HSTA VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION TRUST

VOLUNTARY BENEFITS

May 2019

IMPORTANT

In this booklet, we have attempted to explain as briefly as possible the benefits provided to eligible employees and their dependents. The Trust Agreement, Plan Documents, policies, contracts, and rules and regulations adopted by the Board of Trustees are the final authorities in all matters relating to the HSTA Voluntary Employees Beneficiary Association Trust. Copies of these documents are available for you to inspect at the Trust Office during regular business hours.

HSTA VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION TRUST

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TRUSTEES

Romeo Eleno
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John Kometani
Wilfred Okabe
Colleen Pasco
Dawn Raymond
Amber Riel
Roger Takabayashi

CONTRACT ADMINISTRATOR

Benefit Plan Solutions, Inc.
1259 Aala Street, Suite 202
Honolulu, Hawaii 96817

CONSULTANT

Benefit Plan Solutions, Inc.
680 Iwilei Road, Suite 528
Honolulu, Hawaii 96817

LEGAL COUNSEL

Char Sakamoto Ishii Lum & Ching
841 Bishop Street, Suite 850
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INVESTMENT MONITOR

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HSTA VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION TRUST VOLUNTARY BENEFITS

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SUMMARY OF IMPORTANT BENEFIT CHANGES

Several important benefit changes have been made in your Health and Welfare benefits over the past few years. You have been previously notified of these changes and their effective dates. However, as part of our ongoing process to familiarize you with the benefit programs and to comply with Federal Law, the changes have been incorporated in this booklet revision.

Items that have been significantly changed, along with the page number where the complete text of the change is located, are as follows:

BASIC PLUS LIFE INSURANCE PLAN

A. Effective January 1, 2016, Basic Life Insurance amounts and Supplemental Term Life Insurance unit amounts for Class I (Active and Associate Members) were increased as follows:

ATTAINED AGE	AMOUNT OF BASIC LIFE INSURANCE	UNIT AMOUNT OF SUPPLEMENTAL TERM LIFE INSURANCE
Under Age 45	$ 54,000	$ 29,000
Age 45 - 49	$ 44,000	$ 29,000
Age 50 - 54	$ 38,000	$ 29,000
Age 55 - 59	$ 29,000	$ 20,900
Age 60 - 64	$ 21,000	$ 17,400
Age 65 - 74	$ 14,500	$ 8,500
Age 75 and over	$ 5,500	$ 2,500

B. Effective November 1, 2017:

1) Basic Life Insurance amounts for Class I (Active and Associate Members) were increased (page 10).

2) Basic Life Insurance amounts for Class II (Retired Members) were increased (page 11).

3) Spouses of Class II (Retired Members) are eligible for Dependent Term Life Insurance (page 11).

4) Supplemental Term Life Insurance unit amounts for Class I and Class II members were increased (page 11).

CRITICAL ILLNESS INSURANCE

A. Effective January 1, 2014, Critical Illness Insurance is being offered to eligible participants and their dependents through Metropolitan Life Insurance Company (page 23).

ACCIDENT INSURANCE

A. Effective May 1, 2019, Accident Insurance is being offered to eligible participants and their dependents through UNUM Life Insurance Company of America (page 31).

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

PLAN SPONSOR AND ADMINISTRATOR

Board of Trustees
HSTA Voluntary Employees
Beneficiary Association Trust
1259 Aala Street, Suite 202
Honolulu, Hawaii 96817

IDENTIFICATION NUMBERS

Assigned by Internal Revenue Service – Employer Identification Number (EIN) 23-7296050
Assigned by Plan Sponsor - Plan Number 505

TYPE OF PLAN

Welfare - Life Insurance, Short-Term Disability Income Protection Insurance, Long-Term Income Protection Insurance, Critical Illness Insurance, Accident Insurance and Long-Term Care Insurance

TYPE OF ADMINISTRATION

The Board of Trustees has engaged Benefit Plan Solutions, Inc. at 1259 Aala Street, Suite 202, Honolulu, Hawaii 96817 to serve as Contract Administrator for the HSTA Voluntary Employees Beneficiary Association Trust.

AGENT FOR SERVICE OF LEGAL PROCESS

Charlene Acohido
Benefit Plan Solutions, Inc.
1259 Aala Street, Suite 202
Honolulu, Hawaii 96817

Service of legal process may also be made upon a Plan Trustee.

NAME, TITLE, AND PRINCIPAL PLACE OF BUSINESS ADDRESS OF EACH PLAN TRUSTEE

Romeo Eleno
Trustee
HSTA Voluntary Employees
Beneficiary Association Trust
1259 Aala Street, Suite 202
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Gayle Enriquez
Trustee
HSTA Voluntary Employees
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Vice Chair
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Amber Riel
Secretary/Treasurer
HSTA Voluntary Employees
Beneficiary Association Trust
1259 Aala Street, Suite 202
Honolulu, Hawaii 96817

Roger Takabayashi (Retiree)
Chair
HSTA Voluntary Employees
Beneficiary Association Trust
1259 Aala Street, Suite 202
Honolulu, Hawaii 96817

SOURCE OF CONTRIBUTIONS

The funds out of which all Plan benefits and expenses are paid are contributed by: 1) participants through payroll and retirement check deductions and cash payments, 2) investment earnings, and 3) experience refunds.

FUNDING MEDIUM

All contributions are transmitted to the HSTA Voluntary Employees Beneficiary Association Trust and deposited with First Hawaiian Bank in a checking account out of which premium payments are made to the insurance carriers that provide benefits. Funds in excess of those needed for immediate requirements are held in savings accounts, Time Certificates of Deposit, and other investments in accordance with the investment guidelines established by the Board of Trustees.

FISCAL YEAR

September 1st through the following August 31st

AMENDMENT OR ELIMINATION OF BENEFITS AND TERMINATION OF THE PLAN AND THE TRUST

The Trust Agreement for the HSTA Voluntary Employees Beneficiary Association Trust gives the Board of Trustees sole authority to determine eligibility requirements for Plan benefits, the nature and amount of Plan benefits and required contributions for benefits.

The Trust may be amended or terminated by a two-thirds vote of the entire Board of Trustees at meetings duly called or noticed for that purpose.

The termination of the Plan, or any part of the Plan, shall not by itself terminate the Trust.

If Plan benefits are amended or eliminated, participants and beneficiaries are eligible for only those benefits which are available after the amendment or elimination of benefits. **Participants and beneficiaries have the obligation to read all participant and beneficiary notices issued pertaining to the amendment or elimination of benefits.**

Benefits under the Trust are not vested or guaranteed. If the Trust is terminated, participants and beneficiaries have the obligation to read the Summary Plan Description (SPD) and all participant and beneficiary notices issued concerning termination of the Plan and/or the Trust, and once notified, should contact the various insurance carriers for information on conversion to an individual plan.

Upon termination of the Trust, the assets of the Trust may be transferred to another trust for substantially similar purposes. Otherwise, any and all assets remaining shall be first used to satisfy all legal debts of the Trust, and the remaining assets shall be used solely to provide benefits and for expenses of administration incident to providing said benefits as the Plan may provide. Participants and beneficiaries have no right to any remaining assets of the Trust.

GENERAL INFORMATION

WHO IS ELIGIBLE?

To qualify for coverage under the Trust's benefit plans, you must meet the qualifications stated below for each plan. In addition, you must complete and submit the required enrollment forms to the HSTA Voluntary Employees Beneficiary Association Trust Office. Coverage for you and your eligible dependents, if applicable, will be effective on the first day of the calendar month following the receipt of your completed enrollment forms by the Trust Office.

Life Insurance – Basic Plan

- Be an Active, Associate, or Retired HSTA Member.

Life Insurance – Basic Plus Plan

- Be an Active, Associate, or Retired HSTA Member.

Short-Term Disability Income Protection Insurance

- Be an Active HSTA Member, **and**
- Be actively employed in Bargaining Unit 5 in the field of education and working a minimum of 17.5 hours per week.

Long-Term Income Protection Insurance

- Be an Active HSTA Member regularly employed on a scheduled basis and working a minimum of 17.5 hours per week, **or**
- Be an Associate HSTA Member regularly employed by the State of Hawaii, **or**
- Be a regularly scheduled employee of the Hawaii State Teachers Association.

Critical Illness Insurance

- Be an Active HSTA Member regularly employed on a scheduled basis, **or**
- Be an Associate HSTA Member regularly employed by the State of Hawaii, **or**
- Be a regularly scheduled employee of the Hawaii State Teachers Association.

Accident Insurance

- Be an Active HSTA Member and working a minimum of 17.5 hours per week, **or**
- Be an Associate HSTA Member regularly employed by the State of Hawaii and working a minimum of 17.5 hours per week, **or**
- Be a regularly scheduled employee of the Hawaii State Teachers Association and working a minimum of 17.5 hours per week.

Long-Term Care Insurance

- Be an Active, Associate, or Retired HSTA Member, **and**
- Be enrolled and continuously covered as an eligible participant under one or more of the Trust's benefit plans, other than the Long Term Care Insurance Plan.

DEPENDENT COVERAGE

Dependent coverage is available for Life Insurance, Critical Illness Insurance, Accident Insurance and Long-Term Care Insurance. Please refer to those sections for specific details concerning eligibility and enrollment of dependents.

ENROLLMENT APPLICATIONS

To enroll for coverage under the Trust's benefit plans, you must complete and forward to the Trust Office, the documents stated below.

Life Insurance - Basic Plan

- HSTA Voluntary Employees Beneficiary Association Trust Group Life Insurance Enrollment Application form
- Evidence of Insurability (EOI) form when required

Life Insurance - Basic Plus Plan

- HSTA Voluntary Employees Beneficiary Association Trust Group Life Insurance Enrollment Application form
- Evidence of Insurability (EOI) form when required

Short-Term Disability Income Protection Insurance

- HSTA Voluntary Employees Beneficiary Association Trust Short-Term Disability Income Protection Insurance Enrollment form
- Evidence of Insurability (EOI) form when required

Long-Term Income Protection Insurance

- HSTA Voluntary Employees Beneficiary Association Trust Long-Term Income Protection Insurance Enrollment form
- Evidence of Insurability (EOI) form when required

Critical Illness Insurance

- HSTA Voluntary Employees Beneficiary Association Trust Critical Illness Insurance Enrollment Application form
- HSTA Voluntary Employees Beneficiary Association Trust Critical Illness Salary Assignment/Cancellation form

Accident Insurance

- UNUM Benefit Election form

Long-Term Care Insurance

- HSTA Voluntary Employees Beneficiary Association Trust Long-Term Care Insurance Benefit Election form
- Application for Group Long-Term Care Insurance Evidence of Insurability (EOI) form when required

IMPORTANT – NOTIFY THE TRUST WHEN THERE IS A CHANGE IN YOUR PERSONAL OR FAMILY STATUS

It is important to keep the Trust Office informed of any change in your personal or family status or contact information. Be sure to let the Trust Office know if:

- You or a covered family member has a change of name, mailing address or phone number,
- You get married, divorced, or widowed,
- A covered family member dies,
- You wish to add an additional dependent (such as a new baby or an adopted child) or there is a change in the status of a dependent child,

- You become disabled, or
- You wish to change your beneficiary designation for Life Insurance, Short-Term Disability Income Protection Insurance, Critical Illness Insurance, or Accident Insurance.

In addition, if you are covered under the Short-Term Disability Income Protection Insurance Plan or the Long-Term Income Protection Insurance Plan, you must inform the Trust Office of any change in your salary.

PACIFIC GUARDIAN LIFE INSURANCE COMPANY

Life Insurance

BASIC PLAN*

Active, Associate, and Retired HSTA Members are eligible for coverage under the Basic Plan. If you enroll in the Basic Plan, you are covered for life insurance according to the following schedule:

BASIC PLAN	AMOUNT OF INSURANCE
Class I (Active and Associate Members)	
Under 65 years of age	$ 15,000
Age 65 - 69	$ 9,750
Age 70 - 74	$ 6,750
Age 75 - 79	$ 4,500
Age 80 and over	$ 3,000
Class II (Retired Members)	$ 2,000

BASIC PLUS PLAN*

Active, Associate, and Retired HSTA Members are eligible for coverage under the Basic Plus Plan. If you elect coverage, you and your enrolled dependents are covered according to the following schedule:

BASIC PLUS PLAN	AMOUNT OF INSURANCE
Class I (Active and Associate Members)	
Basic Life Insurance	
Under 45 years of age	$ 55,000
Age 45 - 49	$ 45,000
Age 50 - 54	$ 39,000
Age 55 - 59	$ 30,000
Age 60 - 64	$ 22,000
Age 65 - 69	$ 16,000
Age 70 - 74	$ 16,000
Age 75 and over	$ 7,000
Class I Dependent Term Life Insurance	
Spouse	$ 2,500[1]
Children	
At least 14 days old but under 6 months of age	$ 100
At least 6 months old but less than 2 years of age	$ 400
2 years but less than 3 years of age	$ 800
3 years but less than 4 years of age	$ 1,200
4 years but less than 5 years of age	$ 1,600
5 years to 19 years of age (or to 23 years of age if a full time student, or to any age if handicapped)	$ 2,000

[1] Members may elect to purchase up to a maximum of four units of additional Dependent Term Life Insurance for a covered spouse (each unit is equal to $2,500), up to a maximum coverage amount of $12,500. However, the amount of Spouse insurance (Dependent Term Life Insurance and Supplemental Spouse Term Life Insurance combined) may never exceed 50% of the amount of insurance in force for the member.

Class I Supplemental Spouse Term Life Insurance	$ 6,000

BASIC PLUS PLAN	**AMOUNT OF INSURANCE**
Class II (Retired Members)	
Basic Life Insurance	
Under 60 years of age	$ 16,000
Age 60 - 64	$ 12,300
Age 65 - 74	$ 6,900
Age 75 and over	$ 3,000
Class II Dependent Term Life Insurance	
Spouse	$ 1,500

SUPPLEMENTAL TERM LIFE INSURANCE*

Members enrolled in the Basic Plus Plan may also elect to purchase up to **four** units of optional Supplemental Term Life Insurance up to the maximum total coverage amount (Basic Life Insurance and Supplemental Term Life Insurance combined) shown in the schedule below.

SUPPLEMENTAL TERM LIFE INSURANCE	**UNIT OF SUPPLEMENTAL COVERAGE**	**MAXIMUM TOTAL COVERAGE AMOUNT**
Class I (Active & Associate Members)		
Under 45 years of age	$ 30,000	$ 175,000
Age 45 - 49	$ 30,000	$ 165,000
Age 50 - 54	$ 30,000	$ 159,000
Age 55 - 59	$ 22,000	$ 118,000
Age 60 - 64	$ 19,000	$ 98,000
Age 65 - 69	$ 10,000	$ 56,000
Age 70 - 74	$ 10,000	$ 56,000
Age 75 and over	$ 5,000	$ 27,000
Class II (Retired Members)		
Under 60 years of age	$ 10,000	$ 56,000
Age 60 - 64	$ 7,800	$ 43,500
Age 65 - 74	$ 3,300	$ 20,100
Age 75 and over	$ 800	$ 6,200

*Please refer to the Benefit Schedule which you may obtain from the Trust Office for current monthly premium rates.

EVIDENCE OF INSURABILITY

Evidence of insurability in a form prescribed by Pacific Guardian Life will be required if application for insurance is made more than 60 days after a member's eligibility date, or if a member elects to increase Supplemental or Dependent Life Insurance.

DEPENDENT COVERAGE

Dependent Term Life Insurance is available to eligible dependents of Class I and Class II members enrolled in the Basic Plus Plan. **For Class I members (Active and Associate HSTA Members),** eligible

dependents include your legal spouse and unmarried children under 19 years of age. **For Class II members (Retired Members),** only your legal spouse is eligible for Dependent Term Life Insurance.

The term "children" includes your natural child or legally adopted child. Dependent children who are full-time students at an accredited school, college, or university will continue to be eligible for Dependent Life Insurance from 19 years of age through 22 years of age. In order for your dependent child to be covered as a full-time student, you must certify annually, and as requested by the Trust Office, that he or she is a full-time student at an accredited school, college, or university by completing the Student Certification form issued to you by the Trust Office. **Failure to submit the required certification will result in cancellation of the child's coverage.** You are also responsible for promptly notifying the Trust Office, in writing, of any change in your dependent's eligibility status outside the annual certification.

Dependent Life Insurance will be continued in force for a child who, upon attaining 19 years of age is mentally or physically incapable of earning his or her own living and dependent upon the member for support and maintenance provided that proof of such incapacity is furnished to Pacific Guardian Life within 31 days of the child attaining age 19. Failure to submit required proof of incapacity or to permit an examination of the child when requested by Pacific Guardian Life shall result in termination of the continued coverage. Coverage for such child will terminate upon the earliest of the following: his or her handicap ceases, or insurance would terminate for other reasons other than the dependent child's age.

To enroll a new spouse or dependent child for Dependent Life Insurance coverage, you must submit an application for enrollment within 60 days of the date of marriage, birth, or legal adoption. If you do not submit an enrollment application during this 60-day period, you must wait until the next open enrollment period to enroll your new dependent and submit Evidence of Insurability at that time.

If your spouse is also an eligible participant, he or she cannot be covered as a "Spouse" but must apply for coverage as an individual member. If both you and your spouse are insured members, your children may be covered as dependents of either member, but not both.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (AD&D)

Class I members (Active and Associate HSTA Members) enrolled in the Basic Plus Plan are also covered for Accidental Death and Dismemberment benefits (AD&D). The Principal Sum Amount of AD&D benefits is equal to the insured member's life insurance amount under Basic Life Insurance and Supplemental Term Life Insurance. If you die as a result, directly and solely, from an injury and no other cause, AD&D insurance may pay an additional amount. If you sustain a covered loss as provided in the Table of Losses below, AD&D will pay the benefit as shown in the Table. The covered loss must result directly from an injury caused by an accident and must occur within 90 days following the date of the accident.

AD&D TABLE OF LOSSES

IN THE EVENT OF:	BENEFIT AMOUNT
Loss of life	Full Amount
Loss of both hands or feet	Full Amount
Loss of sight of both eyes	Full Amount
Loss of one hand and one foot	Full Amount
Loss of one hand and sight of one eye	Full Amount
Loss of one foot and sight of one eye	Full Amount
Loss of speech and hearing in both ears	Full Amount
Total paralysis of both upper and both lower extremities (quadriplegia)	Full Amount
Total paralysis of both upper or both lower extremities (paraplegia)	Three-Fourths Full Amount

AD&D TABLE OF LOSSES (continued)

IN THE EVENT OF:	BENEFIT AMOUNT
Total paralysis of one lower extremity and one upper extremity on the same side (hemiplegia)	One-Half Full Amount
Loss of one hand	One-Half Full Amount
Loss of one foot	One-Half Full Amount
Loss of speech	One-Half Full Amount
Loss of hearing in both ears	One-Half Full Amount
Loss of sight of one eye	One-Half Full Amount
Paralysis of one upper or lower limb (uniplegia)	One-Quarter Full Amount
Loss of all four fingers of the same hand	One-Quarter Full Amount
Loss of thumb and index finger of the same hand	One-Quarter Full Amount

- "Loss of a hand or foot" means actual severance at or above the wrist or ankle joint.
- "Loss of sight" means total and irrecoverable loss of sight in the injured eye.
- "Loss of thumb and index finger of the same hand means complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).
- "Paralysis" means complete loss of motor function due to lesion of the neural or muscular mechanism as determined by a physician.
- "Loss of speech" means total, permanent, and irrecoverable loss of audible communication.
- "Loss of hearing" means total, permanent deafness in both ears which cannot be corrected to any functional degree by an aid or device.

AD&D Exclusions

AD&D does not cover a loss that results directly or indirectly from any one or more of the following:

- Sickness, disease, or infirmity of the mind or body including mental or emotional distress
- Ptomaine or bacterial infections, except pus-forming infections resulting from an injury that is not excluded by these exclusions
- Medical or surgical treatment, except when it is both treatment of an injury that meets the requirements of a covered loss and treatment performed within 90 days after the injury occurred
- Any declared or undeclared insurrection, international armed conflict or conflict involving any armed forces, war or act of war
- Unlawful participation in a riot or other public disturbance
- An assault or felony or attempt to commit an assault or felony
- Intentionally self-inflicted injury, whether or not the covered loss was intended
- Suicide or attempted suicide, whether sane or insane
- Riding in or ascending to or descending from any kind of aircraft: as a passenger on any kind of aircraft operated by or for any armed forces; or as a pilot or crew member; or as a participant in aviation training; or as a participant in a sporting event or hobby
- Voluntarily or involuntarily taking any drug or poison or inhaling gas that is not prescribed by a physician
- Intentionally taking any drug that is not prescribed by a physician
- Being under the influence of alcohol as defined by the law of the state where the loss occurs

- Participation in hazardous activities such as skydiving, motor racing, hang-gliding, scuba, skin or deep sea diving, dirt bike racing, mountain climbing, using off-road vehicles, or bungee jumping
- Driving or riding in any speed contest or race or the testing of any land or water motor vehicle on any race track, speedway or testing area, including joyriding and/or street racing
- An accident occurring while serving on full-time active duty of more than 30 days in any armed forces

AD&D Special Education Benefits

A Special Education Benefit may be paid as follows if the insured member dies as the result of a covered loss and is survived by a spouse and one or more dependent children.

Child Benefit: For each child under age 25 who is enrolled as a full-time student at an accredited post secondary educational institution at the time of the insured member's death or is at the 12th grade level and within one year after the insured's death, enrolls as a full-time student at an accredited college, university, or vocational school and incurs expense for tuition, fees, books, room and board, transportation and any other costs payable directly to or approved and certified by such educational institution, the cost of such incurred expense up to 2% of the insured member's Principal Sum Amount or $2,500, whichever is less, will be paid each year, per dependent child, for up to four straight years after enrollment begins.

Spouse Benefit: If, within one year after the insured member's death, his or her surviving spouse enrolls in any accredited school for the purpose of retraining or refreshing skills needed for employment and incurs expense payable directly to or approved and certified by such school, the cost of such incurred expense up to $3,000 will be paid for up to one year after enrollment begins.

AD&D Seat Belt Benefit and Airbag Benefit

An additional 50% of the Accidental Death and Dismemberment Benefit, subject to a maximum of $100,000, may be paid in the event the insured member suffers loss of life or limb as the result of a covered loss which occurs while driving or riding in an automobile if all of the following are true:

- The automobile is equipped with seat belts which meet federal safety standards and were installed by the automobile manufacturer, and which have not been altered.
- The seat belt was in actual use and properly fastened at the time of the accident.
- The position of the seat belt is certified in the official report of the accident or by the investigating officer.
- The insured member is driving or riding in an automobile driven by a licensed driver who was neither intoxicated, driving while impaired, or under the influence of drugs (unless taken as prescribed by a licensed physician), at the time of the accident.

If an automobile is equipped with airbags and an airbag is activated as the result of the same automobile accident causing a covered loss, an additional benefit equal to $10,000 or 10% of the Accidental Death and Dismemberment Benefit, whichever is less, will be payable for each airbag activated within the automobile causing such covered loss. Activation of the airbag must be verified as part of the official report of the accident, or certified, in writing, by the investigating officer. No airbag benefit is payable unless the Seat Belt Benefit is paid.

AD&D Repatriation Benefit

Pacific Guardian Life may pay up to $5,000 for the preparation and transportation of an insured member's body for burial or cremation. Payment may be made if the insured member suffered a loss of life at least 75 miles away from his or her principal residence or in a foreign country.

BENEFICIARY DESIGNATION

On your Group Life Insurance Enrollment Application form, you may name anyone you wish as your beneficiary to receive your life insurance. You may change your beneficiary at any time by submitting a Life Insurance Beneficiary Designation/Name Change form to the Trust Office. The change will take

effect as of the date that you sign the form when it is received by the Trust Office. Pacific Guardian Life will honor a beneficiary change request only if it is recorded before any payment has been made.

When Pacific Guardian Life receives due proof of your death, the amount of life insurance on your life may be paid. Payment will be made in a lump sum to the beneficiary or beneficiaries named in writing by you, provided the names are on file with the Trust Office.

Unless you request otherwise in your filed beneficiary designation, payment shall be made as follows:

(a) If more than one beneficiary is named, each will be paid an equal share.

(b) If any named beneficiary dies before you, his/her share will be divided equally among the named beneficiaries who survive you.

(c) If no beneficiary is named, or if no named beneficiary survives you, Pacific Guardian Life may, at the Company's option, pay the first of the following classes of successive preference beneficiaries who survive you:

(i) all to your surviving spouse; or

(ii) if your spouse does not survive you, in equal shares to your surviving children; or

(iii) if your spouse and no child survives you, in equal shares to your surviving parents; or

(iv) if your spouse, no child, or no parent survives you, in equal shares to your surviving brothers and sisters; or

(v) if none of the above survives you, to your estate.

The life insurance on your spouse or children is payable to you in the event of their death. If you do not survive the payment of the Dependent coverage benefit, Pacific Guardian Life will pay your estate.

Any payment made in accordance with the preceding provisions shall release Pacific Guardian Life from further liability for the amount paid.

TERMINATION OF INSURANCE

Life Insurance coverage for the insured member will end on the earliest of the following dates:

(a) The date this policy terminates;

(b) The date you cease to be a member of an Eligible Class;

(c) The date your Eligible Class is eliminated;

(d) The date you enter the armed forces, other than for reserve duty of 30 days or less; or

(e) The last day of the last period for which timely premium payment was made in full.

Dependent Life Insurance coverage for your enrolled dependents will end on the earliest of the following dates:

(a) The last day of the month in which you die;

(b) The date your life insurance coverage terminates;

(c) The date Dependent Life Insurance benefits are discontinued;

(d) The date you cease to be a member of an Eligible Class that provides for Dependent Life Insurance;

(e) The date the dependent enters any armed forces, other than for reserve duty of 30 days or less;

(f) The date the dependent is no longer defined as an eligible dependent herein; or

(g) The last day of the last period for which timely premium payment was made in full.

CONVERSION RIGHTS

A conversion privilege is allowed when your life insurance terminates for reasons other than non-payment of premiums. If you become ineligible for coverage, your life insurance and Dependent Life Insurance for your dependents will be continued for 31 days following the termination of your eligibility. During this 31-day period, you and/or your dependents have the right to obtain an individual life insurance policy issued by Pacific Guardian Life.

(a) You may convert all or part of the amount of insurance that ends due to the end of your membership in an Eligible Class.

(b) A covered dependent may convert all or part of the amount of Dependent Life Insurance that ends due to termination of the insured member's life insurance because of death or termination of membership in the class eligible for coverage.

A conversion policy may be an individual life insurance policy of any type other than term life insurance but will not include accidental death, disability, or other supplementary benefits. The policy will be issued without medical examination at Pacific Guardian Life's regular premium rates. The amount of your individual policy cannot exceed the amount of insurance for which you were covered under the group policy. You must apply and pay for the first premium within 31 days after your insurance terminates.

If you die during the 31 days allowed for conversion but before an individual policy has become effective, Pacific Guardian Life may pay your beneficiary the amount of life insurance that could have been converted.

HOW TO FILE A CLAIM

Life Insurance and Accidental Death Benefits

- The Trust Office must be notified when a covered individual dies.
- The Beneficiary (or the Beneficiary's authorized representative) must complete and submit **IRS Form W-9** (Request for Taxpayer Identification Number and Certification) and a **certified copy of the Death Certificate** to the Trust Office. If the Beneficiary is a Trust, a copy of the Trust instrument and all amendments, if applicable, must also be submitted to the Trust Office.
- In the case of an Accidental Death claim, an Autopsy Report and Toxicology Report must also be submitted to the Trust Office.
- Upon notification and receipt of the required documentation, the Trust Office will complete the necessary forms and transmit them together with the required documentation to Pacific Guardian Life.

Accidental Dismemberment or Loss of Sight Benefits

- You must complete and submit a **Claim for Group Accidental Dismemberment or Loss of Sight Benefits** form to the Trust Office.
- Upon receipt of the required documentation, the Trust Office will transmit your claim to Pacific Guardian Life.

The preceding life insurance benefits are insured under a contract issued by Pacific Guardian Life Insurance Company, Limited, 1440 Kapiolani Boulevard, Suite 1700, Honolulu, Hawaii 96814. The services provided by Pacific Guardian Life include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your life insurance coverage from Pacific Guardian Life. Its contents are subject to the provisions of the Group Term Life Insurance Master Contract with Pacific Guardian Life Insurance Company, Limited, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the life insurance plan, for specific questions about coverage.

AMERICAN FIDELITY ASSURANCE COMPANY

Short-Term Disability Income Protection Insurance

Short-Term Disability Income Protection Insurance provides income protection if you become disabled due to an accidental injury or sickness and cannot work. It will help replace a portion of the income you would have earned had the disability not occurred. "Disabled" or "Disability" means that you are unable to perform the material and substantial duties of your regular occupation.

WHO IS ELIGIBLE?

All Active HSTA Members who are actively employed in Bargaining Unit 5 in the field of education and working a minimum of 17.5 hours per week are eligible to enroll in the Short-Term Disability Income Protection Insurance Plan. Associate, Retired and Student Members are not eligible for this benefit, nor are substitute teachers.

You must be on Active Employment on the day your coverage would become effective. Otherwise, your coverage will become effective on the first day of the month following the date you resume Active Employment.

"Active Employment" means you are doing in the usual manner all of the regular duties of your employment on a full-time basis on a scheduled work day and these duties are being done at one of the places of business where you normally do such duties or at some location to which your employment sends you. You will be said to be on Active Employment on a day which is not a scheduled work day only if you are **not** disabled and would be able to perform in the usual manner all the regular duties of your employment if it were a scheduled work day. Active Employment includes paid vacation leave.

DISABILITY BENEFITS

Monthly amounts of disability benefits are available from $200 to $7,500 in $100 increments. Your disability benefit will be the amount applied for and issued, not to exceed 60% of your monthly compensation. If applicable, your disability benefit will be reduced by deductible sources of income.

Elimination Period

The Elimination Period is the number of consecutive days you must be disabled and under the regular care of a physician before benefits become payable. The Elimination Period for accidental injury or sickness (includes pregnancy) is as follows:

- Accidental Injury: Seven days **or** after the end of accumulated sick leave, whichever is greater
- Sickness: Seven days **or** after the end of accumulated sick leave, whichever is greater

Your benefits begin on the 8th day of disability **or** after the end of accumulated sick leave, whichever is greater, due to a covered accidental injury or sickness.

Maximum Disability Period

You have the option to purchase Plan I which provides for a 90-day maximum disability period, or Plan II which provides for a 180-day maximum disability period. Your monthly premium will depend on the disability benefit level and the plan selected. Please refer to the Benefit Schedule which you may obtain from the Trust Office for current premium rates.

Leave of Absence

Your coverage may be continued for up to one year during a Leave of Absence approved in writing by your Employer.

WHEN YOU ARE ELIGIBLE FOR A MONTHLY BENEFIT

Disability benefits will be provided when you furnish Proof of Loss that you are disabled and under the regular and appropriate care of a physician. Disability must be due to a covered accidental injury or sickness and begin while your coverage is in force. Disability payments will be provided for each period you remain disabled and under the care of a physician which continues beyond the Elimination Period.

Disability payments will be provided for only one disability when more than one disability exists at the same time or disability results from two or more causes.

If any disability payment is to be paid for less than a full month, the amount of the benefit will be reduced pro rata on the basis that one day's benefit equals one thirtieth (1/30) the disability benefit.

Disability will be deemed to have commenced on the date you first receive personal treatment from a physician following continuous cessation of work.

Successive Disabilities

Successive disabilities are those disabilities which result from the same or related causes for which benefits are payable and will be considered one period of disability unless the disabilities are separated by your return to Active Employment or any other gainful occupation for at least three consecutive months. A disability due to a different or unrelated cause will be considered a new period of disability.

Any disability which begins after termination of coverage will not be considered a successive disability and will not be covered.

TERMINATION OF BENEFITS

Disability payments will end on the earliest of the following dates:

(a) The date you are no longer disabled.

(b) The date your Disability Earnings are more than 60% of your monthly compensation. "Disability Earnings" means the gross monthly earnings you receive while disabled and working.

(c) The date you die.

(d) The last day disability payments are made according to the Schedule of Benefits.

(e) The date you fail to provide written proof of disability satisfactory to American Fidelity.

(f) The date you cease to be under the regular and appropriate care of a physician, or refuse to undergo examination by a physician, or refuse vocational testing when American Fidelity requires such examination or testing.

(g) The date you refuse to receive medical treatment that is generally acknowledged by physicians to cure or improve your condition so as to reduce its disabling effect.

(h) The date you refuse to try or attempt to work with the assistance of modifications made to your work environment, functional job elements or work schedule, or adaptive equipment or devices that a physician has indicated will allow a return to your own occupation and which accommodations are approved by your Employer.

TERMINATION OF INSURANCE

Your insurance coverage will end on the earliest of the following dates:

(a) The date you do not meet the eligibility requirements as defined in the Plan.

(b) The date you retire.

(c) The date you cease to be on Active Employment, except as provided for under the Leave of Absence provision.

(d) The end of the last period for which premium has been paid.

(e) The date the Plan is discontinued.

If your coverage ends as a result of your termination of Active Employment and such termination is caused by an accidental injury or sickness for which disability benefits would be payable and disability is established prior to the termination of Active Employment, then disability benefits will be paid as if such termination had not occurred.

Termination of this Plan will have no effect on disability payments which began before such termination.

EXCLUSIONS

This Plan does not cover any loss which results from:

(a) Intentionally self-inflicted injury.

(b) An act of war.

(c) Accidental injury sustained or sickness contracted while in the service of the armed forces of any country.

(d) Commitment of a felony.

(e) Penal incarceration. Benefits for disability or any other loss will not be paid for any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.

(f) Accidental injury or sickness arising out of and in the course of any occupation for wage or profit for which you are entitled to Workers' Compensation.

HOW TO FILE A CLAIM

Written proof of loss must be sent to American Fidelity Assurance Company at 9000 Cameron Parkway, Oklahoma City, Oklahoma 73114, or to the Trust Office. Such proof of loss should be made within 30 days after any loss covered by the Plan. If it is not reasonably possible to give proof of loss within that time, your claim may not be denied or reduced due to the delay. Proof of loss, provided at your expense, must show:

(a) That you are under the regular and appropriate care of a physician;

(b) The date your disability began;

(c) The cause of your disability;

(d) The appropriate documentation of your monthly compensation;

(e) The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and

(f) The name and address of any hospital or institution where you received treatment, including all attending physicians.

Proof of loss must be sent to American Fidelity within 90 days after the loss. Late proof of loss may be accepted if it was not reasonably possible to give proof within 90 days and the proof of loss is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

The preceding short-term disability income protection insurance benefits are insured under a contract issued by American Fidelity Assurance Company, 9000 Cameron Parkway, Oklahoma City, Oklahoma 73114. The services provided by American Fidelity include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your short-term disability income protection insurance coverage from American Fidelity. Its contents are subject to the provisions of the Group Master Policy with American Fidelity Assurance Company, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the short-term disability income protection insurance plan, for specific questions about coverage.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Long-Term Income Protection Insurance

WHO IS ELIGIBLE?

All Active HSTA Members regularly employed on a scheduled basis and working a minimum of 17.5 hours per week, Associate HSTA Members regularly employed by the State of Hawaii, and regularly scheduled employees of the Hawaii State Teachers Association are eligible to enroll in the Long-Term Income Protection Insurance Plan.

Evidence of insurability in a form prescribed by Hartford will be required if application for insurance is made more than 60 days after a member's eligibility date.

If you are absent from work due to a disabling condition on the day your coverage would otherwise have become effective, your effective date will be deferred until you return to work on an active basis.

BENEFIT OPTIONS

If you become totally disabled and have purchased coverage under the Long-Term Income Protection Insurance Plan, you will receive a percentage of your regular monthly income, depending on which of the following options you have selected:

Option I	50% of your regular monthly income
Option II	60% of your regular monthly income
Option III	66⅔% of your regular monthly income

The maximum benefit amount payable is $5,000.00 per month. Your benefit payments will be offset by any sources of income for which you are eligible, as described in your Certificate of Insurance, such as Workers' Compensation, sick pay and Social Security. However, in no event will your benefit payment be less than $50.00 per month.

ELIMINATION PERIOD OPTIONS

The Elimination Period is the period of time you must be disabled before benefits become payable. Your benefit payments will begin after you have been totally disabled for a specified period of time, depending on which of the following Elimination Periods you have selected:

Option I	Six (6) month Elimination Period
Option II	Nine (9) month Elimination Period
Option III	Eighteen (18) month Elimination Period*
Option IV	Twenty-four (24) month Elimination Period*

***Note**: Effective February 1, 2009, Option III and Option IV are no longer offered to new enrollees.

WHEN YOU ARE ELIGIBLE FOR A MONTHLY BENEFIT

You will be paid a monthly benefit if:

1. You become totally disabled;
2. You are totally disabled throughout the Elimination Period;
3. You remain totally disabled beyond the Elimination Period;
4. You are under the regular care of a physician; and
5. You submit proof of loss satisfactory to Hartford.

"Totally Disabled" means that during the Elimination Period and for the next twenty-four (24) months you are unable to perform the duties of your own occupation on a regularly scheduled basis and as a result, you are earning less than 80% of your pre-disability earnings. Thereafter, "Total Disability" is defined as the inability to perform any occupation or work for which you are or could become qualified by training, education, or experience.

TERMINATION OF BENEFITS

If you become totally disabled, benefits will be paid until the earliest of the following dates:

1. The date you are no longer totally disabled.
2. The date you fail to furnish proof that you are continuously disabled.
3. The date you are no longer under the regular care of a physician or refuse to be examined, if the Hartford requires an examination.
4. The date you die.
5. The date determined in accordance with the Maximum Duration of Benefits Table below, which shows the maximum duration for which benefits may be paid.

MAXIMUM DURATION OF BENEFITS TABLE

Age when Totally Disabled	Maximum Benefit Duration
Prior to age 63	To **Normal Retirement Age*** or 42 months, if greater
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months
Mental Illness/Substance Abuse (if not confined)	24 months
* **Normal Retirement Age** means the Social Security Normal Retirement Age as determined by your date of birth.	

EXCLUSIONS

The Plan does not cover and no benefit will be payable for any disability which is caused by, due to, or contributed to by:

1. Your commission of or attempt to commit a felony, or being engaged in an illegal occupation;
2. An intentionally self-inflicted injury;
3. War or any act of war (declared or not); or
4. A pre-existing condition. (A pre-existing condition means any disability, diagnosed or undiagnosed, for which you received medical care within 90 days prior to the effective date of your coverage or of a change in your coverage.)

HOW TO FILE A CLAIM

If you become totally disabled:

- Notify the HSTA Voluntary Employees Beneficiary Association Trust Office as soon as possible. Written notice of your claim must be provided to Hartford within 30 days after you become disabled. A claim form for providing proof of loss will then be sent to you. Proof of loss may include but not be limited to documentation of your disability, your earnings or income, and medical information.
- You, your physician, and your employer must complete the claim form. The completed claim form is to be sent to the HSTA Voluntary Employees Beneficiary Association Trust Office who will forward the claim form to Hartford. Written proof of loss must be sent to Hartford within 90 days after the start of your disability.

ABILITY ASSIST

Ability Assist is a series of free support benefits for those enrolled in the Long-Term Income Protection Insurance Plan:

1. Toll free access to counselors (800) 964-3577 available 24 hours a day, 7 days a week.
2. Telephone assessments, referrals to local resources and services such as assistive equipment and home remodeling and respite care for caregivers.
3. Ability Assist interactive web services with additional information and resources as well as self-assessment tools.
4. Up to five face to face assessment and counseling sessions.

TRAVEL ASSIST

Travel Assist is available to enrollees who travel more than 100 miles from their primary home. Members can call (800) 243-6108 24 hours a day, 7 days a week for free access to travel assistance including:

1. Pre-trip Information
2. Emergency Medical Assistance
3. Emergency Personal Services

The preceding long-term income protection insurance benefits are insured under a contract issued by Hartford Life and Accident Insurance Company, 200 Hopmeadow Street, Simsbury, Connecticut 06089. The services provided by Hartford Life and Accident Insurance Company include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your long-term income protection insurance coverage from Hartford. Its contents are subject to the provisions of the group insurance policy with Hartford Life and Accident Insurance Company, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the long-term income protection insurance plan, for specific questions about coverage.

METROPOLITAN LIFE INSURANCE COMPANY

Critical Illness Insurance

Critical Illness Insurance will provide a lump sum payment when you are diagnosed with one of the covered conditions. This plan does not provide any type of medical coverage and is not a substitute for medical coverage or disability insurance. You should have medical insurance in place when you apply for coverage under this plan.

WHO IS ELIGIBLE?

All Active and Associate HSTA Members and regularly scheduled employees of the Hawaii State Teachers Association are eligible to enroll in the Critical Illness Insurance Plan.

DEPENDENT COVERAGE

When you apply for insurance for yourself, you may also apply for coverage for your dependents. Eligible dependents include your legal spouse and unmarried children under 19 years of age.

The term "children" includes a natural child, an adopted child, a stepchild, or a foster child who is dependent upon you for financial support. Dependent children who are full-time students at an accredited school, college, or university will continue to be eligible for dependent coverage from 19 years of age through 22 years of age. In order for your dependent child to be covered as a full-time student, you must certify annually, and as requested by the Trust Office, that he or she is a full-time student at an accredited school, college, or university by completing the Student Certification form issued to you by the Trust Office. **Failure to submit the required certification will result in cancellation of the child's coverage.** You are also responsible for promptly notifying the Trust Office, in writing, of any change in your dependent's eligibility status outside the annual certification.

To add a new spouse or dependent child, you must submit an application for enrollment within 30 days of the date of marriage, birth, adoption, or legal guardianship. If you do not submit an enrollment application within this 30-day period, you must wait until the next open enrollment period to add your new dependent.

If your spouse is also an eligible participant, he or she cannot be covered as a "Spouse" but must apply for coverage as an individual member. If both you and your spouse are insured members, your children may be covered as dependents of either member, but not both.

Dependent insurance will take effect on the date MetLife approves each dependent for coverage provided that the dependent is not confined at home under a physician's care, receiving or applying to receive disability benefits from any source, or hospitalized. **Exception:** Approval is not required for your newborn children. Once you have dependent insurance for at least one dependent child, if another child becomes your dependent, that child will automatically be covered.

BENEFIT OPTIONS

You may elect one of the following Benefit Amounts for yourself and your covered dependents:

Option I $15,000

Option II $30,000

TOTAL BENEFIT AMOUNT

Total Benefit Amount means the maximum aggregate amount that the plan will pay for any and all covered conditions combined, per covered person, per lifetime.* The Total Benefit Amount payable is 300% of the Benefit Amount elected:

Option I $45,000

Option II $90,000

***Exception:** Payment of the Major Organ Transplant benefit and the Health Screening benefit does not reduce the Total Benefit Amount.

COVERED CONDITIONS

The Plan provides payments for the following covered conditions based on a percentage of the Benefit Amount elected.

Covered Condition	Initial Benefit	Recurrence Benefit
Alzheimer's Disease	100% of Benefit Amount	None
Coronary Artery Bypass Graft	100% of Benefit Amount	50% of Benefit Amount
Full Benefit Cancer	100% of Benefit Amount	50% of Benefit Amount
Partial Benefit Cancer	25% of Benefit Amount	12.5% of Benefit Amount
Heart Attack	100% of Benefit Amount	50% of Benefit Amount
Kidney Failure	100% of Benefit Amount	None
Major Organ Transplant	100% of Benefit Amount	None
Stroke	100% of Benefit Amount	50% of Benefit Amount
Listed Conditions	25% of Benefit Amount	None

Alzheimer's Disease means the development of multiple, progressive cognitive deficits manifested by memory impairment (impaired ability to learn new information or to recall previously learned information) and one or more of the following cognitive disturbances:

- aphasia (language disturbance)
- apraxia (impaired ability to carry out motor activities despite intact motor function)
- angosia (failure to recognize or identify objects despite intact sensory function)
- disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting)

Benefits for a diagnosis of Alzheimer's Disease will not be paid for:

- other central nervous system conditions that may cause deficits in memory and cognition
- systemic conditions that are known to cause dementia
- substance-induced conditions
- any form of dementia that is not diagnosed as Alzheimer's Disease

Coronary Artery Bypass Graft means the undergoing of open heart surgery performed by a Board certified cardiothoracic surgeon to bypass narrowing or blockage of one or more coronary arteries using venous or arterial grafts. Coronary Artery Bypass Graft does not include:

- angioplasty
- laser relief
- stent insertion
- coronary angiography
- any other intra-catheter technique

Benefits will not be paid for Coronary Artery Bypass Graft:

- performed outside the United States; or
- that does not involve median sternotomy (a surgical incision in which the breastbone is divided down the middle from top to bottom)

Full Benefit Cancer means the presence of one or more malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue, provided that a physician who is Board certified in the medical specialty that is appropriate for the type of cancer involved has determined that:

- surgery, radiotherapy, or chemotherapy is medically necessary;
- there is metastasis; or
- the patient has terminal cancer, is expected to die within 24 months or less from the date of diagnosis and will not benefit from, or has exhausted, curative therapy

Benefits for a diagnosis of Full Benefit Cancer will not be paid for:

- any condition that is a Partial Benefit Cancer
- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth
- any papillary tumor of the bladder classified as Ta under TNM staging
- any tumor of the prostate classified as T1NOMO under TNM staging
- any papillary tumor of the thyroid that is classified as T1NOMO or less under TNM staging and is one centimeter or less in diameter unless there is metastasis
- any tumor in the presence of human immuno-deficiency virus
- any non-melanoma skin cancer unless there is metastasis
- any malignant tumor classified as less than T1NOMO under TNM staging

Partial Benefit Cancer means one of the following conditions that meet TNM staging classification and other qualifications specified below:

- carcinoma in situ classified as TisNOMO, provided that surgery, radiotherapy, or chemotherapy has been determined to be medically necessary by a physician who is Board certified in the medical specialty that is appropriate for the type of cancer involved
- malignant tumors classified as T1NOMO or greater which are treated by endoscopic procedures alone
- malignant melanomas classified as T1NOMO for which a pathology report shows maximum thickness less than or equal to 0.75 millimeters using the Breslow method of determining tumor thickness
- tumors of the prostate classified as T1bNOMO or T1cNOMO, provided they are treated with a radical prostatectomy or external beam radiotherapy

Benefits for a diagnosis of Partial Benefit Cancer will not be paid for:

- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth
- any papillary tumor of the bladder classified as Ta under TNM staging
- any tumor of the prostate classified as T1NOMO under TNM staging
- any papillary tumor of the thyroid that is classified as T1NOMO or less under TNM staging and is one centimeter or less in diameter
- any tumor in the presence of human immuno-deficiency virus
- any non-melanoma skin cancer
- any melanoma in situ classified as TisNOMO under TNM staging

Heart Attack (myocardial infarction) means the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli.

Kidney Failure means the total, end stage, irreversible failure of both kidneys to function, provided that a Board certified nephrologist has determined that such failure requires immediate and regular kidney dialysis (no less than weekly) that is expected to continue for at least 6 months, or a kidney transplant.

Major Organ Transplant means:

- the irreversible failure of a covered person's heart, lung, pancreas, kidneys, or any combination thereof, for which a physician has determined that complete replacement of such organ with an entire organ from a human donor is medically necessary and either such covered person has been placed on the Transplant List or such transplant procedure has been performed;
- the irreversible failure of a covered person's liver for which a physician has determined that complete or partial replacement of the liver with a liver or liver tissue from a human donor is medically necessary and either such covered person has been placed on the Transplant List or such transplant procedure has been performed; or
- the replacement of a covered person's bone marrow with bone marrow from the covered person or another human donor, which replacement is determined to be medically necessary by a Board certified hematologist or oncologist in order to treat irreversible failure of such covered person's bone marrow

Benefits will not be paid for Major Organ Transplants:

- performed outside the United States
- involving non-human organs
- involving implantation of mechanical devices or mechanical organs
- involving stem cell generated transplants
- involving islet cell transplants

The plan will pay for only one Major Organ Transplant per covered person per lifetime. Payment of this benefit will not reduce the Total Benefit Amount.

Stroke means a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment caused by hemorrhage, thrombus, or embolus from an extracranial source, which results in an infarction of brain tissue. Stroke does not include transient ischemic attacks (TIA) or prolonged reversible ischemic attacks.

Benefits for a diagnosis of Stroke will not be paid for:

- cerebral symptoms due to migraine
- cerebral injury resulting from trauma or hypoxia
- vascular disease affecting the eye or optic nerve or vestibular functions

Listed conditions means any of the following diseases:

- Addison's disease (adrenal hypofunction)
- amyotrophic lateral sclerosis (Lou Gehrig's disease)
- cerebrospinal meningitis (bacterial)
- cerebral palsy
- cystic fibrosis
- diphtheria
- encephalitis
- Huntington's disease (Huntington's chorea)
- Legionnaire's disease
- malaria
- multiple sclerosis (definitive diagnosis)
- muscular dystrophy
- myasthenia gravis
- necrotizing fasciitis
- osteomyelitis
- poliomyelitis
- rabies
- sickle cell anemia (excluding sickle cell trait)
- systemic lupus erythematosus (SLE)
- systemic sclerosis (scleroderma)
- tetanus
- tuberculosis

Benefits will not be paid for:

- a diagnosis of multiple sclerosis for clinically isolated syndrome (CIS)
- a diagnosis of systemic lupus erythematosus (SLE) for any form of lupus that is not diagnosed as SLE
- a suspected or probable diagnosis of a Listed Condition

IMPORTANT NOTE: Your Certificate of Coverage contains certain proof requirements, exclusions, limitations, and other provisions that may reduce benefits or prevent a covered person from receiving benefits under the plan. Please read your entire Certificate carefully.

HEALTH SCREENING BENEFIT

Once your coverage has been in effect for 30 days, this plan will pay a Health Screening benefit if you take one of the listed screening/preventive measures and proof is submitted to MetLife. Only one benefit of $50 or $100, depending on which plan is selected, will be paid per covered person per calendar year. Payment of this benefit will not reduce the Total Benefit Amount.

The covered tests are: breast MRI, breast ultrasound, breast sonogram, carotid doppler, colonoscopy, virtual colonoscopy, flexible sigmoidoscopy, endoscopy, digital rectal exam (DRE), electrocardiogram (EKG), fasting blood glucose test, fasting plasma glucose test, two hour post-load plasma glucose test, hemocult stool specimen, mammogram, pap smears or thin prep pap test, prostate-specific antigen (PSA) test, serum cholesterol test to determine LDL and HDL levels, blood test to determine total cholesterol, blood test to determine triglycerides, or stress test on bicycle or treadmill.

HOW TO FILE A CLAIM

You can designate another person to act on your behalf in the handling of your benefit claims. In order to do so, you must complete and file a form with the Trust Office and/or the insurance carrier that identifies the individual that is authorized to act on your behalf as your authorized representative. If you designate an authorized representative to act on your behalf, all correspondence and benefit determinations will be directed to your authorized representative, unless you direct otherwise. You may also request that this information be provided to both you and your authorized representative.

To file a claim for benefits, notice of the claim and proof of the claim must be submitted as follows:

Step 1: You must give notice by writing or calling MetLife within 30 days of the date of your loss.

Step 2: MetLife will send you a claim form and instructions on how to complete it. You should receive the form within 15 days of giving notice of your claim.

Step 3: When you receive the claim form, you should fill it out as instructed and return it with the required proof of claim.

Step 4 You must provide proof of your claim within 90 days of the date of your loss. If notice or proof of your claim is not given within the time limits described, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as reasonably possible, but in no event later than 15 months from the date of your loss.

Your Certificate of Coverage contains specific proof requirements for covered conditions. You may be required to also provide authorization for MetLife to obtain medical records and other information pertinent to your claim and/or be examined by an independent physician at the Company's expense.

For assistance in filing a claim or if you have any questions regarding claims and appeals procedures, contact the Trust Office or a MetLife Customer Service representative toll-free at 1-800-438-6388, Monday through Friday between 8:00 a.m. and 11:00 p.m. Eastern Standard Time. You may also write to MetLife at the following address:

Metropolitan Life Insurance Company
Attention: Critical Illness Service Center
P.O. Box 6120
Scranton, PA 18505-9972
FAX: 1-866-268-2621

PAYMENT OF BENEFITS

Benefit payments will be made to you while you are living and to your designated beneficiary upon your death. On your Critical Illness Insurance Enrollment Application form, you may name anyone you wish as your beneficiary. You may change your beneficiary at any time by submitting a Beneficiary Designation/Name Change form to the Trust Office. The change will take effect as of the date that you sign the form and will not apply to any payment made before the change request was recorded.

If you designate a beneficiary, upon your death, any amount that is due or becomes due will be paid to the beneficiary or beneficiaries named in writing by you, provided the names are on file with the Trust

Office. Unless you request otherwise in your filed beneficiary designation, payment shall be made as follows:

(a) If more than one beneficiary is named, each will be paid an equal share.

(b) If any named beneficiary dies before you, his/her share will be divided equally among the named beneficiaries who survive you.

(c) If no beneficiary is named, or if no named beneficiary survives you, MetLife may, at the Company's option, pay the first of the following classes of successive preference beneficiaries who survive you:

(i) all to your surviving spouse;

(ii) if your spouse does not survive you, in equal shares to your surviving children;

(vi) if no child survives you, in equal shares to your surviving parents;

(vii) if no parent survives you, in equal shares to your surviving brothers and sisters;

(viii) if none of the above survives you, to your estate.

GENERAL EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for the following:

- Covered conditions caused by, or contributed to by, or resulting from a covered person:
  - participating in a felony, riot or insurrection
  - intentionally causing a self-inflicted injury
  - committing or attempting to commit suicide
  - voluntarily taking or using any drug, medication or sedative unless it is taken or used as prescribed by a physician or is an over-the-counter drug, medication or sedative taken according to package directions
  - engaging in an illegal occupation
  - serving in the armed forces or any auxiliary unit of the armed forces of any country
- Covered conditions arising from war or any act of war, even if war is not declared.
- Any covered condition for which diagnosis is made outside the United States, unless the diagnosis is confirmed in the United States, in which case the covered condition will be deemed to occur on the date the diagnosis is made outside the United States.
- Any covered condition that is caused by, contributed to by, or results from a covered person's involvement in an incident, where such covered person is intoxicated at the time of the incident and is the operator of a vehicle involved in the incident. Intoxicated means that the covered person's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident happened.
- A covered condition that is caused by or results from a preexisting condition if the covered condition occurs during the first six (6) months that a covered person is insured under the plan. A preexisting condition is a sickness or injury for which, in the three (3) months before a covered person becomes insured under this plan, medical advice, treatment or care was sought by such covered person, or recommended by, prescribed by or received from a physician or other practitioner of the healing arts; or symptoms or any medical or physical conditions existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment. This exclusion does not apply to benefits relating to a heart attack or stroke.

Benefits may be reduced on account of prior claims paid. The plan will reduce its benefit payment for a claim so that the amount paid, when combined with amounts for all prior claims paid for the same covered person does not exceed the Total Benefit Amount in effect for that covered person on the date of the most recent covered condition. This limitation does not apply to benefit payments for Major Organ Transplant and Health Screening.

There is a 180-day benefit suspension period between recurrences. The plan will not pay a recurrence benefit for a covered condition that recurs within 180 days following the occurrence of a covered condition for which the plan pays a benefit. With respect to Full Benefit Cancer or a Partial Benefit Cancer, the plan will not pay a recurrence benefit unless the covered person has not had symptoms of or been treated for the Full Benefit Cancer or Partial Benefit Cancer for a period of 180 days.

Your Certificate of Coverage contains certain proof requirements, exclusions, limitations, and other provisions that may reduce benefits or prevent a covered person from receiving benefits under the plan. Please read your entire Certificate carefully.

WHEN INSURANCE ENDS

Your insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date you cease to be in an eligible class
- the date insurance ends for your class
- the date you die
- the date this plan ends

A dependent's insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date the person ceases to be an eligible dependent under this plan
- the date your insurance ends
- the date you cease to be in a class that is eligible for dependent insurance
- the date dependent insurance ends for all members or for your class

CONTINUED INSURANCE

If your insurance ends because you cease to be in an eligible class, you may continue coverage for yourself and your dependents by submitting a written request to MetLife within 31 days. You must also make the first premium payment for continued insurance during this 31-day period. Your premium rate for continued insurance will be the same as the premium rate charged under the group plan. Increases or decreases in the group premium will apply to the premium you pay for continued insurance.

If elected, your continued insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date group insurance ends for the class that you are in
- the date group insurance ends for the class you were last in before obtaining continued insurance
- the date you die
- the date this plan ends

If elected, continued dependent insurance will end on the earliest of the following dates:

- the end of the period for which the last full premium has been paid
- the date the person ceases to be an eligible dependent under this plan
- the date your continued insurance ends for any reason
- the date dependent insurance ends for all members under the group insurance
- the date dependent insurance ends for the class that you are in
- the date dependent insurance ends for the class you were last in before obtaining continued insurance

At the end of the continuation periods listed above, if you resume membership in an eligible class at that time, you will continue to be insured under the group policy. If you do not resume membership in an eligible class at that time, your employment will be considered to end and your insurance and dependent insurance will end.

The preceding critical illness insurance benefits are insured under a contract issued by Metropolitan Life Insurance Company, 200 Park Avenue, New York, New York, 10166-0188. The services provided by MetLife include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your critical illness insurance coverage from MetLife. Its contents are subject to the provisions of the group insurance policy with Metropolitan Life Insurance Company, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the critical illness insurance plan, for specific questions about coverage.

UNUM LIFE INSURANCE COMPANY OF AMERICA

Accident Insurance

Accident Insurance will pay lump-sum benefits for covered injuries and expenses, including emergency room care and related surgery. This benefit can help offset your out-of-pocket expenses that medical insurance does not pay, including deductibles and co-pays.

WHO IS ELIGIBLE?

All Active and Associate HSTA Members and regularly scheduled employees of the Hawaii State Teachers Association working at least 17.5 hours per week are eligible to apply for coverage under the Accident Insurance Plan. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

DEPENDENT COVERAGE

As long as you are enrolled for coverage under the Accident Insurance Plan, your family members may also apply for coverage. Eligible family members are your legal spouse and unmarried children under 19 years of age.

The term "children" includes a natural child, an adopted child, a stepchild, or a foster child who is dependent upon you for financial support. Dependent children who are full-time students at an accredited school, college, or university will continue to be eligible for dependent coverage from 19 years of age through 22 years of age. In order for your dependent child to be covered as a full-time student, you must certify annually, and as requested by the Trust Office, that he or she is a full-time student at an accredited school, college, or university by completing the Student Certification form issued to you by the Trust Office. **Failure to submit the required certification will result in cancellation of the child's coverage.** You are also responsible for promptly notifying the Trust Office, in writing, of any change in your dependent's eligibility status outside the annual certification.

To add a new spouse or dependent child, you must submit an application for enrollment within 30 days of the date of marriage, birth, adoption, or legal guardianship. If you do not submit an enrollment application within this 30-day period, you must wait until the next open enrollment period to add your new dependent.

If your spouse is also an eligible participant, he or she cannot be covered as a "Spouse" but must apply for coverage as an individual member. If both you and your spouse are insured members, your children may be covered as dependents of either member, but not both.

EFFECTIVE DATE OF COVERAGE

Coverage becomes effective on the first day of the calendar month following the receipt of your completed enrollment form by the Trust Office.

CHANGES IN COVERAGE

Outside of your initial eligibility period, you can elect coverage and/or make a change in your benefit option only during the annual open enrollment period. You can cancel your coverage at any time by notifying the Trust Office in writing. Coverage for you and any enrolled family members will end on the first day of the month following the date of notification.

BENEFIT OPTIONS

You may elect either the **Gold Plan** or **Platinum Plan** benefit option for yourself and your covered dependents. Before making your selection, please review the current Schedule of Benefits and monthly premium amounts which may be obtained from the Trust Office. The following is a summary of covered injuries and benefits under the Accident Insurance Plan.

SCHEDULE OF BENEFITS

COVERED INJURIES	GOLD PLAN BENEFIT AMOUNT	PLATINUM PLAN BENEFIT AMOUNT
Fractures		
Open Reduction	$100 to $5,000	$150 to $7,500
Closed Reduction	$50 to $2,500	$75 to $3,750
Chips	25% of Closed Amount	25% of Closed Amount
Dislocations		
Open Reduction	$200 to $4,000	$300 to $6,000
Closed Reduction	$100 to $2,000	$150 to $3,000
Burns		
At least 10 square inches but less than 20 square inches	2nd degree - $0 3rd degree - $1,250	2nd degree - $0 3rd degree - $2,500
At least 20 square inches but less than 35 square inches	2nd degree - $0 3rd degree - $2,500	2nd degree - $0 3rd degree - $5,000
35 or more square inches of the body surface	2nd degree - $500 3rd degree - $7,500	2nd degree - $1,000 3rd degree - $10,000
Skin grafts for 2nd and 3rd degree burns	50% of Burn Benefit	50% of Burn Benefit
Skin graft for any other accidental traumatic loss of skin		
At least 10 square inches but less than 20 square inches	$75	$150
At least 20 square inches but less than 35 square inches	$125	$250
35 or more square inches of the body surface	$250	$500
Concussion	$100	$150
Coma	$5,000	$10,000
Ruptured disc	$600	$800
Knee cartilage		
Torn with surgical repair	$500	$750
Exploratory surgery or cartilage shaved, only	$100	$150
Laceration	$25 to $400	$25 to $600
Tendon/ligament and rotator cuff		
Surgical repair of one	$600	$800
Surgical repair of two or more	$900	$1,200
Exploratory surgery without repair	$100	$150

COVERED INJURIES	GOLD PLAN BENEFIT AMOUNT	PLATINUM PLAN BENEFIT AMOUNT
Dental work, emergency		
Extraction	$50	$100
Crown	$150	$300
Eye injury	$200	$300
EMERGENCY AND HOSPITALIZATION BENEFITS		
Ambulance		
Ground, once per accident	$200	$400
Air ambulance	$750	$1,500
Emergency room treatment	$100	$150
Emergency treatment in physician office or urgent care facility	$50	$75
Hospital admission once per covered accident	$750	$1000
Intensive care admission once per covered accident	$1,125	$1500
Hospital confinement per day up to 365 days	$100	$200
Intensive care confinement per day up to 15 days	$300	$400
Medical imaging test once per accident	$100	$200
Outpatient surgery facility service once per accident	$150	$300
Pain management epidural, once per accident	$50	$100
TREATIMENT AND OTHER SERVICES		
Surgery benefit		
Open abdominal, thoracic	$1,000	$1,500
Exploratory without repair	$100	$150
Hernia repair	$100	$150
Physician follow-up visit two visits per accident	$50	$75
Chiropractic visit up to three visits per calendar year	$15	$25

TREATIMENT AND OTHER SERVICES	GOLD PLAN BENEFIT AMOUNT	PLATINUM PLAN BENEFIT AMOUNT
Therapy services up to 10 per accident		
Occupational therapy	$15	$25
Speech therapy	$15	$25
Physical therapy	$15	$25
Prosthetic device or artificial limb		
One	$500	$750
More than one	$1,000	$1,500
Appliance once per accident	$50	$100
Blood, plasma, platelets	$300	$400
Travel due to accident Transportation of more than 50 miles from residence; 3 trips per accident; maximum of 1,200 miles per round trip	$0.30 per mile	$0.40 per mile
Lodging per night up to 30 days per accident	$100	$150
Rehabilitation unit confinement per day up to 15 days; maximum of 30 days per calendar year	$50	$100
ACCIDENTAL DEATH AND OTHER COVERED LOSSES		
Accidental death	***The accidental death benefit doubles** if the insured is injured as a fare paying passenger on a common carrier	***The accidental death benefit triples** if the insured is injured as a fare paying passenger on a common carrier
Employee	$25,000*	$50,000*
Spouse	$10,000*	$20,000*
Child	$5,000*	$10,000*
Initial accidental dismemberment one benefit per accident, not payable with initial accidental loss		
Loss of both hands or both feet	$5,000	$15,000
Loss of one hand and one foot	$5,000	$15,000
Loss of one hand or one foot	$2,500	$7,500
Loss of two or more fingers, toes or any combination	$750	$1,500
Loss of one finger or toe	$250	$750

ACCIDENTAL DEATH AND OTHER COVERED LOSSES	GOLD PLAN BENEFIT AMOUNT	PLATINUM PLAN BENEFIT AMOUNT
Catastrophic accidental dismemberment – loss of both hands or both feet, or loss of one hand and one foot once per lifetime, payable after fulfilling a 365-day elimination period; not payable with catastrophic loss		
Employee under age 65	$10,000	$100,000
Spouse and child	$5,000	$50,000
Employee age 65 through 69	$5,000	$50,000
Spouse and child	$2,500	$25,000
Employee age 70 or older	$2,500	$25,000*
Spouse and child	$1,250	$12,500
Accidental loss – paralysis, sight hearing and speech initial accidental loss - one benefit per accident, not payable with initial dismemberment		
Permanent paralysis	$5,000	$15,000
Loss of sight of both eyes	$5,000	$15,000
Loss of sight of one eye	$2,500	$7,500
Loss of hearing of one ear	$2,500	$7,500
Catastrophic accidental loss – permanent paralysis, or loss of hearing in both ears, or loss of the ability to speak, or loss of sight of both eyes once per lifetime, payable after fulfilling a 365-day elimination period; not payable with catastrophic dismemberment		
Employee under age 65	$10,000	$100,000
Spouse and child	$5,000	$50,000
Employee age 65 through 69	$5,000	$50,000
Spouse and child	$2,500	$25,000
Employee age 70 or older	$2,500	$25,000*
Spouse and child	$1,250	$12,500

EXCLUSIONS

Unum will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of:

- Participating in war or act of war, whether declared or undeclared;
- Committing acts of terrorism;
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test;

- Operating, learning to operate, serving as a crew member of or jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven. This exclusion does not include flying as a fare paying passenger;
- Engaging in hang-gliding, bungee jumping, sail gliding, parasailing, or parakiting;
- Participating or attempting to participate in a felony, being engaged in an illegal occupation or being incarcerated in a penal institution;
- Committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- Practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- Having any sickness or declining process caused by a sickness, including physical or mental infirmity including any treatment for allergic reactions. UNUM also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury.

In addition to the exclusions listed above, UNUM will also not pay the catastrophic accidental dismemberment or catastrophic accidental loss benefit for the following injuries that are caused by or are the result of:

- An insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician; or
- Injuries to a dependent child received during the birth.

HOW TO FILE A CLAIM

If an accident occurs, you must fill out an Accident Claim Form and send it to UNUM. Claim forms are available from the Trust Office. You must send UNUM the claim form no later than 90 days after the accident or as soon as it is reasonably possible to do so, but in no event more than one year after the time this proof is required.

Send the completed Accident Claim Form by mail or fax to:

The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158

Toll free Fax: 1-800-447-2498

Toll free number: 1-800-635-5597

For assistance call toll free Monday through Friday, 8:00 a.m. to 8:00 p.m. (Eastern Standard Time)

CLAIMS APPEALS PROCEDURES

If your claim is denied in whole or in part, you or your authorized representative may file an appeal within 90 days of receiving UNUM's notice of denial.

You have the right to:

- Submit a request for review, in writing, to UNUM;
- Upon request and free of charge, reasonable access to and copies of all documents relevant to your claim; and
- Submit written comments, documents, records and other information relating to your claim for benefits.

Send your written request for review and any other information relating to your claim to:

The Benefits Center
Appeals Unit
P.O. Box 9548
Portland, ME 04104-5058

Fax number: 1-207-575-2354

Toll free number: 1-800-635-5597

For assistance call toll free Monday through Friday, 8:00 a.m. to 8:00 p.m. (Eastern Standard Time)

UNUM will make a full and fair review of your claim and all information submitted by you whether or not presented or available at the initial claim determination. UNUM may require additional documents as it deems necessary or desirable in making such a review.

A final decision on review will be made not later than 60 days following receipt of your written request for review. If special circumstances require an extension of time for processing your request, UNUM may extend the review period by up to 60 days. You will be notified of the reasons for the extension and the date by which a decision is expected. If an extension is required due to your failure to submit information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you must provide it to UNUM. Extension of the review period will begin after the information has been provided to UNUM.

The final decision on review will be furnished in writing and shall include the reasons for the decision with reference to the policy provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Unless there are special circumstances, this administrative appeals process must be completed before you begin any legal action regarding your claim.

The preceding accident insurance benefits are insured under a contract issued by the UNUM Life Insurance Company of America, P.O. Box 9548, Portland, ME 04122-5058. The services provided by UNUM Life Insurance Company of America include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your accident insurance coverage from UNUM. Its contents are subject to the provisions of the group insurance policy with UNUM Life Insurance Company of America, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the accident insurance plan, for specific questions about coverage.

UNUM LIFE INSURANCE COMPANY OF AMERICA

Long-Term Care Insurance

WHO IS ELIGIBLE?

If you are an HSTA Member **and** a Trust participant covered under at least one (1) of the Trust's insurance benefit plans other than the Long-Term Care Insurance Plan, you and your family members are eligible to apply for coverage under the Long-Term Care Insurance Plan.

BASE COVERAGE FOR ACTIVE PARTICIPANTS

If you are an Active Trust Participant working a minimum of 17.5 hours per week, you will be automatically enrolled for Base Coverage at no cost to you. The Base Coverage is as follows:

Elimination (Waiting) Period ..... 90 consecutive days

Monthly Benefit Maximums*
Long Term Care Facility $1,000
Assisted Living Facility $600
Professional Home Care Services $500

Lifetime Maximum Amount* $36,000

In addition to the Base Coverage, you may also apply for Additional Buy-Up Coverage described on following pages. However, you are responsible for the cost of all Additional Buy-Up Coverage. If you apply for Additional Buy-Up Coverage during an open enrollment period, you will not be required to furnish information on your health status. If you apply at any other time, you must submit information on your health status and the insurance company has the right to decide whether to accept or deny your request for coverage.

BASE COVERAGE FOR RETIRED PARTICIPANTS

If you are a Retired Trust Participant under age 85, you will be enrolled for Base Coverage at no cost to you after you have completed a questionnaire and the insurance company determines that you are not disabled at the time of enrollment. (**Note**: If you are currently a Retired Trust Participant but enrolled in the plan when you were an Active Trust Participant and have had continuous coverage, you will continue to have the coverage described for Active Trust Participants). The Base Coverage for Retired Trust Participants is as follows:

Elimination (Waiting) Period ..... 90 consecutive days

Monthly Benefit Maximums*
Long Term Care Facility $1,000
Assisted Living Facility $600
Professional Home Care Services $500

Lifetime Maximum Amount* $24,000

In addition to the Base Coverage, you may also apply for Additional Buy-Up Coverage described on the following pages. However, you are responsible for the cost of all Additional Buy-Up Coverage. You will be required to furnish information on your health status and the insurance company has the right to decide whether to accept or deny your request for coverage.

DEPENDENT COVERAGE

As long as you are enrolled for coverage under the Long-Term Care Insurance Plan, your family members may also apply for coverage. Eligible family members are your spouse, your children, your parents, stepparents, siblings, parents-in-law, grandparents, and grandparents-in-law. All family members applying for coverage must be between the ages of 18 and 84. All applications for coverage of

your family members must include information on health status and the insurance company has the right to decide whether to accept or deny such requests for coverage. At a minimum, eligible family members must apply for the Base Coverage and you or your family member will be responsible for the entire cost of dependent coverage.

ADDITIONAL BUY-UP COVERAGE OPTIONS

You and your enrolled family members may apply for Additional Buy-up Coverage as described below. You or your family members are responsible for the entire cost of Additional Buy-up Coverage.

1. Increased Monthly Benefit Maximum*

Long Term Care Facility Benefit	Additional $500 increments, Up to a Total Monthly Benefit Maximum of $8,000

Note: Your Assisted Living Facility Monthly Benefit Maximum will be 60% of the Long Term Care Facility Monthly Benefit. Your Professional Home Care Services Monthly Benefit Maximum will be 50% of the Long Term Care Facility Monthly Benefit.

2. Total Home Care

If you choose this option, those services covered under Professional Home Care Services may also be provided by an informal caregiver, such as a friend or relative.

3. 5% Annual Simple Growth Inflation Protection

Example: A monthly benefit amount of $1,000 will be increased:

A. By $50 on January 1st of the next calendar year; and

B. By another $50 on each following January 1st.

If you choose this option, as long as your coverage remains in effect, these inflation increases will occur automatically regardless of your health or whether or not you are disabled. If you decline the inflation option at the time you apply for any coverage, you cannot add it to that coverage at a later date.

* Your Monthly Benefit Maximum and Lifetime Maximum Amount will be adjusted to include any inflation option increases, if applicable.

4. Non-Forfeiture Benefit

If you choose this option and your premium payments stop after your coverage has been in force (you were continuously covered) for at least three years, your coverage will continue automatically with the same level of benefits, except for a reduction in your Lifetime Maximum Amount. Your Lifetime Maximum Amount under this option will be equal to the total premium paid up to the date you stopped paying premiums. In no event will the Lifetime Maximum Amount be less than one Long Term Care Facility monthly benefit payment amount or exceed that which would have been paid had you not stopped paying premiums. No inflation protection increases, if applicable, will be made after the end of the period for which your premium payments stop.

5. Increased Lifetime Maximum Amount* (Applies to all Long Term Care benefits)

If you choose this option, you may elect to increase the Lifetime Maximum Amount to:

A. If you are an Active Trust Participant (or eligible family member)

1. 36 times the “Long Term Care Facility” Amount; or
2. 48 times the “Long Term Care Facility” Amount; or
3. 72 times the “Long Term Care Facility” Amount

B. If you are a Retired Trust Participant (or eligible family member)

1. 24 times the "Long Term Care Facility" Amount; or
2. 36 times the "Long Term Care Facility" Amount; or
3. 60 times the "Long Term Care Facility" Amount

WHEN YOU ARE ELIGIBLE FOR A MONTHLY BENEFIT

You are eligible for a Monthly Benefit after all of the following are met:

1. You become disabled; and
2. You are receiving services in a Long Term Care Facility or Assisted Living Facility or Professional Home Care Services (or Total Home Care if your plan includes a Total Home Care Benefit); and
3. You have satisfied your 90-day Elimination Period; and
4. A physician has certified that you are disabled. "Disabled" means you are unable to perform (without substantial assistance from another individual) two or more Activities of Daily Living (ADL) for a period of at least 90 days, or you require substantial supervision by another individual to protect you and others from threats to health or safety due to severe cognitive impairment. You will be required to submit a physician certification every 12 months.

The treatment and services you receive for your disability must be provided in accordance with a written plan of care developed by a licensed health care practitioner.

Important

If you have a loss of Activities of Daily Living (ADL) or severe cognitive impairment before your effective date of coverage, that loss or impairment will never be covered, unless you completely recover from that loss or impairment.

DEFINITIONS AND BENEFITS

Activities of Daily Living (ADL)

Activities of Daily Living (ADL) are:

1. **BATHING** - Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.
2. **DRESSING** - Putting on and taking off all items of clothing, any necessary braces, fasteners, or artificial limbs.
3. **TOILETING** - Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
4. **TRANSFERRING** - Moving into or out of bed, chair, or wheelchair with or without equipment such as canes, walkers, crutches or grab bars or other supportive devices including mechanical or motorized devices.
5. **CONTINENCE** - The ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
6. **EATING** - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Bed Reservation Benefit

If you are receiving a Long Term Care Facility or Assisted Living Facility monthly benefit and your stay in the Facility is interrupted because you are hospitalized, UNUM will continue to pay the monthly benefit if a charge is made to reserve your accommodations in the facility, up to a maximum of 15 days per calendar year.

Elimination Period

The “Elimination Period” is the number of consecutive days during which you must be disabled and under the regular care of a Physician before benefits become payable.

Professional Home Care Services

Each calendar week that you receive at least one day of these services will be counted as seven days towards completing the Elimination Period. However, if you do not receive these services for at least one day within a calendar week, the Elimination Period will begin again.

The amount of your monthly benefit will be based on the coverage options you chose.

For Professional Home Care Services, the benefit payment will be based on the number of days you receive these services each month. A monthly benefit payable for less than one month will be paid at 1/30th of the monthly benefit amount for each day you are eligible for a monthly benefit.

Recurrent Disability

You will not have to complete a new Elimination Period if you become disabled again after the date UNUM stopped making monthly benefit payments to you for your previous disability.

Rehabilitation and Alternative Care Plans

While you are disabled, UNUM may contact you to suggest special services and/or equipment designed to help you regain the ability to independently perform the Activities of Daily Living. The use of such services/equipment must be medically necessary and appropriate for your disability and provided pursuant to a written plan of care developed by a licensed health care practitioner. The services/equipment must be intended to assist you in living at home or other residential housing by eliminating your need for substantial assistance. The services or equipment cannot be covered by other insurance or Medicare. The terms of an alternate care plan and the actual expenses that UNUM will pay will be subject to written mutual agreement between UNUM, you, and your Physician.

If, for any reason, you do not wish to participate in an Alternate Care Plan, your benefits will continue according to the coverage options you chose.

Respite Care Benefits

Care provided to you for a short period to allow your informal caregiver a break from his or her care giving responsibilities. Respite care may be provided to you by a formal caregiver, such as a Home Health Care Provider, Adult Day Care Facility, registered nurse, licensed practical nurse, or an informal caregiver, such as a friend or relative.

If you are not yet receiving monthly Home Care payments because you: 1) have not yet completed the Elimination Period or 2) have completed the Elimination Period but have chosen to postpone receipt of benefits in order to preserve your Lifetime Maximum Amount, you may request UNUM to pay you a benefit equal to 1/30th of your home care benefit for each day that you receive respite care up to a maximum of 15 days per calendar year. Respite care payments made to you count toward your Lifetime Maximum Amount.

Waiver of Premium

Once benefits become payable, there will be no more cost for your coverage as long as you are disabled. If you do not receive Professional Home Care Services for a period of 30 consecutive days, premium payments will again become due. If benefits are no longer payable, you ***must*** resume premium payments to continue your coverage. Premiums are ***not waived*** while you are receiving a payment for respite care.

WHEN MONTHLY BENEFITS END

Monthly benefit payments will end on the earliest of the following dates:

1. The date you are no longer disabled;
2. The expiration of your Physician certification;
3. The date you are no longer eligible for a monthly benefit under the coverage you chose;
4. The date your total benefit payments equal the Lifetime Maximum Amount; or
5. The date you die.

CHANGES IN COVERAGE

You can apply at any time to increase your coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance Evidence of Insurability (EOI) form. Your request is subject to approval by UNUM. If approved, the premium rate to be paid for the new coverage is based on your insurance age. To determine your insurance age, subtract your date of birth from your date of application for the increase in coverage.

CONTINUATION OF COVERAGE

If you become ineligible for coverage under the HSTA Voluntary Employees Beneficiary Association Trust's Long-Term Care Insurance Plan, you may elect converted coverage which means that the same coverage you had under this Plan can continue on a direct billing basis. You may not elect converted coverage if your coverage ended because you stopped paying premiums or if you are not insured under this Plan. Election of converted coverage must be made within 31 days of termination of your eligibility for coverage under the Trust.

HOW TO FILE A CLAIM

If you become disabled, you must fill out a Long Term Care Claim Form and send it to UNUM. Claim forms are available from the Trust Office. You must send UNUM the claim form no later than 90 days after the date you become disabled or as soon as it is reasonably possible to do so, but in no event more than one year after the time this proof is required.

You will be required to give UNUM information on your continued disability, when requested. UNUM may also require a claims assessment, which is a review done by UNUM to help in evaluating the disability. A face-to-face interview or examination by a Physician may also be required. If required, however, UNUM will pay for the cost of the interview or examination.

EXCLUSIONS

Coverage is not provided for:

- Disability caused by war (whether declared or not) or any act of war;
- Disability caused by attempted suicide (while sane or insane) or self-destruction;
- Disability caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law;
- Disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days;
- Disability caused by alcoholism or alcohol abuse;
- Disability caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a Physician ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments thereto);
- Periods in which you are confined in a hospital other than if you are confined in a nursing facility that is a distinctly separate part of a hospital, (this exclusion does not apply to those periods covered under the Bed Reservation Benefit).

The preceding long-term care insurance benefits are insured under a contract issued by UNUM Life Insurance Company of America, P.O. Box 9548, Portland, ME 04122. The services provided by UNUM Life Insurance Company of America include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary provided to help you understand your long-term care insurance coverage from UNUM. Its contents are subject to the provisions of the group insurance policy with UNUM Life Insurance Company of America, and all amendments thereto, which contain all the terms and conditions of coverage and benefits. These documents are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. If the terms of the preceding Plan summary differ from the policy documents, the policy will govern. Please refer to the policy documents and your Certificate of Insurance, which you received when you enrolled in the long-term care insurance plan, for specific questions about coverage.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The HSTA Voluntary Employees Beneficiary Association Trust is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, to maintain the privacy of your health information. The Trust and its business associates may use or disclose your health information for the following purposes:

- Treatment;
- Payment;
- Health plan operations and plan administration; and
- As permitted or required by law.

Other than for the purposes stated above, your health information will not be used or disclosed without your written authorization. If you authorize the Trust to use or disclose your health information, you may revoke that authorization at any time in writing.

Under HIPAA, you have the following rights regarding your health information. You have the right to:

- Request restrictions on certain uses and disclosure of your health information;
- Receive confidential communications of your health information;
- Inspect and copy your health information;
- Request amendment of your health information if you believe your health records are inaccurate or incomplete; and
- Request a list of certain disclosures by the Trust of your health information.

You also have the right to make complaints to the Trust as well as the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to: *Privacy Officer, HSTA Voluntary Employees Beneficiary Association Trust Office, 1259 Aala Street, Suite 202, Honolulu, Hawaii 96817.* You will not be retaliated against, in any way, for filing a complaint.

The Trust has designated Benefit Plan Solutions, Inc. as the Trust's Privacy Officer and as its contact person for all issues regarding patient privacy and your privacy rights. For a copy of the privacy notice which provides a complete description of your rights under HIPAA's privacy rules, contact the Trust's Privacy Officer at *1259 Aala Street, Suite 202, Honolulu, Hawaii 96817, phone: 440-6940 (Oahu) or 1(800) 637-4926 (Neighbor Islands), Monday through Friday, 8:00 a.m. to 5:00 p.m.*

For any questions or complaints regarding your health information and privacy rights related to the plans listed below, contact the following:

Life Insurance Plan

Pacific Guardian Life Insurance Company, Ltd.
1440 Kapiolani Boulevard, Suite 1700
Honolulu, Hawaii 96814
Attn: Group Department

Short-Term Disability Income Protection Insurance Plan

American Fidelity Assurance Company
9000 Cameron Parkway
Oklahoma City, Oklahoma 73114
Attn: Chief Compliance Officer/HIPAA

Long-Term Income Protection Insurance Plan

Hartford Life and Accident Insurance Company
Attn: Privacy Officer
33 New Montgomery Street
San Francisco, CA 94105
Attn: Employee Benefits Department Manager

Critical Illness Insurance Plan

MetLife Privacy Office
P.O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

Accident Insurance Plan

Privacy Officer
UNUM Group
211 Congress Street, B267
Portland, ME 04122

Long-Term Care Insurance Plan

UNUM Life Insurance Company of America
Attn: Privacy Officer
Long Term Care Quality Review – C467
211 Congress Street, M347
Portland, ME 04122

CLAIMS AND APPEALS PROCEDURE

If your claim or that of your dependent(s) for any benefit is wholly or partially denied by the Plan Administrator or insurance carrier, you will be provided with a written determination explaining the reasons for the denial.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

You can designate another person to act on your behalf in the handling of your benefit claims. In order to do so, you must complete and file a form with the Plan Administrator and/or the insurance carrier that identifies the individual that is authorized to act on your behalf as your authorized representative. If you designate an authorized representative to act on your behalf, all correspondence and benefit determinations will be directed to your authorized representative, unless you direct otherwise. You may also request that this information be provided to both you and your authorized representative.

INSURED CLAIMS

Life insurance benefits are provided through Pacific Guardian Life Insurance Company. Short-Term Disability Income Protection Insurance benefits are provided through American Fidelity Assurance Company and Long-Term Income Protection Insurance benefits are provided through Hartford Life and Accident Insurance Company. Critical Illness Insurance benefits are provided through Metropolitan Life Insurance Company. Accident Insurance and Long-Term Care Insurance benefits are provided through Unum Life Insurance Company. If you have any questions regarding the claims and appeals procedures for these insured plans, contact the carrier at the address listed below.

Life Insurance Plan

Pacific Guardian Life Insurance Company, Ltd.
1440 Kapiolani Boulevard, Suite 1700
Honolulu, Hawaii 96814
Attn: Group Claims Department

Short-Term Disability Income Protection Insurance Plan

American Fidelity Assurance Company
AFES Benefits Department
P.O. Box 25160
Oklahoma City, Oklahoma 73125-0160

Long-Term Income Protection Insurance Plan

Benefit Management Services
Sacramento Disability Claim Office
The Hartford
P.O. Box 14302
Lexington, Kentucky 40512-4302

Critical Illness Insurance Plan

Metropolitan Life Insurance Company
Critical Illness Insurance Service Center
P.O. Box 6120
Scranton, PA 18505-9972

Accident Insurance Plan

UNUM Life Insurance Company of America
The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158

Long-Term Care Insurance Plan

UNUM Life Insurance Company of America
Attn: Benefits Center Compliance Department
P.O. Box 9548
Portland, ME 04122

OTHER APPEALS

The Trust Office serves as the Plan Administrator of the HSTA Voluntary Employees Beneficiary Association Trust and maintains the records regarding your eligibility for benefits. Questions regarding enrollment, change in employee status, or change in dependent coverage should be directed to the Trust Office. Any disagreement regarding your eligibility status or the status of your dependent that cannot be resolved by the Plan Administrator may be submitted to the Board of Trustees for review.

You have the right to appeal any decision of the Plan Administrator based on Plan rules adopted by the Board of Trustees (e.g., denial of eligibility or loss of eligibility) by filing a written request for review with the Board of Trustees. Your written request should be filed within 60 days after notification of the Plan Administrator's decision and describe your version of the facts and reasons why you feel that the decision was not proper. You should submit any documents, records, and other information in support of your claim not already furnished to the Plan. If you wish, you (or your authorized representative) may review and obtain copies of all Plan documents, records, and other information relevant to your claim, free of charge.

Upon receipt of your written request for review, the Board of Trustees (or a sub-committee thereof) will review your case and take into account all evidence submitted by you (or your authorized representative), without regard to whether such evidence was submitted or considered in the initial claim determination. The Board of Trustees (or a subcommittee thereof) will determine whether or not a hearing will be held on your case. If a hearing is to be held, you will be notified of the time and place at least two weeks in advance of the hearing (unless you agree in writing to a shorter notice period). You and/or your authorized representative may appear at the hearing.

The Board of Trustees (or sub-committee thereof) will render its decision within 60 days after receipt of your written request, unless special circumstances require an extension of time for processing your request, in which case the decision shall be rendered as soon as possible, but not later than 120 days after receipt of your written request. If an extension is required, the Board of Trustees (or sub-committee thereof) will notify you, in writing, prior to the end of the initial 60-day review period and indicate the special circumstances that make the extension necessary and the date by which a decision is expected.

The decision of the Board of Trustees (or sub-committee thereof) will be written in clear, easily understood language and provide the reasons for their decision and the specific Plan provisions that support it. If you disagree with the decision on review, you may file suit in Federal or state court. If your suit is successful, the court may award you legal costs, including attorneys' fees.

The preceding is for informational purposes only, and is a summary of the claims and appeals procedure in general. This summary is subject to the provisions of the Plan Documents and all amendments made thereto, which are on file with the HSTA Voluntary Employees Beneficiary Association Trust Office. In the event of a conflict between the information contained in this booklet and the Plan Documents, the Plan Document will control. Please refer to these documents for specific questions about claims and appeals procedure.

STATEMENT OF ERISA RIGHTS

As a participant in the HSTA Voluntary Employees Beneficiary Association Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.