 Dependent Coverage

You may elect coverage for an eligible Spouse/Domestic Partner and Dependent Child(ren) if you are enrolled and maintain required Member coverage. Dependents must meet eligibility requirements at enrollment and at claim. Continued premium payment does not create coverage for an ineligible dependent. Dependent Child generally means a child from birth through age 26 who meets Policy requirements. Certain children over 26 may remain eligible if unable to support themselves due to qualifying incapacity, reside with and are financially dependent on the Member, and meet other Policy requirements. You must promptly notify the plan administrator if a dependent loses eligibility. Claims for ineligible dependents may be denied per the Policy.

12.6 When Accident Insurance Coverage Ends

Coverage ends on the earliest of:

- Policy termination or end of coverage for your eligible class.
- End of the month in which the union's participation ends.
- End of the month in which you are no longer in Active Service or no longer meet eligibility.
- End of the month for which premiums are paid (subject to any grace period).
- End of the month in which you cease to be a Member in good standing.
- Any other termination event described in the Policy.

Dependent coverage ends when Member coverage ends, when premiums are not paid, or when the dependent loses eligibility. Termination does not affect a Covered Loss from an Accident that occurred while coverage was active.

12.7 Continuation of Accident Insurance Coverage

If you are no longer in Active Service, you may be eligible to continue coverage by paying required premiums and meeting Policy conditions. Continuation may apply during approved family/medical leave, other leave of absence, furlough, reduction in hours, temporary layoff, strike or labor dispute, or military service. Continuation ends at the earliest of the maximum continuation period, failure to pay premiums, return to employment if prohibited by the Policy, or another termination event.

12.8 Portability

If you lose coverage due to ending Active Service, leaving an eligible class, or the union terminating coverage without replacement within the permitted timeframe, you may continue coverage on a direct-billed basis (Portability/Continuation of Insurance with Premium Payment), subject to Policy eligibility and timelines. Ported coverage typically continues the amount in effect on the eligibility date for portability; increases may not be allowed unless permitted by the Policy. Late application or nonpayment may permanently forfeit portability rights.

12.9 Exclusions

No benefits are payable for losses caused or contributed to by excluded circumstances stated in the Policy. Exclusions include, but are not limited to:

- disease, sickness, bodily infirmity, or treatment for such conditions;
- infection not directly resulting from an Injury;
- suicide or attempted suicide;
- intentionally self-inflicted injury;
- certain aircraft activities;
- war or acts of war;
- participation in riots, insurrection, or terrorist activity;
- commission or attempted commission of a felony;
- certain drug or alcohol-related events;
- racing activities;
- certain military activities;
- bungee jumping;
- illegal occupations or activities;
- rock or mountain climbing; and
- certain aeronautic activities.

State-specific variations may apply based on situs state and employee residence. Refer to the Policy Certificate for applicable state modifications to exclusions and definitions.

12.10 Claims and Benefit Payments

Provide written notice of claim within 31 days after a Covered Loss occurs or begins, or as soon as reasonably possible. After notice, claim forms and instructions will be provided. Written Proof of Loss is generally due within 90 days after the Covered Loss unless not reasonably possible. I must supply all requested documentation, including medical records and treatment information. Failure to cooperate may result in claim denial or termination. Benefits are paid per the Policy’s payment provisions, typically to the Member unless another payment arrangement applies.

13. Critical Illness Insurance Terms

13.1 Nature of Coverage

This is a Voluntary Group Critical Illness Insurance plan offered through the union. It is designed to provide a lump-sum cash benefit if I am diagnosed with certain covered critical illnesses while coverage is in force, subject to the terms, definitions, waiting periods, limitations, and exclusions contained in the Group Critical Illness Insurance Policy issued by Sun Life.

Critical Illness Insurance is not medical insurance and is not intended to replace health insurance. Benefits are paid directly to me and may be used for any purpose, including deductibles, coinsurance, household expenses, mortgage payments, lost income, travel expenses, or any other financial need. Benefits are paid according to the policy's benefit schedule and are not based on actual medical expenses incurred.

Because this is group coverage, it should not be my only or primary source of financial protection. The union or insurance company may terminate, amend, replace, or non-renew the group policy at renewal, subject to applicable law.

13.2 Eligibility and Coverage Amounts

I must be an actively-at-work employee, reside in the United States, remain an active, full dues-paying Member of the union, and otherwise satisfy the eligibility requirements of the group policy in order to enroll. Coverage is issued on a Guaranteed Issue basis during the initial enrollment period, provided I satisfy the actively-at-work requirement and any other policy requirements applicable to my dependents.

• I may elect Member Critical Illness coverage of $5,000, $10,000, $15,000, or $20,000, subject to the group policy.

• If dependent coverage is elected:

- Spouse or Domestic Partner coverage equals 100% of my elected benefit amount.
- Eligible Child coverage equals 50% of my elected benefit amount.

I cannot enroll a dependent unless I am enrolled in Member Critical Illness Insurance. Neither my spouse/domestic partner nor I may be insured simultaneously as both a Member and a dependent spouse/domestic partner under this Plan. A dependent child may not be covered under more than one Member under this Plan. Retirees are not eligible to enroll unless specifically permitted by the group policy. Any increase, decrease, or change in coverage is subject to the group policy, active work requirements, administrative rules, and applicable enrollment periods.

13.3 Effective Date of Coverage

Coverage becomes effective on the date determined under the group policy, provided:

• I satisfy the actively-at-work requirement;

• required enrollment has been completed;

• required premium has been paid; and

• all other policy conditions have been met.

Coverage for an eligible dependent does not become effective unless the dependent satisfies the eligibility requirements and any medical restrictions contained in the policy. No benefit is payable for any covered condition occurring before the effective date of coverage.

13.4 Covered Conditions and Benefit Payments

Benefits are payable only for Covered Conditions specifically listed in the Group Critical Illness Policy and only if the diagnosis satisfies the policy definitions.

Covered Critical Illnesses may include, subject to the Policy:

• Stroke;
• Heart Attack;
• Coronary Artery Disease with Bypass;
• Major Organ Transplant;
• End Stage (Renal) Kidney Failure;
• Invasive Cancer;
• Non-Invasive Cancer;
• Skin Cancer;
• Severe Burns;
• Type 1 Diabetes;
• Coma;
• Paralysis;
• Alzheimer’s Disease; and
• Multiple Sclerosis.

Each Covered Condition pays the percentage of the elected Benefit Amount specified in the policy schedule. Some conditions pay 100% of the Benefit Amount, while others pay smaller percentages. Benefits are paid according to the policy schedule and are not based on actual medical expenses. Benefits may be subject to specific diagnostic requirements, physician certification, medical documentation, waiting periods, benefit percentages, recurrence requirements, and other limitations contained in the Policy. Critical Illness Insurance does not reimburse all medical expenses and does not replace health insurance, disability coverage, or other sources of financial protection. A diagnosis of a condition that is not specifically covered under the policy does not create eligibility for benefits.

13.5 Recurrence Benefits

Certain Covered Conditions are eligible for a Recurrence Benefit if the same Covered Condition occurs again after the applicable separation period and all policy requirements are satisfied.

Unless otherwise provided by the policy, only one recurrence benefit is payable for each covered condition. No recurrence benefit is payable within the policy's recurrence separation period. Cancer and benign brain tumor recurrence benefits additionally require satisfaction of the policy's treatment-free period. Recurrence benefits are payable only for conditions specifically designated by the policy as recurrence-eligible. The policy also contains an Initial Benefit Separation Period during which benefits are not payable for certain different covered conditions occurring shortly after another covered condition.

13.6 Exclusions and Limitations

Benefits are subject to all exclusions and limitations contained in the Group Policy.

Among other exclusions, benefits generally are not payable for losses resulting from circumstances such as:

• war or acts of war;

• active participation in riots, rebellions, or insurrections where applicable under the governing state policy;

• intentionally self-inflicted injuries;

• suicide or attempted suicide where permitted by applicable law;

• certain criminal activity or felonies;

• intoxicated operation of a motor vehicle where applicable;

• illegal drug use or misuse of medications as described in the policy; or

• military activities where excluded by the policy.

State-specific variations may modify or eliminate certain exclusions. The governing Certificate of Insurance issued for my state of residence controls. Benefits are payable only for Covered Conditions satisfying the policy definitions, diagnosis requirements, and all other conditions of coverage.

13.7 Portability (Continuation of Coverage)

If I cease to be eligible under the group policy because I leave covered employment, retire, change employment classification, or otherwise lose eligibility, I may be eligible to continue my Critical Illness coverage directly with Sun Life through the policy's Continuation of Insurance (Portability) provision. Portability is not automatic. To continue coverage, I must satisfy all eligibility requirements, timely submit any required application, and pay premiums directly to Sun Life within the deadlines established by the policy. If portability is not elected or is unavailable, coverage terminates as provided by the group policy. Unlike Group Life Insurance, Group Critical Illness Insurance generally does **not** include conversion rights to an individual permanent insurance policy.

13.8 Premiums and Age-Based Premium Changes

Premiums are determined using Sun Life's attained-age rate structure. My premium may increase automatically as I enter a new age band, even if my elected Benefit Amount remains unchanged. Premium rates are also subject to change as permitted by the group policy, including class-wide rate changes approved by the insurer. Premiums collected after coverage has terminated do not continue, reinstate, or create coverage. Any refundable premium is handled under Section 18.4.

13.9 Termination of Coverage

Coverage terminates on the earliest of:

• the date I cease to be an eligible Member;

• the date I cease active employment, unless continuation is available under the policy;

• my retirement, unless portability is elected and approved;

• termination of the group policy;

• my failure to pay required premium;

• my request to cancel coverage; or

• any other termination event described in the group policy.

Dependent coverage terminates when:

• the dependent no longer qualifies as an eligible dependent;

• my Member coverage terminates;

• required premium is not paid; or

• another policy termination event occurs.

I am responsible for promptly notifying Union One whenever a dependent becomes ineligible. Continued premium payment does not create coverage for an ineligible dependent.

13.10 Claims and Proof of Loss

Benefits are payable only after Sun Life receives satisfactory proof that coverage was in force on the date the Covered Condition occurred, the Covered Condition satisfies the policy definition, all policy waiting periods and benefit requirements have been met, and all required medical documentation has been provided. Diagnosis outside the United States, Canada, or Mexico may require confirmation in accordance with the policy before benefits are payable. Payment of one benefit does not guarantee payment of any future claim.

14. Claims, Participant Responsibilities, and Carrier Review

14.1 Carrier Authority and Policy Control

All eligibility determinations, coverage approvals, benefit calculations, premium determinations, claim decisions, and policy interpretations are subject to the terms, conditions, limitations, exclusions, and provisions of the applicable group insurance policy and applicable law. Final authority regarding claim determinations and benefit eligibility rests with the applicable insurance carrier, subject to any appeal rights required by the policy or applicable law. Union One assists with Plan administration, premium administration, member service, and claim support, but does not replace the insurance carrier's claim authority.

14.2 General Claim Eligibility Responsibilities

If my date of disability, date of death, or date of covered loss occurs before the applicable coverage effective date, it will not be covered. I must remain eligible for coverage, satisfy all applicable policy requirements, and pay all required premium and fees through the applicable date of disability, date of death, or date of covered loss. Nothing in this section supersedes the group policy. For questions or assistance at any stage of the claims process, I may contact the IUPAT VIP Customer Service Center at (224) 357-7880.

Claim eligibility depends not only on my medical, loss, income, or beneficiary documentation, but also on my continued eligibility for coverage, payment of required premiums and fees, and compliance with the eligibility notification requirements described in Section 2.

14.3 Disability Claims - Short-Term Disability, Long-Term Disability, Accident and Critical Illness

I must contact Union One at (224) 357-7880 as soon as possible after my disability begins. Written notice should generally be given within twenty (20) days after the date my disability begins for STD claims, and within thirty (30) days for all other claims subject to state qualifiers. Written proof of claim must be submitted to Sun Life no later than ninety (90) days after my Elimination Period ends, subject to the policy and applicable law.

I may be required to complete Union One's claim form and provide or authorize access to:

- W-2s, recent pay stubs, tax records, or other income documentation;
- documentation showing my last day worked;
- medical, pharmacy, Explanation of Benefits, employment, and other records Sun Life requests; and
- any further records or information requested by Sun Life during claim review.

Delays in obtaining records — including delays by my providers — may delay Sun Life's claim decision and any benefit payments.

To be approved, I must meet the applicable definition of disability, satisfy the Elimination Period, be under the regular care of a doctor, submit proof satisfactory to Sun Life, and meet all other policy requirements. STD and LTD have different definitions, formulas, elimination periods, durations, deductible-income rules, and claim requirements.

Being under the regular care of a licensed physician or other qualifying provider is a mandatory, ongoing requirement — not only when I file a claim, but throughout the period I seek or receive benefits. My claim may be denied, delayed,

suspended, or terminated if I am not under regular care, do not receive care as often as medically required, do not follow appropriate treatment recommendations, or do not provide proof of continuing disability satisfactory to Sun Life.

If my disability begins within twelve (12) months of my coverage effective date or within twelve (12) months of any coverage increase, Sun Life may conduct a pre-existing condition review. As part of that review, I may be required to provide complete medical records from providers I saw during the three (3) month look-back period (even if unrelated to my current condition), Explanation of Benefits statements, pharmacy and prescription records, and any other records Sun Life requests.

If I provided income during enrollment that is higher than what I actually make, my benefit cannot exceed the percentage of income I can prove at claim, based on the policy's income definition. I will not receive benefits on overstated income.

Verification of hours worked may be required when I file a claim. Not meeting the minimum hours requirement may make me ineligible for benefits. I must notify Union One immediately if my earnings change or if I no longer meet the minimum hours requirement; failure to do so may result in loss of premium, loss of eligibility, or claim denial.

My disability benefit may be reduced by offsets from other income sources described in the policy. I may be required to apply for other benefits I may be eligible for, report all such income, and repay any overpayments I receive — even if the overpayment was not my fault.

Premium obligations may differ by coverage while I am on claim. STD contributions may continue while I receive STD benefit payments. LTD contributions may not be required while I receive LTD benefit payments. I should review the policy booklet and contact Union One with questions.

If I receive an overpayment, improperly paid benefit, premium credit, premium refund, or any payment to which I am not entitled, I may be required to repay it. To the extent permitted by the group policy and applicable law, I authorize Union One, the Plan Administrator, and the insurance carrier to recover overpayments, missed premium, premium shortfalls, or premium owed through benefit offsets, premium adjustments, direct reimbursement requests, refund offsets, collection activity, or other lawful means.

I must notify Union One and Sun Life immediately if I return to work in any capacity, receive disability earnings, begin receiving any deductible source of income, or experience any change that may affect my claim or benefit amount.

Reporting Side Work and Other Work Activity During a Disability Claim. Any work or work activity during a period of claimed disability — paid or unpaid — must be reported immediately to Union One and Sun Life. This includes side work, second jobs, rideshare or delivery work, gig work, self-employment, 1099 work, cash work, freelance work, contract work, family business work, and volunteer work consistent with my regular occupation. Such work may show ability to perform my regular occupation (during the own-occupation period) or any gainful occupation (after the Section 7.3 transition), may reduce or terminate benefits, may result in claim denial, and may result in overpayment recovery. Failure to report or misrepresentation may be treated as fraud under the policy and applicable law.

Burden of Proof for Date of Disability; Backdated Records. The burden is on me to prove the date my disability began. If my claimed date of disability is at or near the date my coverage ended, lapsed, or was rescinded, I must prove by contemporaneous documentation — medical records, doctor's notes, treatment records, pharmacy records, employment records, payroll, time records, and other evidence created during the relevant period — that my disability began while coverage was in force.

Sun Life may give less weight to, or reject, medical opinions, doctor's notes, or attestations generated after coverage ended if they are inconsistent with contemporaneous records, lack supporting clinical findings, are not based on contemporaneous examination of me, or are otherwise unreliable. Backdated disability dates not supported by contemporaneous evidence may result in claim denial.

Independent Medical Examinations and Cooperation. As a condition of receiving and continuing STD or LTD benefits, I must cooperate fully with Sun Life's claim review. I must attend Independent Medical Examinations (IMEs), Functional Capacity Evaluations (FCEs), vocational evaluations, and other examinations requested by Sun Life at its expense, in a reasonable location and at a reasonable time. I must sign authorizations for release of medical, pharmacy, EOB, employment, income, and other records Sun Life requests. Refusal to attend a requested examination, refusal to sign authorizations, missed appointments without good cause, refusal to provide records, or other failure to cooperate may result in denial, suspension, or termination of benefits.

Other Disability Determinations Do Not Bind Sun Life. The Social Security Administration, state disability agencies, workers' compensation programs, the VA, and other public or private disability programs use different definitions and standards than the group policy. Approval (or denial) of SSDI, state disability, workers' compensation, VA disability, or any other disability benefit does not entitle me to (or preclude) STD or LTD benefits under this Plan and does not bind Sun Life's evaluation of my claim. I may still be required under the policy to apply for and pursue other benefits as offsets.

Death During a Pending or Approved Disability Claim. If I die while a disability claim is pending or while receiving disability benefits, any STD or LTD benefits accrued and owed for periods before my death may be payable to my estate or designated representative under the group policy. The Life Insurance death benefit is a separate claim under Sections

9 and 12.4. Disability benefits do not continue past the date of death. My beneficiary or personal representative should notify Union One of the death promptly.

If my claim is denied, I may have the right to appeal in writing to Sun Life within the timeframe stated in the denial notice and policy booklet, generally within one hundred eighty (180) days. Union One can help me understand the process, but Sun Life decides claims and appeals.

14.4 Life Insurance and AD&D Claims

To file a Life Insurance or AD&D claim, I or my designated beneficiary should contact Union One at (224) 357-7880 without delay. Required documentation may include a completed claim form, certified death certificate for Life or AD&D death claims, documentation of the accidental loss for AD&D claims, income documentation if needed to verify the elected benefit amount, beneficiary documentation, and any other information requested by Sun Life. Proof of loss must be submitted within the timeframe required by the policy and applicable law.

Member Life coverage is subject to the policy maximums, including the lesser of 500% of my verifiable annual earnings or $500,000. If the amount I elected is based on annual earnings I cannot substantiate when required, the payable benefit may be adjusted according to the policy. Member AD&D coverage generally corresponds to my approved Member Life amount and is subject to the AD&D policy terms, limits, and exclusions.

For Life Insurance exclusions, including the suicide exclusion, see Section 9 and the Life Insurance policy booklet. For AD&D covered losses, additional AD&D benefits, and AD&D exclusions, see Section 11 and the AD&D policy booklet.

Missing or Presumed Dead Member. Proof of death for a Life or AD&D claim ordinarily requires a certified death certificate. If I am missing and no certified death certificate is available, a Life or AD&D claim cannot be paid until proof of death satisfactory to Sun Life is provided. This generally requires a court order declaring me legally dead under applicable state law, a death certificate issued under a presumption-of-death statute, or other documentation acceptable to Sun Life. Premium remains due during any missing-person period to maintain coverage; failure to pay premium during that period may result in lapse under Section 18.2 before death is established. If the date of death is later established, premium collected after that date will be treated under Section 18.4.

14.5 Complaints and Inquiries

If I have a question, concern, or complaint regarding the Plan, I should first contact Union One at info@unionone.com or (224) 357-7880. Union One will work in good faith to address administrative complaints, billing concerns, enrollment issues, and other matters within Union One's administrative authority.

Claim-related complaints, including disagreements with a claim or appeal determination, should be directed to Sun Life under the claim appeal procedures described in Section 14.3 and the policy booklet, and ultimately under any applicable carrier appeal and external review rights.

If my complaint is not resolved to my satisfaction through Union One or Sun Life, I may have the right to file a complaint with the insurance regulator of the state in which I reside or in which the group policy is filed. State insurance regulators oversee both the insurance carrier and the Third-Party Administrator licensed in their state. Contact information for state insurance regulators is generally available at the website of the National Association of Insurance Commissioners (www.naic.org) and at my state's insurance department website.

15. Communication Acknowledgement

By enrolling in the IUPAT VIP Plan, I consent to the use of electronic records, electronic signatures, electronic enrollment, and electronic delivery of notices, disclosures, communications, policy documents, billing notices, premium notices, lapse notices, renewal notices, claim-related communications, and other records relating to the Plan, to the extent permitted by applicable law.

Post-Enrollment Email Confirmation. Following my submission of enrollment, Union One will send a confirmation email to the email address on file that includes a copy of these Plan Terms and Conditions and a summary of my coverage elections, premium, beneficiary designations, and other enrollment details. Delivery of this email to the address on file is effective delivery, whether or not I open it. I am responsible for reviewing the confirmation email promptly and for contacting Union One at info@unionone.com or (224) 357-7880 if any information is incorrect or if I did not receive the email. The current Plan Terms and Conditions and related Plan materials are also available at https://iupatvip.com/plan-termsandconditions/.

Electronic communications may be sent by email, text message, enrollment platform, member portal, or other electronic delivery method used by Union One or its authorized service providers. I am responsible for keeping my email address, mailing address, telephone number, and other contact information current.

By providing my cell phone number and email address, I am opting in to receive periodic text messages, emails, and electronic communications from Union One regarding the Plan's benefits, renewals, open enrollments, claims, eligibility, payment status, lapse risk, cancellation notices, administrative notices, and periodic union or Plan updates. Data we

collect about text message notifications may include my cell phone number, cell phone carrier, the date, time, and content of messages, and other information I provide.

Privacy, Data Use, and Information Authorization. By enrolling and participating in the Plan, I authorize Union One, the insurance carrier, the policyholder, and their respective authorized service providers, agents, and contractors to collect, use, store, disclose, and share my personal information, contact information, employment information, financial information (including ACH and payment information), beneficiary information, and (for disability or other medical claims) my medical, pharmacy, treatment, and health information, to the extent reasonably necessary to: enroll me in the Plan; administer the Plan and my coverage; verify my eligibility; bill, collect, and refund premium; adjudicate, pay, and audit claims; prevent, detect, and investigate fraud and abuse; comply with applicable law and regulatory requests; and exercise any rights under the Plan, the group policy, and these Terms.

Collection, use, and disclosure of my information are subject to applicable federal and state privacy laws, including, where applicable, the Health Insurance Portability and Accountability Act (HIPAA), the Gramm-Leach-Bliley Act, state insurance information and privacy protection acts, and state consumer privacy laws. To the extent required for claim adjudication and Plan administration, I authorize my health care providers, prior insurers, employers, financial institutions, and government agencies to release my information to Union One and the insurance carrier upon request. Union One maintains administrative, technical, and physical safeguards designed to protect the confidentiality of my information consistent with applicable law and industry practice.

I can cancel text and email notifications at any time by contacting Union One. Message and data rates may apply. Union One will not be liable for delays in receiving text or email messages, as delivery is subject to effective transmission by my mobile carrier, email provider, or internet service provider. By subscribing to or using the service, I acknowledge and agree that Union One may change and/or terminate the service at any time, with or without cause and/or advance notice.

Opting out of text or email communications does not remove my obligation to remain informed about my eligibility, coverage, premium payments, renewal changes, claim responsibilities, or policy deadlines.

Electronic systems used for the Plan — including websites, enrollment platforms, payment platforms, communication systems, email, text messaging, mobile services, member portals, and electronic document delivery systems, may be temporarily unavailable due to maintenance, technical issues, cybersecurity events, transmission failures, banking interruptions, or third-party service disruptions. I remain responsible for timely reviewing Plan communications, maintaining current contact information, paying required premiums, and contacting Union One directly if I believe I have not received an expected notice, confirmation, or billing communication.

16. Data Privacy, Plan Administration, and Third-Party Service Providers

Administration of the IUPAT VIP Plan requires Union One Benefits Administration, Inc., the applicable insurance carrier, and their authorized administrators, payment processors, technology vendors, communication platforms, service providers, and affiliated entities to collect, use, store, process, and disclose information necessary to administer my coverage, premium payments, eligibility, communications, claims support, and other Plan-related services.

This information may include personal information, contact information, union and employment information, premium and payment information, dependent information, claim-related information, and health-related information when necessary for eligibility review, claim administration, carrier review, billing, payment processing, member service, compliance, reporting, or other lawful Plan administration purposes.

I authorize Union One, the applicable insurance carrier, and their authorized vendors and service providers to use and disclose such information as reasonably necessary to administer the Plan, process premiums, support claims, verify eligibility, communicate with me, comply with applicable law, and enforce Plan terms.

Union One may use third-party vendors, administrators, payment processors, communication platforms, software providers, cloud storage providers, mailing vendors, enrollment platforms, and other service providers for administration of the Plan. These vendors may receive or process information as necessary to perform services for the Plan, subject to applicable law and contractual or administrative requirements.

17. ACH Authorization, Draft Dates, and Payment Information

17.1 ACH Authorization

I authorize Union One Benefits Administration, Inc. ("Union One") to electronically debit and credit my designated deposit account at my designated depository financial institution (my "Bank Account") via ACH and, if applicable, to correct debits and credits via ACH.

Bank Account Must Belong to the Member; No Third-Party Rights. I represent that the Bank Account I designate is an account I own or jointly own and am authorized to use to pay premium. If premium is paid from an account that does not belong to me — including a spouse, domestic partner, parent, child, employer, union, or other third party — that third party acquires no rights of any kind under the group policy or these Terms. A third-party payer is not a Member, insured,

or beneficiary, has no right to refund or claim, no standing to make or appeal a claim, no right to information about my coverage, and no right to direct, change, cancel, or continue coverage. All coverage, refund, claim, beneficiary, and information rights remain solely with the eligible Member.

Personal Authorization Required; Third-Party Enrollment Is Void. Enrollment, eligibility attestations, coverage elections, beneficiary designations, and ACH authorizations must be made personally by the Member. Any of these actions completed by someone else — spouse, domestic partner, child, family member, friend, employer or union representative, or any third party — without the Member's personal authorization is void. Coverage obtained through such unauthorized action is void from the original effective date, premium is refunded under Section 18.4, and no claim entitlement is created. Personal authorization includes the use of credentials, secure links, or other authentication methods established by Union One for the Member's use.

On the closest Business Day to the date of my selected draft, Union One may process debit entries to my account. Debits and credits may not necessarily occur every Business Day. "Business Day" means Monday through Friday, excluding federal banking holidays.

This authorization remains in effect until I notify Union One in writing that I wish to revoke it. I can do this by emailing info@unionone.com or mailing notice to 28160 W. Northwest Hwy., Suite 203, Lake Barrington, IL 60010. Revocation requires at least thirty (30) days' notice before my next payment date.

If I cancel this authorization, I may no longer have access to my Union One account or the services provided by this Plan, except as expressly provided in these Terms or the policy. Cancellation of ACH authorization does not cancel any unpaid premium obligations already incurred.

Revoking ACH Does Not Cancel Coverage; Coverage May Lapse Without an Active Payment Method. Revoking my ACH authorization does not by itself cancel my coverage and does not waive my premium obligations. If I do not set up another Union One-approved payment method before my next scheduled premium, my premium will not be paid. My coverage will enter the grace period described in Section 18.2 and may lapse or terminate for non-payment. Reinstatement after lapse, if available, is subject to the rules in Section 18.2.

If I want to cancel coverage in addition to revoking ACH, I must separately request cancellation of coverage. Cancellation of coverage is governed by Section 18.4 and is prospective only (it takes effect going forward, not backward).

ACH Files Already in Flight. An ACH debit entry that has already been submitted to the originating financial institution before my cancellation or ACH revocation takes effect under Section 17.1 or Section 18.4 may still settle. The resulting payment is treated as premium paid for the period through the cancellation or revocation effective date. Any premium collected for periods after the cancellation or revocation effective date is refunded under Section 18.4, less non-refundable fees.

Bank Disputes, Chargebacks, and ACH Reversals; Recovery and Legal Action. I authorize ACH drafts under Section 17.1 as the contractual method of paying premium for coverage I have personally elected. If I initiate a dispute, chargeback, ACH reversal, or other return of any premium draft with my bank or financial institution, the following consequences apply:

- The reversed amount is treated as unpaid premium as of the original draft date, and my coverage may retroactively enter the grace period described in Section 16.2 or lapse for non-payment as of that date.
- Any claim paid, benefit paid, or service provided by Union One, the Plan Administrator, the insurance carrier, or any vendor for periods covered by the reversed premium may be recovered as an overpayment under Section 14.3 and the group policy, including through benefit offsets, direct reimbursement demands, collection activity, and litigation.
- A bank dispute, chargeback, or ACH reversal is not a substitute for cancelling coverage under Section 18.4 and does not retroactively cancel coverage. Coverage was in force during the periods for which premium was originally drafted, and the dispute does not undo that coverage or the carrier's exposure during those periods.
- If I initiated a dispute, chargeback, or reversal of premium drafts that I personally authorized, after coverage was provided to me in good faith — particularly if the dispute is initiated after a claim has been filed, after a claim has been denied, after coverage has been used, or otherwise to recover premium for periods during which coverage was in force and I had the benefit of coverage — the dispute is not a permissible mechanism for obtaining a refund and may constitute breach of contract, wrongful conversion, unjust enrichment, or insurance fraud, subject to applicable law.
- Union One, the Plan Administrator, and the insurance carrier reserve all rights to pursue legal action to recover reversed premium for periods during which coverage was in force, any claim payments or benefits paid during those periods, costs of collection, court costs, attorneys' fees to the extent permitted by applicable law, and pre- and post-judgment interest. Such action may include civil collection, set-off against any other amounts owed to me, referral to credit reporting agencies to the extent permitted by law, and referral to state and federal authorities for investigation under applicable insurance fraud, wire fraud, electronic funds transfer, and consumer protection statutes.
- Repeated reversals, reversals coordinated with claim activity, or reversals inconsistent with my prior authorizations may also be grounds for rescission of coverage under Section 1 or Section 19, denial of pending claims, recovery of paid claims, and reporting to the insurance carrier's special investigations unit.

If I believe a premium draft was unauthorized, was processed in error, or should not have been collected, the proper remedy is to contact Union One directly at (224) 357-7880 or info@unionone.com to request review and, where appropriate, a refund under Section 18.4. I will not use my bank's dispute process as a substitute for working with Union One.

Premium rates and benefits may change at or before renewal as agreed upon by the union group policyholder and the insurance carrier. The premium rates for elected coverages may be determined by age and may increase over time as I get older. If group policy or premium adjustments occur, I authorize Union One to update my account and adjust ACH payments for continued coverage, unless I timely cancel or reduce coverage as permitted by the policy and administrative rules.

"UNIONHUB PYMT" will appear on my bank statements, and my monthly or bimonthly costs for elected benefits will be deducted on the day(s) I selected when enrolling, subject to banking holidays and processing rules.

In addition to any other representations and warranties in these Terms, I represent that: (a) my browser is equipped with at least 128-bit security encryption; (b) I am capable of printing, storing, or otherwise saving a copy of this electronic authorization for my records; and (c) the ACH transactions I authorize are for benefits for which I am eligible and have personally chosen and elected.

17.2 Draft Date Changes and Payment Restrictions

- I may only change my elected draft date(s) once within any twelve (12) month period. If I choose to update my draft date(s), I will not be eligible to make another draft date change until twelve (12) months have passed from the effective date of the prior change.
- Payments may not be deferred from the current month to a future month. Timely payment is required to avoid termination of coverage due to non-payment.
- Draft date change requests are subject to Union One administrative review and approval. To be considered, my account must be current, my member and coverage status must be confirmed in Union One's system of record, and the requested change must comply with Union One's administrative rules. A draft date change may not move a current-month premium obligation into a future month. Same-month draft date change requests must be received with sufficient business-day processing time before the requested draft date. Requests involving a pending claim, unclear status, unavailable system records, inconsistent records, or an exception request may require escalation and may not be approved immediately.
- A one-time payment or one-time ACH shift payment may be used only if permitted by Union One's administrative rules. A one-time payment or one-time ACH shift payment does not automatically change my recurring draft schedule unless Union One separately approves and records a recurring draft date change.
- If my scheduled ACH draft results in an overdraft of my bank account, Union One is not responsible for overdraft fees, insufficient funds charges, returned item fees, or any other related fees assessed by my financial institution.
- Union One is not responsible for overdraft fees, insufficient funds charges, delayed payments, rejected transactions, bank processing errors, payment processor errors, or other actions or fees imposed by my financial institution or payment processor for authorized ACH activity, except to the extent caused by Union One's gross negligence or willful misconduct.
- If I have questions regarding draft date(s) or payments, I should contact Union One's Billing Department at 847-387-3564.

18. Premiums, Renewals, Grace Periods, Fees, and Refunds

18.1 Renewal Notice and Auto-Enrollment

This is a group insurance plan offered through the union. At renewal, rates and benefits may change, coverage options may change, or the Plan may be non-renewed based on overall claims experience, participation requirements, underwriting requirements, changes in group demographics, carrier requirements, union decisions, or other circumstances permitted by the group policy and applicable law. Changes to rates may also occur at any time during the policy term if deemed necessary to protect the long-term sustainability of the Plan. Any mid-policy or mid-rate-guarantee rate increase must be approved by the insurance carrier and the policyholder (the union).

I understand, agree, and authorize Union One to increase my monthly premium when approved rate changes occur so that I may remain enrolled in the same benefit elections I am enrolled in at the time of the rate increase. I further understand that I may reduce or cancel coverage at any time, subject to the policy and administrative rules, but I may only add coverage or increase coverage during an approved open enrollment period or other approved enrollment opportunity.

18.2 Failure to Make a Payment

Participating Members may miss a premium payment from time to time. The current Plan allows a sixty (60) day grace period for Life, LTD, and STD, and a thirty-one (31) day grace period for Accident and CI to make up missed premium

payments. Failure to pay required premiums within the allowed grace period may result in lapse or termination of coverage. A claim arising after coverage has lapsed or terminated for non-payment may be denied. If a claim arises during a grace period, any unpaid premium may be deducted from benefits or otherwise required to be paid, subject to the policy.

If a premium payment fails, is returned, is rejected, or remains unpaid, Union One may send payment reminders, delinquency notices, pending lapse notices, final warning notices, lapse confirmations, ACH failure notices, reinstatement confirmations, or other payment-related communications by email, U.S. mail, text message, member portal, or other delivery method permitted by these Terms, administrative procedures, the group policy, and applicable law. I am responsible for keeping my mailing address, email address, telephone number, and banking information current. Failure to receive, open, or read a notice does not waive my responsibility to pay required premiums on time or maintain current payment information.

If my coverage lapses or terminates for non-payment, any payment submitted or received after the lapse or termination date will not automatically reinstate coverage. Reinstatement, if available, is subject to the group policy, carrier approval, Union One administrative rules, payment of all required amounts, eligibility verification, and any other applicable requirements.

18.3 Administrative and Transaction Costs

All administrative and transaction fees are included in my monthly costs. These include:

- $2 technology fee included in all STD and LTD monthly costs;
- $1 technology fee included in all Member Life and Spouse/Domestic Partner Life monthly costs;
- $2 technology fee per line of coverage included in all Accident and Critical Illness monthly costs; and
- $1.00 Payment Transaction Fee each time a payment is collected.

These fees cover costs associated with, including but not limited to, premium processing, premium returns, postage, policy correspondence, claims advocacy, and other ancillary administrative expenses associated with administering my elections. These monthly fees apply to all coverages shown on the Summary of Benefits & Rates. Technology and transaction fees are non-refundable. Administrative and transaction costs, including technology fees and Payment Transaction Fees, may change at any time. I understand, agree, and authorize Union One Benefits Administration to adjust my monthly or bimonthly ACH deduction accordingly when these changes occur so that I will remain covered by the benefit elections I am enrolled in at the time of the administrative or transaction cost change.

18.4 Refund Policy

I must promptly notify Union One of any change in status that affects my union membership, dues, employment, active work status, or eligibility. Qualifying events include:

- resignation, dismissal, or termination;
- employer closure or loss of the IUPAT CBA;
- layoff, retirement, or disability;
- FMLA leave, other leave of absence, military leave, or strike;
- leaving the union or loss of full dues-paying status;
- improper enrollment or loss of covered class status; and
- any other status change that ends active union membership or covered employment.

The 90-Day Refund Framework. To be eligible for a premium refund, I must notify Union One within ninety (90) days of the qualifying event. Notifications within the 90-day window result in a refund of eligible premium paid after the qualifying event, less non-refundable technology and transaction fees, and subject to policy terms and administrative review. Notifications submitted after the 90-day window result in forfeiture of the standard refund.

Right to Appeal Late Refund Requests. Appeal rights exist for refund requests received after 90 days. Appeals are reviewed case-by-case based on the facts, my communications with Union One, Plan terms, policy requirements, applicable law, and any supporting documentation. Appeals must be submitted in writing by USPS mail and must include documentation of the date I became ineligible and my last day worked (such as pay stubs, an employer or union letter, or a termination or layoff notice).

Improper Enrollment. Members who improperly enroll are subject to the same refund rules. Improper enrollment includes providing inaccurate information, failing to meet membership/work/employment requirements, enrolling while ineligible, failing to disclose ineligibility, or violating union membership policies.

To submit a notification or for questions, contact the IUPAT VIP Customer Service Center at (224) 357-7880 or info@unionone.com. All transaction and technology fees are non-refundable.

Master Refund Rule; Resolution of Apparent Conflicts. This Section 18.4 is the master refund rule for the Plan. Where any other section of these Terms (Section 1, Section 2.2, Section 10, or any other) references a refund of premium, that reference is governed by and limited by this Section 18.4 and the group policy. The framework is:

- **Rescission for member misrepresentation or fraud.** If coverage is rescinded under Section 1 or Section 19 for false statements, misrepresentations, or fraud, refund is limited to what the group policy and applicable law require, less non-refundable fees. The carrier may retain premium or seek other remedies permitted by law. The 90-day refund cap does not give a Member who engaged in misrepresentation or fraud a more generous refund.
- **Rescission for innocent ineligibility (member or administrative error).** If coverage is rescinded under Section 1 (innocent member mistake) or Section 1.1 (administrative error without member fault), premium refund follows the 90-day framework above, with appeal rights for additional refund. A Member or beneficiary is not entitled to a full refund of all premium ever paid solely because coverage is rescinded.
- **Loss of ongoing eligibility.** If I or a covered dependent lose eligibility under Section 2.2 or Section 10 (divorce, loss of dependent status, employer closure, drop in hours, leaving the union, retirement, or any other status change), premium refund follows the 90-day framework above, with appeal rights for additional refund.
- **Post-death premium collection.** Premium collected after a Member's death (because the death has not been reported) is refunded under the 90-day framework, with appeal rights for additional refund. Consistent with Section 9.6, post-death premium does not extend coverage, create new coverage, or increase any benefit.
- **Voluntary cancellation is prospective only.** Voluntary cancellation takes effect on the date Union One processes the request or the next premium draft date, whichever is later. Coverage cannot be cancelled retroactively, and premium paid for periods of valid, in-force coverage will not be refunded based on a later decision that the coverage was unnecessary, unused, or unwanted. Refunds in voluntary cancellation are limited to premium paid for periods after cancellation takes effect, less non-refundable fees.
- **Death before voluntary cancellation takes effect.** If I request cancellation but die before it takes effect, my coverage was in force at my date of death and the Life Insurance death benefit, if any, is payable to my beneficiary under Section 9, subject to any unpaid premium. A pending cancellation request does not retroactively defeat benefits payable for a death while coverage was in force.
- **Non-refundable items.** Technology fees, Payment Transaction Fees, and other administrative or transaction fees under Section 18.3 are non-refundable, except where required by applicable law.

In the event of any apparent conflict between this Section 18.4 and another section regarding premium refund, this Section 18.4 controls, subject only to the group policy and applicable law.

19. Misrepresentations, Incontestability, and Premium Adjustments

Statements made in my enrollment or application are representations. If any statement is incomplete, inaccurate, or untrue when made, the insurance carrier may reduce or deny a claim, cancel coverage from the original effective date, or make a fair adjustment of premium, subject to the policy and applicable law.

Union One, the Plan Administrator, and the applicable insurance carrier may rely on the accuracy and completeness of all information I provide during enrollment, eligibility verification, premium administration, claim submission, appeal review, and other Plan-related activities.

The policy may include incontestability provisions. Incontestability rules do not give me a right to benefits for which I was never eligible, do not excuse fraud or misrepresentation where permitted by law, and do not eliminate my responsibility to promptly report changes affecting eligibility.

Union One and the applicable insurance carrier reserve all rights available under the group policy, these Terms and Conditions, applicable law, equity, and administrative procedures, including the right to investigate eligibility, request supporting documentation, verify employment, dues, union, dependent, income, and membership status, recover overpayments, correct administrative errors, adjust premiums, terminate or rescind coverage where permitted, and enforce Plan provisions.

20. Amendment, Modification, Termination, and No Guarantee of Continued Coverage

The IUPAT VIP Plan, these Terms and Conditions, premium rates, administrative procedures, eligibility requirements, benefits, limitations, exclusions, participating carriers, vendors, enrollment rules, payment procedures, administrative fees, and related Plan practices may be amended, modified, suspended, discontinued, or terminated at any time by the applicable policyholder, insurance carrier, sponsor, or administrator, subject to the group policy and applicable law.

Any such change will become effective on the date determined by the applicable policyholder, insurance carrier, sponsor, or administrator, subject to any notice required by the group policy or applicable law. Continued participation in the Plan after the effective date of a change constitutes acceptance of the revised Terms and Conditions, revised administrative procedures, revised premiums, revised fees, or revised Plan rules, as applicable. When required, notice of changes will be provided, and updated Plan Terms and Conditions, policy booklets, and related Plan materials will be made available at https://iupatvip.com/plan-termsandconditions/.

Enrollment in the Plan does not guarantee continued eligibility, continued participation, future renewability, continued premium rates, continued administrative fees, continued availability of any specific coverage option, benefit amount, carrier, vendor, or program feature. Nothing in these Terms and Conditions creates a vested right to continued coverage, specific benefits, premium rates, eligibility status, or continued participation in the Plan.

If there is any conflict between these Terms and Conditions and the applicable group insurance policy, certificate, booklet, endorsement, state-specific requirement, or applicable law, the group policy and applicable law will control.

Severability. If any provision of these Terms and Conditions is held to be invalid, unenforceable, or unlawful by a court of competent jurisdiction or by operation of applicable law, that provision will be modified to the minimum extent necessary to make it valid, enforceable, and lawful, or, if it cannot be so modified, will be severed from these Terms and Conditions. The remaining provisions of these Terms and Conditions will continue in full force and effect.

Anti-Assignment. My rights and obligations under these Terms and Conditions, and my coverage under the Plan, are personal to me and may not be assigned, transferred, pledged, or otherwise disposed of, except to the extent expressly permitted by the group policy (for example, designation of beneficiaries under Section 9.6 or conversion rights under Section 9.4). Any purported assignment in violation of this provision is void.

No Third-Party Beneficiary. These Terms and Conditions are entered into for the benefit of Union One, the insurance carrier, the policyholder, and me. No other person or entity has any rights as a third-party beneficiary under these Terms and Conditions, except to the extent the group policy or applicable law expressly provides otherwise (for example, beneficiaries of Life Insurance proceeds under Section 9.6, who claim rights under the group policy rather than as third-party beneficiaries of these Terms and Conditions).

Successors and Assigns. These Terms and Conditions are binding upon and inure to the benefit of Union One, the insurance carrier, the policyholder, and their respective successors and permitted assigns. Union One may assign or transfer its rights and obligations under these Terms and Conditions to a successor Third-Party Administrator or other entity approved under the group policy and applicable law without my consent, provided that the successor or assignee assumes Union One's obligations under these Terms and Conditions. The change of insurance carrier, if any, is governed by the group policy and not by this provision.

21. Contact Information

Purpose	Contact
IUPAT VIP Customer Service Center	(224) 357-7880 | info@unionone.com
Union One Billing Department	847-387-3564
Written ACH Revocation / Notices	Union One Benefits Administration, Inc., 28160 W. Northwest Hwy., Suite 203, Lake Barrington, IL 60010 | info@unionone.com
Sun Life Conversion Application	1-800-786-5433 | Contract Number 259136-1-G | Monday-Friday, 8:00 a.m. to 8:00 p.m. Eastern Time
Sun Life State-Specific Requirements	https://www.sunlife.com/us/en/employers/products-and-services/paid-family-medical-leave/ | 1-800-638-5433

22. Member Acknowledgement

By completing enrollment and accepting these Terms and Conditions, I acknowledge that I have reviewed, understand, and agree to the Terms and Conditions applicable to the IUPAT VIP coverage(s) I elected. These Terms and Conditions are part of the enrollment receipt and administrative acknowledgement process and do not replace the group policy, certificate, booklet, endorsements, or applicable state-specific requirements.

I further acknowledge that I am responsible for maintaining eligibility, paying required premiums, keeping my ACH authorization current, reviewing Plan communications, notifying Union One of any change affecting eligibility, and complying with all claim, conversion, reinstatement, and administrative deadlines.

Opportunity to Review; Affirmative Opt-In. I acknowledge that I have been given the opportunity to read these Plan Terms and Conditions in full before submitting my enrollment, to ask questions, and to decline to enroll if I do not agree. I am opting in to participation in the IUPAT VIP Plan by affirmatively checking the acknowledgment box(es) presented at enrollment and submitting my enrollment. I am not required to enroll in the Plan, and my enrollment is voluntary.

Electronic Signature and Acknowledgment. I agree that my electronic acknowledgment of these Plan Terms and Conditions, completed by checking the acknowledgment box(es) at enrollment and submitting my enrollment, has the same legal effect as a handwritten signature under the federal Electronic Signatures in Global and National Commerce Act (E-SIGN), the Uniform Electronic Transactions Act (UETA), and other applicable law. My electronic acknowledgment, together with the enrollment record retained by Union One under Section 1.1, constitutes a valid and enforceable acknowledgment of these Terms and Conditions.

Post-Enrollment Email Copy. I acknowledge that, following submission of my enrollment, Union One will send a confirmation email to the email address on file that includes a copy of these Plan Terms and Conditions and a summary of my coverage elections, as described in Section 15. The current Plan Terms and Conditions and related Plan materials

are also available at https://iupatvip.com/plan-termsandconditions/. I am responsible for reviewing the confirmation email promptly and for contacting Union One if any information is incorrect.